State of Nevada
Governor's Finance Office
Division of Internal Audits

Audit Report

Nevada Department of Veterans Services

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Southern Nevada State Veterans Home

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Improving procedures will strengthen the operating environment of the department.

DIA Report No. 25-02
October 29, 2024

EXECUTIVE SUMMARY
Nevada Department of Veterans Services
Southern Nevada State Veterans Home

Objective: Improve Operations of the Southern Nevada State Veterans Home

As of July 1, 2024, over $1 million was more than 90 days past due to the Nevada Department of Veterans Services (NDVS) from Southern Nevada State Veterans Home (South Home) residents, none of which had been submitted to the State Controller. The majority of past due balances are the responsibility of residents that never pursued Medicaid coverage, while the remaining balances are the responsibility of residents that were either approved for Medicaid but denied retroactive coverage or were denied Medicaid coverage altogether.

Statute designates the State Controller as the state's collection agent and mandates that state agencies submit their past due debts to the State Controller once those debts are 60 days past due. Submitting past due debts will allow the State Controller to begin collection efforts, improve financial reporting, and bring NDVS in compliance with statutes.

NDVS faces certain challenges with accounts receivable and the accumulation of resident debt that are inherent to operating a state veterans home. Among these challenges are the fact residents do not become eligible for Medicaid coverage until they have resided in the home for 30 consecutive days. The process to apply and qualify for Medicaid can sometimes take a year or more to finalize, during which time the residents accumulate a balance.

NDVS has an MOU with the State Controller's Office that provides an exemption to the 60-day requirement for collections for balances associated with a pending Medicaid application. The MOU lacks detailed instructions, such as a reasonable time frame for submitting past due Private Pay debt or a mandate for NDVS to designate the balances of residents denied Medicaid coverage as Private Pay. Clarifying this information by revising debt submission guidelines in an updated MOU would help NDVS better understand its responsibilities in the debt collection process and provide NDVS with guidance to better manage its accounts receivable.

Recording South Home accounts receivable (AR) in accordance with governmental generally accepted accounting principles (GAAP) will comply with statute and ensure AR balances are accurately recorded. Prepayments received from residents and refunds due to residents are being recorded as credits to AR, which is an incorrect accounting method. GAAP considers these transactions to be liability account transactions. Crediting AR results in an inaccurate reflection of financial assets due to the home.

The fiscal year-end AR balances from state agencies are compiled into the statewide AR balance; therefore, the inaccurate South Home AR balance leads to an inaccurate statewide AR balance.

Statute requires GAAP to be followed throughout the accounting process, at both the agency level and the state level. Implementing a process to record prepayments to either a liability account or to the residents' individual trust fund accounts, while promptly correcting any refunds credited to AR by the system, would ensure compliance with statutory requirements and improve the reliability of financial reports.

The South Home application for admission does not mention Medicaid, and Admissions Coordinators are only expected to verbally discuss Medicaid eligibility and coverage when it is highly likely the applicant will need coverage following admission screening procedures. Approximately $228,000 of past due debt is owed by residents denied Medicaid coverage, which is usually the result of discovering a disallowed transfer of assets in the past five years. Including Medicaid information in the admission application will increase transparency with South Home applicants by providing a better opportunity to disclose important Medicaid eligibility information. Addressing Medicaid as part of the admission process would prevent issues arising long after a resident's admission, which are generally a byproduct of the stringent eligibility requirements for Medicaid coverage.

Medicaid applications are currently submitted 30 days or later from a resident's move-in date, due to the requirement that residents be institutionalized for 30 consecutive days to qualify. Late submission is unavoidable in some cases, such as when a resident requires care for much longer than anticipated. Otherwise, applications can be processed early if the applicant's physician states the applicant is likely to be in the institution at least 30 consecutive days. Obtaining this information from the applicant's physician will allow the South Home to be proactive in preparing Medicaid applications. Submitting Medicaid applications at the start of the admission process and training staff on updated procedures will ensure Medicaid-related issues are addressed in a timely manner, improving both transparency and financial outcomes for residents and NDVS, and will expedite Medicaid appeals and limit accumulated debt.

The South Home has experienced high staff attrition since the COVID-19 pandemic. Recent research concluded the state needs an additional 4,000 nurses to meet the national population-to-RN ratio, while also asserting 67% of the state's population reside in primary medical care health professional shortage areas. Joining the Nurse Licensure Compact (NLC) will enhance Nevada's disaster preparedness and increase access to healthcare by increasing the pool of medical providers permitted to provide care within the state. Membership in the NLC will make Nevada competitive with other states, as Nevada is one of only four states that have not joined the compact or have pending legislation to do so.

Increasing the pool of healthcare providers would support recent state legislation. Assembly Bill 292, enacted during the 2015 Legislative session, declared it is the public policy of the state to encourage and facilitate the provision of services through telehealth to improve public health and the quality of healthcare provided to patients. Senate Bill 375, enacted in 2023, appropriated $10 million per fiscal year in 2024 and 2025 to the Nevada System of Higher Education to expand undergraduate and graduate nursing programs.

Unlike NLC member states, Nevada had to await an emergency directive to employ nurses from out of state during the COVID-19 pandemic, which took approximately three weeks from the initial declaration of a nationwide emergency. The directive allowed providers to practice without being vetted or receiving board approval, potentially enabling providers with a revoked license in another state to practice undetected in Nevada. In contrast, Nurses with an NLC license have been subject to stringent uniform requirements of the compact that include a fingerprint criminal background check. The compact also facilitates the exchange of information in the areas of nurse regulation, investigation, and adverse actions between member states.

In 2015, the Nevada Legislature adopted legislation to join the Interstate Medical Licensure Compact (IMLC), making Nevada one of the first member states when the IMLC became operational in 2017. The IMLC applies to medical doctors, but not to nurses. Like the NLC, the IMLC was implemented to reduce regulatory burdens to practicing medicine across state lines and increase mobility of licensed physicians. Data shows that IMLC licenses accounted for over half of the physician licenses issued in the state, suggesting a preference for multi-state licensure versus single-state licensure.

Nurses who travel for work are able to earn a much higher salary, increasing the appeal of a multi-state license. Nevada is at a disadvantage by offering only a single-state nursing license. As a direct stakeholder, NDVS has a vested interest in making efforts to modernize and advance the healthcare profession in Nevada.

INTRODUCTION

At the direction of the Executive Branch Audit Committee, the Division of Internal Audits (DIA) conducted an audit of the Nevada Department of Veterans Services (NDVS). The audit focused on the operations of the Southern Nevada State Veterans Home. The audit scope and methodology, background, and acknowledgments are included in Appendix A.

DIA's audit objective was to develop recommendations to:

- ✓ Improve Operations of the Southern Nevada State Veterans Home.

Nevada Department of Veterans Services Response and Implementation Plan

DIA provided draft copies of this report to NDVS for review and comment. DIA considered NDVS' comments in the preparation of this report; NDVS' response is included in Appendix B. In its response, NDVS accepted the recommendations. Appendix C includes a timetable to implement the recommendations.

NRS 353A.090 requires within six months after the final report is issued to the Executive Branch Audit Committee, the Administrator of the Division of Internal Audits shall evaluate the steps NDVS has taken to implement the recommendations and shall determine whether the steps are achieving the desired results. The Administrator shall report the six-month follow-up results to the committee and NDVS.

The following report (DIA Report No. 25-02) contains DIA's *findings, conclusions,* and *recommendations*.

Improve Operations of the Southern Nevada State Veterans Home

The Nevada Department of Veterans Services (NDVS) can improve operations of the Southern Nevada State Veterans Home (South Home) by:

- Submitting applicable past due debts to the State Controller for collections;
- Pursuing an updated MOU with the State Controller's Office;
- Recording accounts receivable in accordance with GAAP;
- Revising the admission application to include Medicaid information;
- Submitting the Medicaid application at the start of the admission process and training staff on the updated admission processes; and
- Seeking a BDR to join the Nurse Licensure Compact.

Improving operations of the South Home will enhance financial management through timely debt collections, ensure adherence to GAAP for accurate financial reporting, and proactively address staffing challenges by expanding access to the labor market of qualified nurses.

Submit Applicable Past Due Debts to the State Controller for Collections

The Nevada Department of Veterans Services (NDVS) should submit applicable past due debts to the State Controller. Nevada Revised Statutes (NRS) designate the State Controller as the state's collection agent and mandate that state agencies submit their past due debts to the State Controller.[1] Submitting past due debts will allow the State Controller to begin collection efforts on past due accounts receivable, improve financial reporting, and bring NDVS in compliance with statutory requirements. Additionally, submitting the debts for collections will allow NDVS to write off uncollectable accounts receivable that should no longer be recognized.

Over $1 Million in Past Due Accounts Receivable

At the close of fiscal year 2024, over $1 million in Private Pay balances owed to NDVS from Southern Nevada State Veterans Home (South Home) residents was 90 or more days past due. Private Pay balances are those not covered by the U.S. Department of Veterans Affairs (VA) or another third-party payor and are the responsibility of the resident. Approximately $983,000 of the past due balance had been outstanding for more than 209 days, with some individuals' debt outstanding for more than six years. Exhibit I shows the past due debt by periods outstanding and origin of the debt.

[1] NRS 353C.195(1) and (2).

Exhibit I

Past Due Debt

Origination	Past Due 90 to 209 Days	210 Days or More Past Due	Total 90 Days or More
Private Pay from Day One	$ 22,352.90	$ 631,728.89	$ 654,081.79
Medicaid Denied	$ 2,157.94	$ 225,732.45	$ 227,890.39
Preceding Medicaid Approval	$ 105.61	$ 125,630.07	$ 125,735.68
Gross Total Past Due	$ 24,616.45	$ 983,091.41	$ 1,007,707.86

Source: DIA analysis of NDVS accounts receivable balances.

The Private Pay from Day One balances are owed by residents that never pursued or obtained Medicaid coverage. The Medicaid Denied balances are due from residents that were denied Medicaid coverage after incurring the costs associated with residing in the home. The Preceding Medicaid Approval balances are due from residents that were approved for Medicaid moving forward, but not for retroactive coverage.

Several Payors Cover South Home Charges

The South Home accepts payment from several payor sources. The foremost of those sources is the VA. The VA covers the entire cost of care, including room and board plus medical expenses, for eligible veterans that have been diagnosed with a service-connected disability rated 70% or higher.[2] The VA pays a daily basic per diem for all other veterans eligible to reside in the South Home, which is the lesser of the posted rate or half the cost of care. For those residents not receiving full coverage from the VA, the South Home accepts insurance, including Medicare, Medicaid, and private insurance. Balances not covered by the VA or another third-party payor are Private Pay balances.

Medicaid covers a resident's room and board charges; however, this coverage is a distinct type of Medicaid. Long-term care Medicaid, or Institutional Medicaid, is separate from regular Medicaid and comes with much stricter eligibility requirements. Any references to regular Medicaid in this report will use the term "regular Medicaid." Long-term care Medicaid and Institutional Medicaid are referred to as Medicaid throughout this report. Statute stipulates that individuals must be institutionalized in a medical or nursing facility for no less than 30 days to qualify for this type of Medicaid coverage.[3]

Strict income and asset limits must be met to qualify for Medicaid coverage. Applicants are generally allowed to retain certain exempt personal property, such as an automobile, furnishings, and a primary residence. Non-exempt assets, such as cash, stocks, or a non-primary residence, will render the applicant ineligible when the total value is above the state-imposed $2,000 asset limit.

[2] Disability rating percentage represents how much the individual's disabilities decrease their overall health and ability to function.
[3] NRS 422.272(1)(a).

Medicaid Application Process Can
Take an Extended Period of Time

The application process for Medicaid can take an extended period of time for many reasons. In particular, applications are not being submitted until the applicant has resided in the home for 30 days at the earliest. The process can be extended further by human error, appeals of denied applications, and requests for additional information from the Department of Health and Human Services, Division of Healthcare Financing and Policy (DHCFP). During the approval process, residents are considered in "Medicaid Pending" status. Those residents are still charged the costs of residing at the home while their application is pending, though payment to the South Home is deferred until Medicaid is approved.

DHCFP imposes a 60-month "look-back" period, during which the agency investigates whether the applicant gifted or transferred ownership of non-exempt assets or sold assets for less than fair market value.[4] The applicant is deemed ineligible for Medicaid coverage if any disallowed transfers of assets are found during the previous 60 months. A Medicaid applicant ultimately denied coverage is responsible for charges incurred.

State Controller Designated the State Collection Agent

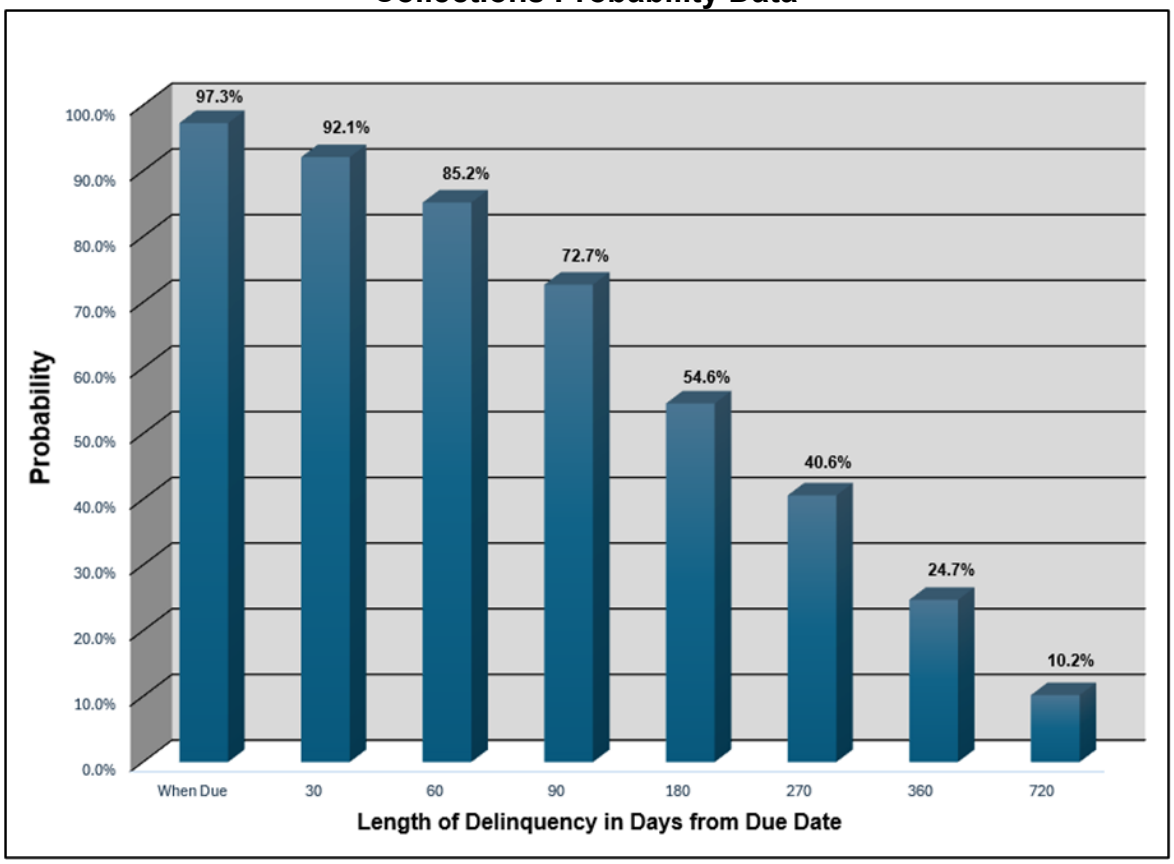
In 2009, the Legislature passed Assembly Bill (AB) 87 to amend NRS 353C, requiring state agencies to assign past due debts to the State Controller for collections. Prior to amending the law, submission of past due debts was voluntary, and state agencies were free to conduct their own collection efforts. Moreover, agencies were allowed to submit past due debts to the State Controller at their discretion. In 2009, the State Controller found this arrangement to be ineffective.

As part of a presentation given during the 2009 legislative session, the State Controller asserted the probability of collections significantly decreases the longer debt remains delinquent. The average age of debt being submitted for collection was 486 days old, or 722 days when omitting the Department of Motor Vehicles (DMV) from the average.[5] Collections probability data submitted with the State Controller's presentation is shown in Exhibit II.

[4] Selling assets, transferring ownership, or gifting assets is collectively referred to in this report as "transferring assets" or "asset transfers."
[5] DMV debt was recognized as an outlier due to having a relatively high collection rate – a reflection of a debtor's need to obtain a license and register a car.

Exhibit II

Collections Probability Data



Source: February 25, 2009, Assembly Committee on Government Affairs meeting minutes.

The argument that state agencies were not adequately conducting their own debt collection efforts was successful and AB 87 was enacted to amend NRS 353C, requiring state agencies turn over any debts that have been outstanding for 60 or more days to the State Controller.

Statute Requires Agencies to Assign Debts to State Controller

NRS 353C.195 requires state agencies coordinate all debt collection efforts through the State Controller. Unless a different timeframe has been agreed upon, those debts must be assigned for collection no later than 60 days after the debts become past due. The State Controller must determine the agency has the resources to engage in its own debt collection efforts or has shown good cause for the requirement to be waived.

The Accounts Receivable Policies and Procedures manual issued by the State Controller's Office (SCO) directs agencies to prepare monthly billings for balances owed to the agency. Once an outstanding balance becomes 30 days past due, the agency must issue a first request for payment letter. At 60 days past due, the agency must issue a final request for payment letter, then submit the delinquent account to the State Controller for collection. Alternative arrangements can be

made for agencies identifying a conflict between the collections policy and the unique circumstances of their accounts receivable. Alternative arrangements are documented in a Memorandum of Understanding (MOU) with the SCO.

Past Due Debt Has Not Been Assigned to the State Controller

To date, NDVS has not assigned past due debt to the State Controller in accordance with state law and the SCO's Debt Collection Policies and Procedures. The longer individual debts are outstanding, the lower the likelihood of collection becomes. It is unlikely the State Controller will be able to collect on most debts exceeding 210 days past due; however, there is no chance of collecting when no action is taken. Submitting debt to the State Controller to begin collection efforts will increase the likelihood of recovering some of the debt owed to NDVS.

Uncollectible Accounts Receivable Should Be Written-Off

As discussed later in this report, state agencies are required to record accounts receivable in accordance with governmental Generally Accepted Accounting Principles (GAAP). GAAP considers leaving uncollectable past due debts in accounts receivable an overstatement of financial assets.

NDVS needs to write off debt balances deemed uncollectable in order to comply with GAAP, but accounts receivable may not be written-off until approved by the State Board of Examiners (BOE). Pursuant to statute, the State Controller may request the BOE designate a debt as bad debt (i.e. an uncollectable account) after the State Controller determines that it is impossible or impractical to collect.[6] Assigning past due debts to the State Controller will initiate the process necessary to write off uncollectable accounts receivable.

Conclusion

State agencies must submit past due debts to the State Controller for collection to comply with state law and must write off the debt balances deemed uncollectable to comply with GAAP. Over $1 million in Private Pay accounts receivable balances have not been referred to the State Controller and remain uncollected. Submitting these debts to the State Controller will comply with statutes, increase the likelihood of collection, and ensure NDVS can begin the process of writing off uncollectible accounts, thereby preventing overstatement of financial assets.

Recommendation

1. Submit applicable past due debts to the State Controller for collections.

[6] NRS 353C.220(1).

Pursue an Updated MOU with the State Controller's Office

The Nevada Department of Veterans Services (NDVS) should pursue an updated Memorandum of Understanding (MOU) with the State Controller's Office (SCO) for the treatment of past due accounts receivable. An updated MOU can provide detailed guidance to NDVS to navigate the unique circumstances involved in managing its accounts receivable. The current MOU does not identify a reasonable time frame for submitting past due Private Pay debt to the SCO nor does it instruct NDVS to designate the balances of residents denied Medicaid coverage as Private Pay. Clarifying this information by revising debt submission guidelines in the MOU would help NDVS better understand its responsibilities in the debt collection process.

NDVS Faces Challenges Managing Past Due Debt

NDVS faces challenges managing past due debt. There are many reasons for individual accounts receivable balances remaining unpaid, including Medicaid misunderstandings, combative family members, and residents refusing to pay despite having the means to do so. Generally, past due accounts receivable balances of the Southern Nevada State Veterans Home (South Home) are a byproduct of the complex environment in which the home operates.

The South Home is a skilled nursing facility providing residents with short- and long-term nursing care, at least 75% of which are veterans of the United States armed forces.[7] Residents need assistance with Activities of Daily Living, whether due to age or medical condition. There are factors inherent to this model of operation that present challenges when it comes to collecting amounts owed by residents. These factors include:

- State veterans homes generally do not deny applicants based solely on having no income or an otherwise inability to self-pay, due to the fact that funds are anticipated from third-party payors. The U.S. Department of Veterans Affairs (VA) pays state veterans homes a prevailing rate per diem for each veteran residing in the home with a service-connected disability rated 70% or higher, intended to cover the full cost of providing care to those veterans. A basic rate per diem is paid for all other eligible veterans residing in the home to subsidize the cost of providing care. Applicants without income are expected to qualify for the medical insurance necessary to cover any balances due.

- Certain low-income applicants are expected to qualify for Medicaid to pay for costs not covered by the VA; however, NRS stipulates those individuals are not eligible for Medicaid until they have been admitted to the home for no less than 30 days. Therefore, the South Home is assuming risk when admitting an individual without the ability to self-pay. The resident begins

[7] Non-veteran spouses and gold-star parents (the parents of children who passed away in service) may reside at the South Home, up to 25% of its capacity.

incurring charges immediately upon moving into the home, without assurance Medicaid coverage will be approved.

- Federal regulations state that a resident cannot be discharged from a skilled nursing facility for failure to pay when their Medicaid application is in "pending" status, which extends to denied applications pending appeal. The Medicaid approval process can take months – a period during which the resident incurs charges that go unpaid. This creates a balance of past due debt for residents ultimately denied Medicaid coverage. Similarly, a resident may not become eligible until a date long after moving into the home, creating a situation where Medicaid approves coverage going forward, but will not cover charges incurred up to the eligibility date.

- Federal regulations state a skilled nursing facility cannot request or require a third-party guarantee of payment as a condition of admission or continued stay in a facility. Though many elderly and disabled veterans rely on family members or other representatives to assist with completing the application process, the South Home cannot expect or compel those third-party individuals to guarantee payment, leaving any past due balances the sole responsibility of the resident.

The process to apply and qualify for Medicaid can be lengthy, sometimes taking a year or more to finalize. As such, the date the South Home ultimately receives Medicaid payments can be past the 60-day deadline to commence collection efforts imposed by statute. To address this issue, NDVS signed an MOU with the SCO in December 2011, which exempts balances expected to be paid by Medicaid from submission for collections.

The MOU stipulates residents will be billed as Private Pay residents while their applications are pending. The Private Pay charges are reversed once the applications are approved. The MOU does not, however, make clear that balances of those denied Medicaid coverage should be treated as Private Pay balances for purposes of collection efforts. Exhibit III shows the agreement terms in the MOU between the SCO and NDVS.

Exhibit III

NDVS Collections MOU

Memorandum of Understanding

This document constitutes a Memorandum of Understanding (MOU) between the Nevada State Controller's Office and the Office of Veterans' Services.

Scope

This MOU concerns compliance with NRS 353C.195, and establishes an agreement regarding when debts will be turned over to the Controller's Office for collection.

Agreement

1. For debts owed by Private Pay residents, the Office of Veterans' Services will turn over past due debts to the Controller's Office for collection when they are 70 days old.
2. For those residents who appear and will be deemed to be qualified for Medicaid or Clark County assistance, a complete exemption is granted and these accounts are not required to be turned over to the Controller's Office for collection. While the application for assistance is pending, the resident is billed at the private resident rate, but these charges are reversed by a credit when the application is accepted. The resident's account is then charged at the Medicaid/Clark County rate and the reimbursement is applied.
3. When accounts are turned over to the Controller's Office for debt collection, the accounts shall be removed from the agency's books as accounts receivable. Those accounts waiting for a Medicaid/Clark County determination should not be included in the quarterly accounts receivable reports.
4. All accounts to be written off must be submitted to the Controller's Office to be written off. The Controller's Office will then submit them to the Board of Examiners to be written off.

Source: State Controller's Office.

The MOU terms can be updated to clarify the process for submitting past due debts to the SCO. NDVS should consider the following factors when updating the MOU:

- The MOU does not explicitly instruct NDVS to designate unpaid balances as Private Pay once Medicaid coverage has been denied.

- Currently, Private Pay debt must be turned over to the SCO once it is 70 days past due. Ten more days than the standard 60 days afforded to state agencies by statute appears to be an arbitrary amount of time.

- The MOU does not identify when unpaid balances of residents denied Medicaid should be submitted for collections. Specifically, it does not indicate whether the past due debt should be submitted as soon as the Medicaid application is denied, or whether the 70-day timeframe begins on the Private Pay debt upon denial.

- The MOU provides an exception for residents who appear and will be deemed to be qualified for Medicaid, without explicitly requiring the application to be actively pending. This distinction provides leeway to NDVS to delay debt assignment without having submitted a Medicaid application, based on any earlier determination the resident may qualify for coverage. A debt could be outstanding for longer than 70 days before the Medicaid application is even submitted.

- The MOU does not define a termination timeframe of the exception for pending Medicaid applications. The exception is provided in perpetuity, meaning past due balances can remain unpaid past a year due to the Medicaid approval process. Federal regulations state a nursing home resident may not be evicted as long as their Medicaid application is pending, but these restrictions do not apply to collecting the debt. While there may not be a specific requirement to start collecting on debt at a certain point in time, NDVS should recognize debts become harder to collect the longer they remain outstanding. Collaborating with the SCO on a plan of action when the Medicaid approval process exceeds a reasonable timeframe would be in the best interest of the state.

Distribution of Collected Funds Unaddressed in MOU

The MOU does not address the distribution of money collected by the State Controller on past due debts. The South Home budget account does not receive funding from the State General Fund, meaning the home operates exclusively from other revenue sources. NDVS leadership expressed concerns with not receiving the money collected by the State Controller on past due debts owed to NDVS. However, NDVS can expect to receive any recovered funds, which aligns with the direction outlined in statute. Exhibit IV shows the statute governing the distribution of money collected by the State Controller.

Exhibit IV

Statute Governing the Distribution of Money Collected

NRS 353C.224 Distribution of Money Collected from Debtor.

1. If the State Controller collects any money owed to an agency from a debtor or receives any money from the employer of a debtor or a private debt collector or other person to whom the State Controller has assigned the collection of a debt owed to an agency, the State Controller shall, unless prohibited by federal law, transfer the net amount of money owed to the agency:

(a) Except as otherwise provided in paragraph (c), to the Debt Recovery Account created by NRS 353C.226 if the debt is owed to an agency whose budget is supported exclusively or in part from the State General Fund.

(b) Except as otherwise provided in paragraph (c), to an account specified by the agency if the debt is owed to an agency whose budget is supported exclusively from sources other than the State General Fund.

(c) If a specific statute requires the money to be deposited in a specific account or used for a specific purpose, to the specific account required by statute or to the account from which money is expended for the purpose specified.

Source: Nevada State Legislature Law Library.

Acknowledging in the MOU that the South Home operates independently from the General Fund may provide NDVS with a level of assurance that it will receive recovered funds.

Submission to State Controller
Does Not Result in Eviction

Another concern expressed by NDVS leadership is a desire to avoid evicting residents, which suppresses their urgency to confront past due debt. While facing a need to evict a resident is a complex matter that warrants delicate handling, it does not coincide with resolving past due debt. As indicated above, federal regulations prohibit the eviction of a resident while their Medicaid application is pending approval, but do not prevent collection efforts on past due debt while the resident remains in the home.

This distinction is particularly relevant when a resident becomes eligible for Medicaid coverage long after being admitted to the South Home. There have been instances in which a resident is approved for Medicaid coverage moving forward but was denied retroactive coverage for balances accrued prior to the Medicaid application date. NDVS has no incentive to take action against residents in this situation because Medicaid payments have commenced. While the commencement of Medicaid payments is a positive development, the past due balance must still be addressed through collection efforts and writing off the estimated uncollectible amounts. These factors would be best coordinated with the SCO and addressed in a revised MOU.

Conclusion

Updating the MOU between NDVS and the SCO will significantly improve the management of past due accounts receivable. This modification will establish clear guidelines for when and how Private Pay debts, including those of residents denied Medicaid coverage, should be submitted for collections, reducing ambiguity in current processes. By ensuring debts are submitted promptly and consistently to the SCO, NDVS can comply with state requirements and increase the likelihood of recovering amounts owed.

Recommendation

2. Pursue an updated MOU with the State Controller's Office.

Record Accounts Receivable in Accordance with GAAP

The Nevada Department of Veterans Services (NDVS) should record Southern Nevada State Veterans Home (South Home) accounts receivable (receivables) in accordance with governmental Generally Accepted Accounting Principles (GAAP). Statute and the Accounts Receivable Policies and Procedures manual issued by the State Controller's Office (SCO) directs agencies to record and report receivables in accordance with GAAP.[8] Recording South Home receivables according to GAAP will bring NDVS in compliance with statutory requirements, while also reflecting an accurate South Home receivables balance.

NDVS Records Prepayments as Credits to Receivables

Residents' prepayments for future charges and refunds due to residents are being recorded as credits or a reduction to receivables, instead of deferred inflows or liabilities as required by GAAP. These credit entries understate receivables and liabilities at the agency level and flow into statewide financial statements.

Accounts Receivable Balances Misstated

The accounting system and processes at the South Home have not been configured to properly address residents' prepayments. To avoid system complications, NDVS records these prepayments as credits to the resident's receivables balance, which is an incorrect method of accounting. Deferred inflows are considered liabilities for the South Home because it is obligated to provide the services for which the resident prepaid; whereas receivables are considered assets because they represent funds due to the South Home. Recording credits to receivables makes it appear the South Home is owed less than actually due.

Accounts Receivable Policies and Procedures Manual
Requires Agencies to Submit Receivables Reports to the SCO

The SCO's Accounts Receivable Policies and Procedures manual instructs state agencies to submit fiscal year-end receivables reports to the SCO, specifying the information provided must be accurate and realistic. The year-end receivables balances from each agency are compiled and reported as the total receivables balance in the statewide Annual Comprehensive Financial Report (ACFR). Because the South Home's receivables balance is reported inaccurately in the fiscal year-end reports, the compiled statewide receivables total is also inaccurate.

The monetary total of credits incorrectly recorded to South Home receivables is not great enough to materially misstate the statewide financial statements. However, the statewide receivables balance does not comply with GAAP and statutory requirements. Statute requires state agencies to follow GAAP throughout the accounting and reporting process to accurately present the state's financial

[8] NRS 353.3245(1).

position. The current practice of recording prepayments as credits to receivables does not comply with statute, SCO guidance, or GAAP.

NDVS Can Ensure Compliance by Adjusting Receivables

NDVS administers trust fund banking for South Home residents using a single bank account but maintains separate accounting for each individual resident. Federal regulations allow payments to the home to be made from the trust fund, with the resident's authorization. To avoid issues created by recording residents' prepayments as credits to receivables, prepayments could be recorded residents' individual accounts, which could be used to pay bills when they come due.[9] This method would comply with state and federal requirements and help avoid recording incorrect accounting transactions.

Credits automatically recorded to receivables by the system for resident refunds cannot be avoided and system modification is not cost-effective. NDVS should take prompt action to adjust credit entries to receivables to ensure accuracy and compliance with state and federal requirements. This can be done by either paying the resident the refund due or recording an entry to move the credit to a liability account.

Conclusion

To ensure compliance with statute, the SCO's guidance, and GAAP, NDVS must revise how the South Home records its receivables transactions. Currently, the practice of recording residents' prepayments as credits to receivables results in an inaccurate balance that does not reflect GAAP standards. By properly classifying prepayments as deferred inflows, which is a liability, NDVS can avoid misstatements in the South Home's receivables balance. Additionally, implementing a system to either refund or move credit balances to a liability account would correct existing inaccuracies and improve the reliability of year-end financial reports.

Recommendation

3. Record accounts receivable in accordance with GAAP.

[9] The residents not participating would need to sign up for an account.

Revise Admission Application to Include Medicaid Information

The Nevada Department of Veterans Services (NDVS) should revise the Southern Nevada State Veterans Home (South Home) admission application to include Medicaid information. Including Medicaid information in the admission packet will increase transparency with applicants and ensure that Medicaid is addressed as part of the admission process. Increasing transparency will provide applicants with a better opportunity to disclose important information, ask relevant questions, and initiate discussions to improve their understanding of Medicaid eligibility requirements. An enhanced understanding of Medicaid eligibility requirements will reduce the applicant's chances of being denied coverage and subsequently burdened with debt.

Stringent Eligibility Requirements for Medicaid

Medicaid that covers long-term care in a skilled nursing facility is distinct from regular Medicaid and has stringent eligibility requirements that are sometimes difficult for applicants to understand. Some of the more stringent requirements include:

- Recipients/applicants must only receive a limited amount of income.[10] The recipient's/applicant's income less authorized allowances must be paid to the nursing facility.

- The recipient/applicant must own a limited value of total assets.[11] Certain exempt assets, such as a primary automobile or primary residence, do not count against this limit. Non-exempt assets, such as a savings account or a second residence, will render the recipient ineligible when the combined total value is above the limit.

- Recipients/applicants are permitted to relinquish assets to meet the asset limit, but only through authorized methods. For example, excess funds in a savings account can be spent to modify a primary residence, but those funds cannot be gifted to a family member. Gifting assets is a disallowed transfer that would render the recipient ineligible.

- The Department of Health and Human Services, Division of Healthcare Financing and Policy (DHCFP) enforces a 60-month "look-back" period for disallowed asset transfers, meaning that any such transfers discovered within the past 5 years would render the recipient/applicant ineligible.

- The resident's care is not covered until they have been admitted to a facility for at least 30 consecutive days.

[10] DHCFP limits income to 300% of the federal benefit rate for Supplemental Security Income, which is currently $943 per month. Income for Medicaid eligibility is therefore limited to $2,829 or less per month.
[11] DHCFP enforces a $2,000 asset limit.

Navigating Medicaid eligibility requirements can be complicated and overwhelming for applicants. Applications are the responsibility of the residents; however, NDVS has a vested interest in helping residents apply for Medicaid coverage at the time of admission.

Admission Process Lacks Transparency

The NDVS admission process lacks transparency over the Medicaid application process. Medicaid is not addressed within the five-page application for admission to the South Home. Ensuring applicants are aware of, and apply for, Medicaid coverage will increase transparency in the admission process. NDVS relies on Admissions Coordinators to make verbal disclosures regarding potential Medicaid coverage only if it appears likely the resident will need coverage. This does not typically occur until after the admission process is well underway.

No Mandate to Address Medicaid

NDVS does not require Admissions Coordinators to ensure the applicant or their representative is made aware of Medicaid coverage availability. The focus, from a financial standpoint, is primarily placed on VA Per Diem and Medicare coverage.[12] If an applicant appears likely to require Medicaid coverage following the preadmission screening procedures, Admissions Coordinators are expected to verbally notify the applicant or their representative of Medicaid eligibility requirements, which could easily be overlooked. Additionally, not making Medicaid a required discussion results in Admissions Coordinators being the decision makers for who may or may not need Medicaid information.

The failure to discuss Medicaid could be due to the perception that the applicant will not likely need coverage, which could turn out to be inaccurate. For instance, the length of stay at the home has run much longer than initially expected for some residents, after which point the resident would need Medicaid. Some Admissions Coordinators are not appropriately trained in the complex nature of eligibility requirements for when Medicaid discussions do take place, leading to either incomplete or inaccurate information being provided to the applicant.

Verbal Disclosures Insufficient to Ensure Applicants Understand Medicaid Eligibility

Relying solely on verbal disclosures from Admissions Coordinators is an insufficient method of ensuring South Home applicants understand Medicaid eligibility and its relationship to their overall financial standing. Medicaid qualification criteria can be difficult to understand for a number of reasons. Some South Home applicants that qualify for, or are currently covered by, regular Medicaid may be unaware there is a distinction between regular Medicaid coverage and long-term Medicaid coverage in a skilled nursing facility. Other applicants may not understand what a “non-

[12] Medicare covers short-term stays in a skilled nursing facility, up to a limited number of days.

exempt asset" is in regard to asset limits, or what qualifies as an "asset." Some applicants may fail to understand that all of their income after allowances must be paid to the home. NDVS reports that it regularly receives calls from confused residents or their representatives complaining they were not made to understand something or were not made aware of certain information related to Medicaid coverage. NDVS can improve its role in reducing confusion by documenting a Medicaid eligibility review as part of the admission process.

A Majority of States Address Medicaid on Admission Applications

A review of admission application packets for state veterans homes around the country revealed an overwhelming majority of homes that are Medicaid-certified as a nursing facility mention Medicaid.[13,14] Simply mentioning "Medicaid" may not ensure applicants disclose relevant details or provide certainty all necessary Medicaid information is discussed and documented. However, including Medicaid as a topic during admission will prompt further discussion on the subject. The majority of states include Medicaid as a topic in their application packets, but several states go much further into detail, making it clear to the applicant there will be a need to apply for coverage. Exhibit V shows the Medicaid notifications included in application packets used by a sample other states.

Exhibit V

Sample of State Medicaid Notifications

State	Medicaid Notification
New Mexico	*If Medicaid is not applied for, application will not be approved for admission.*
Florida	*All Veterans who are required to pay a share of cost must apply for monetary benefits for which they may qualify that will assist in paying for their care at the facility (i.e. Medicaid).*
Kansas	*If it is determined that I will pay less than the full rate, I understand that as a condition for continued residency, I must apply for Medicaid benefits.*
North Dakota	*Prior to admission, residents may need to apply for all monetary benefits to which they may be entitled from both the state and federal governments (Including but not limited to: Aid and Attendance, Medicaid, etc.).*
Virginia	*If you do not have at least 6 months of liquid assets available to you ($40,000), then you should apply for Medicaid in the county in which you currently reside.*

Source: State veterans homes application packets from a selection of the surveyed states.

[13] Not all state veterans homes become Medicaid and/or Medicare certified, meaning they do not accept or receive these types of coverage. Any such state was disregarded in this survey for purposes of analyzing admission packets.

[14] 30 of 38 Medicaid-certified states post their veterans home application online. 24 of the 30 reference Medicaid.

These notifications do not ensure that an applicant will apply, but bring to the applicant's attention that applying for Medicaid will be a factor of admission to the veterans' home. This increases the likelihood the applicant will ask questions or provide details they may not otherwise provide in the absence of similar notifications.

Other States Include
Declaration Statements

Several states include declaration statements detailing the applicant's financial responsibilities, which must be attested to by the applicant. Exhibit VI shows the declaration statements included in application packets used by a sample of other states.

Exhibit VI

Sample of State Application Declarations

State	Declaration Statement
Idaho	*I do hereby affirm, to the best of my knowledge that the above statements are true and I understand that any falsification regarding my monthly income or assets will be reason for discharge from the Home. If applying for nursing care, I further affirm that my income may be such that I am unable to defray the necessary expenses of the medical care for which I am applying. I further understand that I can be discharged from the Home for refusal or failure to pay the established maintenance charge or related expenses.*
Indiana	*Do you, in consideration of being admitted and maintained in the Indiana Veterans' Home, understand that you or your estate are obligated to pay full cost of care and maintenance? (Depending on the amount of your current assets and income from any source this rate may be reduced).*
North Dakota	*I agree to furnish on request certification as to my assets, income, and sources of income. My spouse and/or resident representative also agree to provide financial information as may be required for application for Medicaid benefits. I agree to pay for my cost of care from my income and assets according to current rates set by the State of North Dakota as long as I am a resident. When my funds are not enough, I agree to comply with eligibility requirements and will apply for State of North Dakota Medicaid acceptance.*
Maryland	*I agree to furnish, upon request, verification of assets and all sources of income. My spouse and/or designated representative also agree to provide financial information as required to apply for Medicaid benefits. I agree to pay for my cost of care from my income and assets according to current rates set by the State of Maryland as long as I am a resident. In case that available funding cannot cover my cost of care, I agree to comply with the necessary steps in applying for Maryland Medicaid assistance and benefits.*
Pennsylvania	*I understand that, if I am admitted to a Pennsylvania Veterans Home, my estate and I will be legally obligated to pay for the full cost of my care and maintenance while a resident of the Home. I further understand that the Commonwealth is authorized to recover the costs of maintaining persons in Pennsylvania Veterans Homes in accordance with Pennsylvania law .*

Source: State veterans homes application packets from other states.

Though not all of these declaration statements reference Medicaid, each statement makes clear the resident will be responsible for their share of cost. Placing an increased emphasis on the applicant's financial responsibilities may compel the

applicant or their representative to make a greater effort to ensure their cost of care at the home is going to be covered.

Additionally, some states provide supplemental forms or packets as part of the admission process that go into further detail regarding payment for care, such as the Actual Cost of Care Acknowledgement form used by South Dakota shown in Exhibit VII.

Exhibit VII

South Dakota Cost of Care Acknowledgement

South Dakota Department of Veterans Affairs

Michael J. Fitzmaurice South Dakota Veterans Home

ACTUAL COST OF CARE ACKNOWLEDGEMENT

I, _____ (Applicant/Representative) understand that if accepted as a resident at the South Dakota State Veterans Home, I will be responsible to pay the daily care rate of $325.00 per day. Statements will be submitted by SDVH on the 1st of each month and is payable to SDVH by the 15th of the month.

It is understood that the South Dakota State Veterans Home is not responsible for the personal finances of the resident. As the resident spends down their account for their cost of care, the applicant/representative will inform the SDVH Business Office when their bank account is diminished to $10,000 as a flag for the Medicaid application process.

The Medicaid application process is the responsibility of the applicant/representative. SDVH Business Office can assist with this process if needed by contacting 605-745-5127 Ext. 1500114 or 1500120.

Should the Medicaid application be denied by the Department of Social Services, I, _____ (Applicant/Representative) understand that I will continue to be responsible to pay the daily care rate.

_____ _____

Signature of Applicant or Representative Date

Source: South Dakota Department of Veterans Affairs.

Obtaining this completed form from the applicant provides some transparency to the admission process in South Dakota. The form draws attention to the Medicaid application process, while also making clear the applicant will be responsible for their share of costs at the home in the absence of Medicaid coverage. For comparison, Exhibit VIII shows the only declaration statement in the South Home's admission application requiring certification from the applicant.

Exhibit VIII

South Home Application Certification Page

ATD-1202B

Has the applicant sold, transferred ownership, or gifted any property or financial assets in the last five (5) years? ☐ **No** ☐ **Yes**

Are you/is the applicant:

Capable of making informed decisions relative to their healthcare? ☐ **No** ☐ **Yes**

Capable of making informed decisions relative to their finances? ☐ **No** ☐ **Yes**

COMMENTS

_____

_____

_____

_____

_____

WITH MY SIGNATURE BELOW, I CERTIFY THE INFORMATION PROVIDED HEREIN IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF:

_____ **Signature**

_____ **Printed Name**

_____ **Date**

_____ **Relationship to Applicant**

Source: South Home application packet.

The South Home application does not address Medicaid or the applicant's financial responsibilities. NDVS leadership represents Medicaid information is communicated verbally after it appears likely the applicant would need Medicaid coverage to reside at the home, but Admissions Coordinators do not document this information. Documenting Medicaid and financial information disclosed during admission provides more transparency in the application process and ensures relevant information is communicated timely to applicants.

Past Due Debt Is the Outcome of Denied Medicaid

Approximately $228,000 of the $1 million in debt that is at least 90 days past due is the responsibility of residents who were denied Medicaid coverage. This means those residents received a combined $228,000 in care at the home while expecting Medicaid to cover the charges, just to ultimately be denied and burdened with the debt. Although the eligibility requirements for coverage may be strict, the reasons an individual may be disqualified are publicly available and accessible to NDVS. An increased effort to obtain details from the applicant prior to admission to the home would help mitigate the risks of admitting someone ineligible for coverage or proceeding with a prolonged Medicaid application process for a resident that will be denied coverage. While NDVS is not obligated to submit Medicaid applications, it should perform due diligence in ensuring applicants will qualify for coverage.

No Probe for Asset
Transfer Details

NDVS points to the Department of Health and Human Services, Division of Healthcare Financing and Policy (DHCFP)'s discovery of disallowed asset transfers as the most common reason Medicaid coverage is denied. It appears NDVS does not make a sufficient effort to obtain asset details from the applicant during the admission process. Applicants are asked whether or not they transferred any assets in the past 5 years but are given no follow-up questions or additional information. Asking follow-up questions may better assist applicants or their representatives understand what qualifies as an "asset" as it relates to Medicaid eligibility requirements. Furthermore, the internal checklist of instructions for Admissions Coordinators only directs the application reviewer to inquire about assets if the applicant checked "yes," meaning asset details may go unaddressed when mistakenly checked "no."

NDVS conducts a background check independently from applicant involvement, such as a search for property in the applicant's name using LexisNexis. This is a highly relevant and constructive procedure to perform whether or not the applicant provides asset details, but not giving the applicant a better opportunity to volunteer information is inefficient and could lead to incorrect determinations. For example, a home owned by the applicant may not show up in a background check, while the applicant might have volunteered that information had appropriate inquiries been made.

In reviewing state veterans home applications around the country, DIA noted that the majority of homes that ask whether any assets were transferred in the past five years follow-up with a request for details. Some of those requests may be as simple as asking the applicant to provide the value of the asset and the date of transfer. Some states, such as Iowa, make a noted effort to obtain extended details from the applicant. Exhibit IX shows the supplemental page from Iowa's application packet.

Exhibit IX

Iowa Request for Asset Transfer Details

SUPPLEMENT TO APPLICATION FOR ADMISSION TO THE IOWA VETERANS HOME

Have you or your spouse sold or given away any property (land, cash [including bonds, stocks, Certificates of Deposit], home, etc.) in the last 60 months or placed assets into a trust within the last 60 months?

Yes _____ No _____

If you answered YES to this question, please provide documentation of the property sold/given away and complete the following information for each circumstance. Use additional sheets as necessary.

a. Description of the property, which was sold, given away, or placed in a trust: _____

_____

_____

b. What was the value of the property at the time you sold or gave it away? _____

c. How much did you receive as compensation for the property? _____

d. When did you sell or give the property away? _____

e. Who did you sell or give the property to? _____

f. What is your relationship to this person? _____

g. If compensation received for the property was less than the value of the property, please explain your reasons for accepting less than the fair market value for the property: _____

_____

_____

_____

h. Did you attempt to sell the property at its fair market value? Yes _____ No _____

I understand I assume full responsibility for the accuracy of the statement on this form and I understand the Iowa Veterans Home will use this statement to determine charges for care and treatment.

I am aware that Iowa laws provide anyone who obtains, or attempts to obtain, or who aids or abets any person to obtain public assistance to which he or she is not entitled is guilty of violating the laws of the State of Iowa, including but not limited to Chapter 35D of the Code of Iowa.

I HEREBY CERTIFY THAT THE STATEMENTS MADE HEREIN ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____

Signature or Mark of Applicant (or Financial Legal Representative) DATE

_____

Applicant's Name (Please type or print) Social Security Number

475-0843 (Rev 12/13)

Source: Iowa Veterans Home application packet.

The follow-up questions may help the applicant better understand the relevance of asking whether any assets were transferred in the previous five years. Some applicants may be unaware they possess potentially non-exempt assets until these details are requested from them. These details may prompt additional questions or initiate conversations with Admissions Coordinators that may not otherwise occur.

Conclusion

Integrating Medicaid-related questions and applicable information into NDVS' admission packet will enhance transparency, allowing applicants to better understand Medicaid's stringent eligibility requirements and engage in relevant discussions regarding their financial responsibilities. The lack of transparency and communication in the application process involving Medicaid requirements has led to confusion among applicants, many of whom were unprepared for denial of coverage and the subsequent accumulation of debt. Documenting Medicaid disclosures to applicants early in the admission process would mitigate such risks and ensure compliance with industry best practices, as followed by other state veterans homes. This revision is critical for reducing misunderstandings and minimizing financial liabilities, both for residents and NDVS.

Recommendation

4. Revise admission application to include Medicaid information.

Submit Medicaid Application at Start of Admission Process and Train Staff on Updated Admission Processes

The Nevada Department of Veterans Services (NDVS) should submit the Medicaid application at the start of the Southern Nevada State Veterans Home (South Home) admission process for applicants expecting to need Medicaid and train staff on updated admission processes. Submitting Medicaid applications at the start of the admission process would expedite any potential Medicaid appeals and decrease the amount of accumulated debt of residents denied Medicaid coverage.

Medicaid Applications Submitted Unnecessarily Late

Medicaid applications are currently submitted no less than 30 days following the resident's move-in date, based on the statutory requirement that the resident be institutionalized a minimum of 30 consecutive days to qualify. However, applications can be processed sooner if the applicant's physician states that the applicant is likely to be in the institution at least 30 consecutive days.

NDVS waits 30 days or longer after the resident is admitted to the South Home to submit their Medicaid application. There may be certain instances where untimely Medicaid application submissions are unavoidable, such as unexpectedly longer stays. Some residents are admitted expecting a short-term stay, only to see their health decline to the point that they require care well past 30 days, at which point the need for Medicaid becomes a factor.

Aside from unexpected circumstances, determining the potential need for Medicaid coverage at the start of the admission process is straightforward. All applicants are required to provide the income and financial asset information necessary to begin Medicaid eligibility procedures as part of the admission process. While NDVS may be limited in its ability to ensure applicants provide accurate information, it can still take steps towards preparing and submitting the Medicaid applications for those with a high likelihood of qualifying for coverage.

Early Processing Allowed

The Medical Assistance Manual published by the Department of Health and Human Services, Division of Welfare and Supportive Services (DWSS), which details eligibility policy for all medical assistance programs, including Medicaid, outlines an exception to waiting 30 days to submit Medicaid applications. Those applications may be processed sooner when the applicant's physician states the applicant will likely be in the institution at least 30 consecutive days.[15] Exhibit X shows the 30-day exception from DWSS's Medical Assistance Manual, chapter "Long Term Care Services," section F-100.

[15] Applicant is designated "customer" in the Medicaid Assistance Manual

Exhibit X

30-Day Exception

MEDICAID MEDICAID MEDICAID MEDICAID MEDICAID MEDICAID

LONG TERM CARE SERVICES

F-100 PERSONS INSTITUTIONALIZED AT LEAST 30 CONSECUTIVE DAYS

The term "institutionalized" refers to a person who is receiving long-term care services in a medical or nursing facility, or has been screened and approved to receive Medicaid-covered Long-Term Care (LTC) services in the person's home or community setting. The individual must be in the institution at least 30 consecutive days. In determining the number of days in a medical institution for eligibility purposes, include the date of admission, but not the date of discharge/death. Applications can be processed under this category prior to the 30th day based on a licensed physician's statement the customer is likely to be in the institution at least 30 consecutive days.

Source: Division of Welfare and Supportive Services.

This exception recognizes when it is evident a resident will need Medicaid coverage, there is no need to postpone submission of the application. Actual coverage will not begin until after the resident has been admitted for 30 consecutive days. However, if the physician confirms the resident will likely reach that minimum stay, it is in all parties' best interest to initiate the application process immediately.

Medicaid Application Can
Be Prepared for Short Stay

NDVS can still be proactive in preparing for a change in status even if the physician does not believe the applicant will be admitted to the home for at least 30 days. Residents may experience a decline in their health during their stay and need care for a longer period than anticipated. All the information necessary to reasonably assess whether South Home applicants will be able to self-pay balances due is collected during the admission process. It would be efficient to prepare the necessary information for those who appear to have insufficient income to self-pay, even if NDVS may not yet be able to submit the Medicaid application.

South Home applicants are required to submit a medical certification packet completed by their physician as part of the admission process. The packet provides an analysis of a wide array of medical information, such as the applicant's level of memory impairment, the applicant's diet, and whether the applicant has a history of drug use. There is a section for an evaluation of the applicant's need for assistance with activities of daily living, such as bathing, dressing, toileting, and grooming. The packet requests a description from the physician of the applicant's need for 24-hour nursing care.

The packet does not provide a section for the physician to state if the applicant is likely to be admitted to the home for at least 30 consecutive days. The exception to processing the Medicaid application early does not require the physician to affirm that the applicant will be admitted to the home for at least 30 days; it only requires

the physician's input as to whether a 30-day stay is likely. This important distinction simplifies the matter of revising the medical certification packet to obtain this information.

Ongoing Deficiency Noted by Legislative Auditor in 2021

Submitting untimely Medicaid applications is not a recent challenge for NDVS. A performance audit of NDVS conducted by the Legislative Auditor in 2021, found that NDVS was struggling with Medicaid enrollment. Specifically, the audit found NDVS did not have an established, formalized process for assisting residents with enrollment into Medicaid. Testing procedures performed during the audit found it took over 140 days to submit an application for some residents, while others who may have qualified for Medicaid were never enrolled. The audit found untimely Medicaid enrollment could result in less revenue for NDVS and unnecessary debt for disadvantaged veterans.

Written Policy Updated
and Staff Added

As a result of the Legislative audit, NDVS updated its written policy and procedure for assisting residents with enrollment into Medicaid. Policy # G-1265, "Veterans, Medicaid, and Medicare Information," was revised on December 10, 2021, with the following two primary changes aimed towards improving Medicaid enrollment:

- *At the time of inquiry about admissions to the Southern Nevada State Veterans Home, the Admissions Coordinator or designee will provide information on filling out the Medicaid/Medicare application, contact information to apply for benefits under Medicaid and Medicare rules and regulations, and set up a meeting with the Veterans Services Officer to discuss potential veterans' benefits.*

- *The Social Worker assigned to the resident will follow up in 15 days from the date of admission with the resident or their representative regarding any needed assistance or documentation needed to complete a Medicaid or Medicare application.*

In addition to updating the written policy, NDVS coordinated with the DWSS outreach program to staff a DWSS-funded Medicaid eligibility worker meant to assist with Medicaid enrollment in the South Home on a part-time basis.

Corrective Actions Should
Be Communicated to Staff

The effort by NDVS to revise its written policy was a constructive step towards improving Medicaid enrollment deficiencies; however, changes to the written policy alone does not ensure that Medicaid eligibility issues are addressed with the South Home applicants, or in a timely manner. Admissions Coordinators may not always discuss Medicaid with the applicant or may lack the proper training in Medicaid

eligibility requirements to accurately address the subject. Furthermore, Admissions Coordinators are only expected to bring Medicaid to the attention of applicants appearing to need coverage, which may exclude those for whom coverage has been inaccurately assessed as unnecessary.

The staff-focused changes are primarily geared towards addressing Medicaid issues subsequent to a resident's admission to the home. Staff are not expected to assist with Medicaid enrollments until after the resident has already been admitted, after which there is less recourse to ensure that the applicant will be eligible for Medicaid coverage or can self-pay their balances.

Moreover, staff are only expected to assist the resident with enrollment after a determination is made to submit an application and with following up on requests for additional info from Department of Health and Human Services, Division of Healthcare Financing and Policy, application appeals, and pending Medicaid applications. Staff are not responsible for ensuring South Home applicants have been properly screened for Medicaid eligibility or that pertinent Medicaid matters have been adequately addressed with the applicant prior to admission. There is no mechanism to ensure social workers follow-up with the resident within 15 days as required in the written policy revision. Staff should receive training on the updated admission procedures to ensure staff are aware of the existing and recommended updates to admission procedures.

Conclusion

NDVS can reduce the time residents spend in "Medicaid Pending" status by submitting applications at the start of the admission process for applicants expected to need Medicaid coverage. This can accelerate potential appeals and mitigate the financial burden for residents denied coverage. Current inefficiencies, including late submissions and a lack of clarity regarding Medicaid requirements during admissions, resulted in delayed coverage. Although previous corrective actions were taken, such as updating written policies and adding Medicaid workers, these steps were insufficiently enforced. Training staff on the admission process would address these gaps, ensuring that Medicaid-related issues are properly discussed and addressed from the start of the admission process, thus improving both transparency and financial outcomes for residents and NDVS.

Recommendation

5. Submit Medicaid application at start of admission process and train staff on updated admission processes.

Seek a BDR to Join the Nurse Licensure Compact

The Nevada Department of Veterans Services (NDVS) should seek a Bill Draft Request (BDR) to join the Nurse Licensure Compact (NLC). Joining the NLC would make Nevada competitive with other states. Nevada is one of only four states that have not yet joined the NLC or do not currently have pending legislation to join the compact. NLC membership enhances disaster preparedness and increases access to healthcare by increasing the pool of medical providers permitted to provide care within the state. In the event of an emergency, nurses from other member states can be hired immediately across state lines.

Nevada Hit by Critical Nursing Shortage

Research provided to the Legislature during the 2023 legislative session emphasized Nevada's critical nursing shortage. The Nevada Health Workforce Research Center (the Center) at the University of Nevada, Reno School of Medicine reported Nevada needs an estimated 4,000 additional registered nurses (RN) to meet the national population-to-RN average. The Center further reported that 67% of the state's population resides in what are considered primary medical care health professional shortage areas. Recent data shows Nevada ranks in the bottom five states for RNs per 1,000 people.

Healthcare Shortages
Directly Affect NDVS

As a 180-bed skilled nursing facility, the Southern Nevada State Veterans Home (South Home) is heavily reliant on the nursing workforce and is affected by nursing shortages. Both the South Home and the Northern Nevada State Veterans Home (North Home) have struggled with high turnover and vacancies over the years, facing issues such as competition for benefits and amenities, low pay, and the South Home's remote location. As of September 23, 2024, there were 20 vacant Certified Nursing Assistant (CNA) positions, four vacant Licensed Practical Nurse (LPN) positions, and one vacant Registered Nurse (RN) position at the South Home.[16] NDVS has made commendable efforts towards improving recruitment and retention, such as providing a tuition-free CNA training program and coordinating with local colleges to promote South Home job opportunities, but continues to experience difficulties recruiting and retaining healthcare professionals.

The Center Recommended Joining the Nurse Licensure Compact

The Center's report to the Legislature included 12 overlapping policy options and strategies to help combat the nursing shortage. One strategy is to implement policy measures to expedite the licensure of RNs and nurse practitioners from other states by enacting Nevada's participation in the NLC. The NLC is an interstate agreement allowing nurses to practice in other member states without the need to obtain a

[16] CNAs are not immediately impacted by changes to nurse licensing, as they are not licensed nurses. However, some CNAs work towards nurse licensure and will be influenced by career prospects once eligible for licensure.

separate license in those states. Nurses may have a multistate NLC license, a single state license, or both.

40 States Are Members of the Compact and 6 Are Pending

The NLC officially began operating in January 2000 with just four states – Maryland, Texas, Utah, and Wisconsin. As of July 2024, 40 states are now members of the compact and six more had pending legislation to join the NLC. Only Oregon, Nevada, Hawaii, and Alaska had not joined the compact and had no pending legislation to do so.

NLC Member States Are Better Prepared to Respond to Disasters

Membership in the NLC increases access to healthcare and enhances disaster preparedness. In a letter to the State Nurses Association submitted during the 2023 legislative session, representatives of the Interstate Commission of Nurse Licensure Compact Administrators emphasized the NLC does not purport to alleviate a nursing shortage. The compact simply allows a nurse with an NLC license to practice in another member state without obtaining a license in that state. It does not increase the supply of nurses.

One of the primary purposes of the compact is to allow nurses to practice in other states in the event of a disaster or other public health emergency. The recent COVID-19 pandemic is a prime example of the need for rapid mobilization, when hospitals and medical facilities experienced drastic increases in patients' need for immediate medical attention. Nurses from NLC member states were able to provide critical care immediately across state lines. Meanwhile, non-member states were left to navigate the crisis using only nurses licensed in-state until executive orders were issued to temporarily rescind regulatory requirements.

Considerable support for Nevada to Join the Compact

Assembly Bill (AB) 108 was referred to the Committee on Commerce and Labor during the 2023 legislative session, which would have entered Nevada into the NLC. The bill did not receive a vote, but a considerable amount of testimony from individuals and institutions was submitted to the Legislature in support of Nevada joining the compact. Exhibit XI shows a list of institutions that submitted testimony in support of joining the NLC.

Exhibit XI

Support for Joining the Nurse Licensure Compact

National Council of State Boards of Nursing	Case Management Association of Las Vegas
Nevada Hospital Association	Infinity Hospice Care
Unitek College (Nursing School)	Dept. of Defense, Military Community & Family Policy
Advanced Medical Technology Association	Nevada Action Coalition
High Sierra Area Health Education Center	Nevada Alliance for Nursing Excellence
Nevada Healthcare Association	Nevada Care Providers
Incline Village Community Hospital	Nevada Community Health Center
Nevada Nurses Association	Nevada Health Professionals Network
Solidarity Mental Health Services, LLC	Nevada Nursing Student Association
Carson Tahoe Health	Perry Foundation
Renown Regional Medical Center	Philippine Nurses Association of Nevada
Alta Skilled Nursing and Rehabilitation Center	Revive Senior Care Management, LLC
Asian American Group	Nevada Pathological Association
Sunrise Health System	UNLV School of Nursing
Centennial Hills Hospital	University of the Philippines Alumni Association of NV
Desert Springs Hospital	Wingfield Skilled Nursing and Rehabilitation Center
Dignity Health - St. Rose Dominican	Nevada Rural Children's Mental Health Consortium
Intermountain Healthcare	Nevada Health Workforce Research Center - UNR
Humboldt General Hospital	HCA Healthcare

Source: DIA analysis of AB 108 exhibits.

These institutions are direct stakeholders in the nursing profession, from those that educate the labor force to those that provide employment. As direct stakeholders, these institutions possess firsthand knowledge of the issues impacting the nursing profession and of the anticipated benefits of Nevada joining the NLC.

NDVS is a Stakeholder of Healthcare in Nevada

The South Home is heavily reliant on healthcare professionals, with 82 CNA, 27 LPN, and 24 RN positions authorized. Additionally, the North Home employs 64 CNAs, 20 LPNs, and 27 RNs.[17] These state veterans homes are skilled nursing facilities operating for the purpose of providing medical care to the residents. NDVS has a vested interest in making efforts to modernize and advance healthcare professions in Nevada as a direct stakeholder.

Participation in NLC Recognized as an Issue Affecting Veterans

The Nevada Legislature enacted AB 62 in 2015, requiring the NDVS Director to transmit a digital report summarizing passed legislation affecting veterans to each

[17] Staff at the North Home are employees of the third-party management company; however, oversight of the home is the responsibility of NDVS.

Nevada veteran with an email address on file. The report must be transmitted following the end of each regular legislative session and must include a description of issues affecting veterans considered by the Legislature but not enacted. Issues affecting veterans are identified through input received directly from veterans during community events, including:

- The Veterans Legislative Symposium;
- The Veterans Legislative Summit; and
- Veterans and Military Day at the Legislature.

Input is solicited at these events for issues important to veterans that could be considered for a BDR and to facilitate the participation of veterans, their families, and their supporters in the legislative process. The Report on the 82nd Legislative Session in 2023 recognized five separate statewide themes based on input from event participants, the first of which was to "improve medical and mental health care programs." The report further recognized AB 108 was among the bills under consideration by the Legislature that would have had an impact on improving medical and mental healthcare for Nevada's veterans.

Nevada Was Proactive in Joining an Interstate Compact for Physicians

During the annual meeting of the Federation of State Medical Boards in 2013, delegates unanimously approved a resolution to convene representatives from state medical boards and special experts to study the development of an interstate compact for licensing physicians. The resolution was introduced as a mechanism to streamline physician licensing processes, better accommodate the use of telemedicine in the delivery of healthcare, and protect the public. An early version of what would become the Interstate Medical Licensure Compact (IMLC) was introduced in 2014, which was adopted by a number of state legislatures, including Nevada during the 2015 legislative session. The IMLC became operational in April 2017, making Nevada among the first states to begin modernizing the physician licensure process in fast-evolving medical professions.

The Nevada State Board of Medical Examiners (Board) reported a surge in issued medical licenses in a recent press release. As of July 1, 2024, the number of licenses issued was 16,760, an increase of 1,011 from the prior year. The Executive Director of the Board attributed the boost in medical license seekers, in part, to IMLC membership. IMLC-issued medical doctors licenses in Nevada now account for 51.2% of the total medical doctor licenses issued, suggesting there is a preference for multi-state licensure versus single-state licensure.

<u>Lack of Success in Joining NLC</u>
<u>Inconsistent with IMLC Efforts</u>

Nevada's lack of success in joining the NLC appears inconsistent with the state's previous preemptive ratification of the IMLC. The provisions and objectives of the IMLC emulate those of the NLC that came before it. Both compacts were implemented to reduce regulatory burdens to practicing medicine across state lines

and increase mobility of healthcare professionals. Both compacts recognize the evolution of remote telemedicine/telehealth as a means for providing health care.

Member states of each compact retain regulatory autonomy for issuing licenses and disciplining licensees practicing in their state. Membership in each compact facilitates a streamlined exchange of investigative information on licensees and disciplinary action taken across states. The expected benefits from joining the NLC could be similar to the benefits Nevada received by joining the IMLC.

Ability to Travel
Lucrative for Nurses

A multi-state license allows for practicing as a traveling nurse, making it preferable to a single state license. Hospitals and other healthcare facilities hire traveling nurses on short-term contracts during periods of short staffing. Traveling nurses tend to earn a higher salary, earning an average of $133,376 per year, compared to staff nurses who earn an average of $93,676 per year.[18]. Other benefits for traveling nurses include:

- Travel exposure – The opportunity to work and live in a variety of locations in the country and across the world;
- Unique professional experience – Working in different environments offers exposure to different ways of performing nursing tasks in various healthcare systems; and
- Lifestyle flexibility – Short-term contracts offer the opportunity to take preferred time off before committing to the next contract.

These benefits increase the appeal of an NLC license, which allows the holder to travel between member states for work without having to obtain a new license. Those with an NLC license are not required to travel for work, but have the option to do so without additional hassle. This contrasts with Nevada, where nurses holding a Nevada license would have to obtain a separate license to secure an out-of-state travel opportunity.

NLC Membership Facilitates Remote Practice

Demand is increasing nationwide for remote telemedicine/telehealth and online medical training and education. Nurses wishing to provide telehealth or instruct online training courses must have a valid license in the state where the services are received. This means Nevada institutions are limited to only those nurses with a Nevada license. NLC member states can utilize nurses located in any other member state, giving member states access to a much larger pool of available nurses.

[18] According to Indeed.com, a job search website that maintains data on salaries by occupation.

State Policy to
Boost Telehealth

In 2015, the Legislature passed AB 292 to amend NRS 629. The bill declares it is the public policy of the state to encourage and facilitate the provision of services through telehealth to improve public health and the quality of healthcare provided to patients. The law was amended prior to the massive increase in demand for telehealth services necessitated by the COVID-19 pandemic. The Legislature made several observations specifically related to healthcare issues in remote, underserved areas of the state, including:

- The shortage of healthcare providers in remote areas affects people's ability to obtain services;
- Parts of the state experience difficulties attracting and retaining healthcare providers and supporting healthcare facilities; and
- Healthcare providers in remote areas may not have access to mentors and colleagues or information resources to assist them in practice.

The bill recognized that telehealth has the potential to help address the problem of an inadequate distribution of providers and to increase the quality of, and access to, healthcare in underserved areas of the state.

The federal Health Resources and Services Administration has designated all 17 counties in Nevada as health professional shortage areas to varying degrees. Fourteen counties are recognized as entirely rural, while primarily urban counties Clark and Washoe are recognized as containing some rural areas. Carson City is recognized as fully urban.

Lawmakers Moved to
Expand Nursing Programs

The Legislature enacted Senate Bill 375 in 2023, appropriating $10 million for each of fiscal years 2024 and 2025 to the Nevada System of Higher Education (NSHE). NSHE must use the appropriation to create a targeted funding grant program to expand undergraduate and graduate nursing programs. The Legislature recognized in the bill that funding will help address the nursing shortage and shortage of faculty and clinical instructors.

If any expansion of the nursing programs involves the utilization of online courses, then postsecondary institutions will be limited to only those instructors with a Nevada nursing license. The state would have access to a much larger pool of potential instructors for online courses by joining the NLC. Additionally, employing out-of-state faculty to instruct online courses may free up the limited number of faculty located in-state to concentrate on in-person, clinical-centric nursing courses.

Nursing Education
Evolving Online

Postsecondary enrollment in online courses has grown significantly the last few decades. The number of students enrolled in at least one online course grew from approximately 26% in 2012 to over 54% in 2022. Similarly, enrollment in online graduate nursing courses increased by more than 13% from 2015 to 2019. In 2020, over 90% of nursing programs used some level of virtual or online learning. Some advantages to attending online nursing courses include:

- Accessibility to students residing in rural areas;
- Flexibility; and
- A variety of learning formats.

Deficiencies in Emergency Directive

The COVID-19 pandemic, which was declared a nationwide emergency on March 13, 2020, provided a significant example of a sudden, urgent need for expanded medical services. Like the rest of the globe, Nevada was in dire need of more medical professionals to address the surge in the population affected by the illness. Emergency Directive 011 was signed by former Governor Sisolak on April 1, 2020, to expand the pool of available medical providers. The directive waived the licensing requirements of NRS 414, allowing medical providers to practice in Nevada without being licensed in the state. No such directive was necessary for NLC member states to use out-of-state providers.

Help was Delayed
for Three Weeks

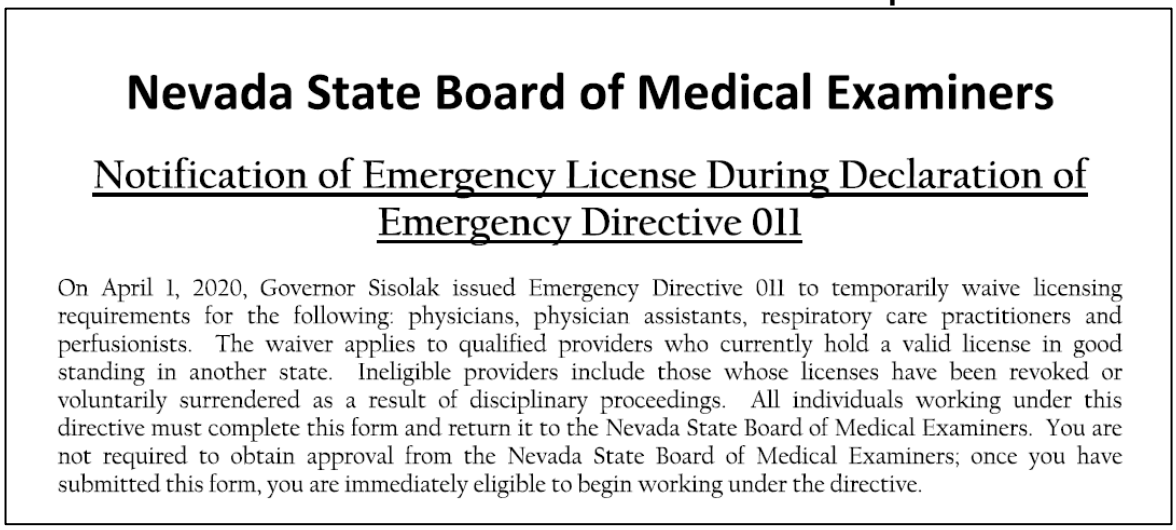
Approximately three weeks elapsed between the declaration of a nationwide emergency and implementation of Emergency Directive 011. Nurses without a Nevada license could not practice in the state during that period. In contrast, NLC member states did not need emergency directives to allow nurses to practice across state lines.

Providers wishing to practice in the state under the directive were required to notify the applicable Nevada licensing board and provide any requested information. This was yet another step that would not have been required under the NLC. Delaying the ability to employ additional medical providers until licensing requirements were waived resulted in a delayed response to the healthcare needs of Nevadans.

Additionally, information required by applicable Nevada licensing boards during the pandemic appears to have been limited and was not constructed to screen medical providers wishing to practice under the directive. The waiver form required by the Nevada State Board of Medical Examiners allowed providers to begin practicing as soon as the form was submitted, without approval. Exhibit XII shows the language of the waiver required by the emergency directive.

Exhibit XII

Board of Medical Examiners Waiver Excerpt



Nevada State Board of Medical Examiners

Notification of Emergency License During Declaration of Emergency Directive 011

On April 1, 2020, Governor Sisolak issued Emergency Directive 011 to temporarily waive licensing requirements for the following: physicians, physician assistants, respiratory care practitioners and perfusionists. The waiver applies to qualified providers who currently hold a valid license in good standing in another state. Ineligible providers include those whose licenses have been revoked or voluntarily surrendered as a result of disciplinary proceedings. All individuals working under this directive must complete this form and return it to the Nevada State Board of Medical Examiners. You are not required to obtain approval from the Nevada State Board of Medical Examiners; once you have submitted this form, you are immediately eligible to begin working under the directive.

Source: Nevada State Board of Medical Examiners.

By allowing individuals to begin working without being vetted or receiving board approval, an unscrupulous out-of-state provider with a revoked license could have performed medical services without being detected. Similarly, the only information requested from the Nevada State Board of Nursing was a notification to the board attesting that the nurse met the requirements of the emergency directive.

Nurses wishing to obtain an NLC license are subject to the stringent uniform requirements of the compact that include a fingerprint criminal background check. Nurses convicted of felony or misdemeanor offenses related to the practice of nursing are ineligible for licensure. Further, the compact facilitates the exchange of information in the areas of nurse regulation, investigation, and adverse actions between member states. Public safety is enhanced through these actions by ensuring nurses with an active NLC license have been properly vetted.

Directive Exposes Flaws
in NLC Opposition

The Nevada State Board of Nursing requires 30 hours of nursing-related continuing education (CE) per license renewal cycle to maintain a license. Opponents contend joining the NLC would lower standards for licensure because a number of member states do not require CE hours. The CE requirement for Nevada, however, was waived as part of Emergency Directive 011, allowing nurses to practice without having obtained the CE hours. The directive effectively recognized that this barrier to practice became less relevant when faced with a surge in the need for nursing care during an emergency.

Opponents also contend joining the NLC will not improve staffing shortages, but the purpose of the NLC is not to alleviate staffing shortages. Rather, membership in the NLC is meant to help cover gaps in care during patient surges and emergencies by allowing nurses to practice across state lines. The need to cover gaps in care during

the COVID-19 pandemic was the objective of Emergency Directive 011, showing Nevada stood to benefit from NLC membership.

Conclusion

Nevada's participation in the NLC will help address critical challenges to healthcare access in the state and enhance disaster preparedness by expanding the available nursing workforce. Joining the NLC would streamline the nurse licensure process, allowing nurses from other member states to practice without obtaining additional licensure, thereby alleviating short-term staffing needs. The state has already demonstrated a proactive approach by adopting a similar compact for physicians, indicating that NLC membership could yield similar benefits in the nursing field. Enhancing Nevada’s ability to respond rapidly during public health emergencies will improve overall healthcare access, particularly in underserved areas of the state.

Recommendation

6. Seek a BDR to join the Nurse Licensure Compact.

Appendix A

Scope and Methodology, Background, and Acknowledgments

Scope and Methodology

We began the audit in February 2024. In the course of our work, we interviewed members of management from the Nevada Department of Veterans Services (NDVS) to discuss processes inherent to NDVS's operations. We reviewed NDVS records and researched legislative history, state budget manual procedures, applicable Nevada Revised Statutes, Nevada Administrative Code, Nevada State Administrative Manual, governmental generally accepted accounting principles, and other state and federal guidelines. We concluded fieldwork in September 2024.

We conducted our audit in conformance with the *International Standards for the Professional Practice of Internal Auditing.*

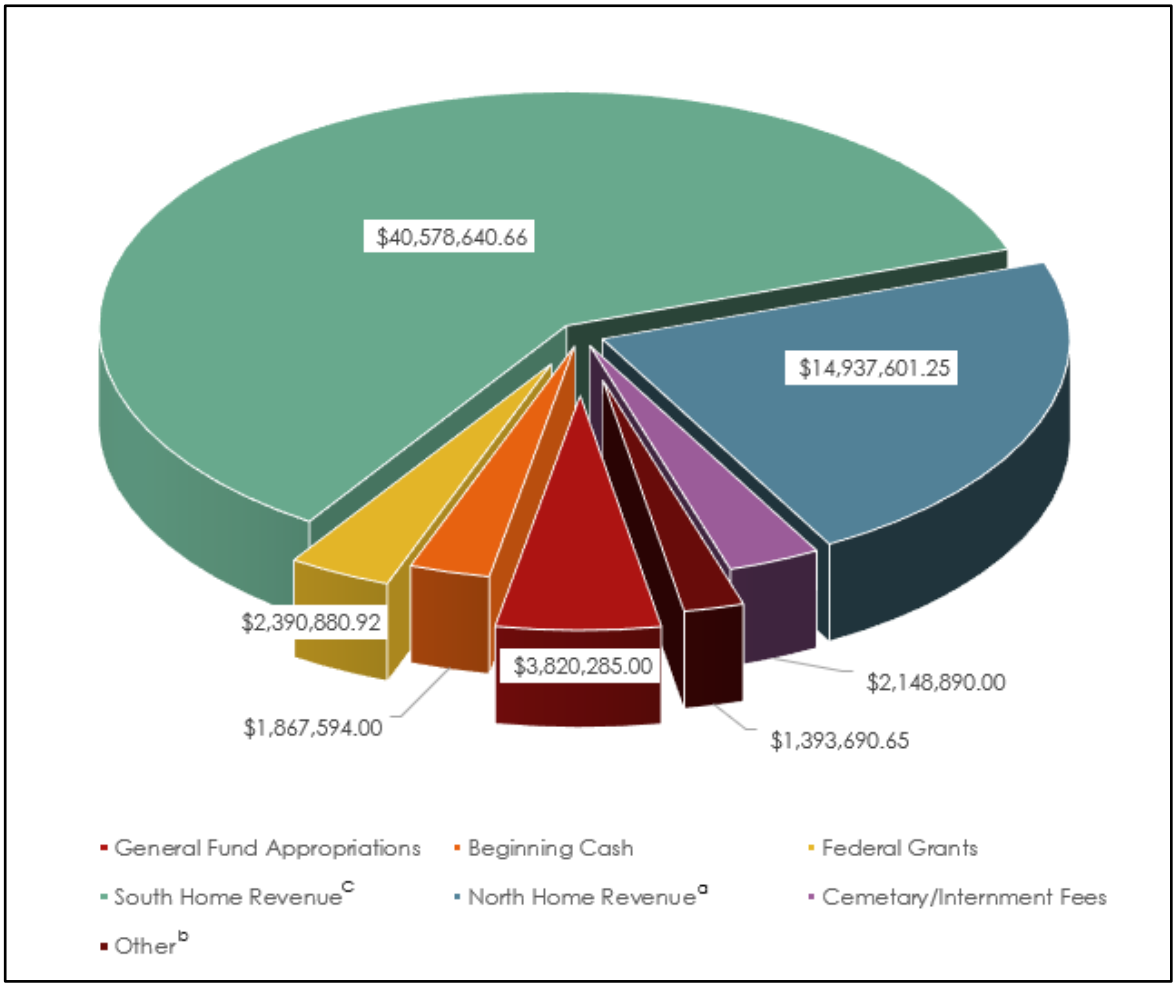
Background

For over 75 years, the Nevada Department of Veterans Services (NDVS) has been dedicated to helping an estimated 250,000 Nevada veterans get the services, benefits, and quality of life they deserve. The men and women of NDVS are honored to address any issue, problem, or concern of Nevada's veterans, serving military, and their families.

In addition to offering benefits, counseling, and assistance, including filing U.S. Department of Veterans Affairs (VA) claims at no cost, NDVS operates a nationally recognized Southern Nevada State Veterans Home (South Home) in Boulder City and the Northern Nevada State Veterans Home (North Home) in Sparks. NDVS also offers burial services and support with obtaining military honors at memorial cemeteries located in Northern and Southern Nevada. Exhibit XIII shows NDVS's revenue by funding source for fiscal year 2024.

Exhibit XIII

NDVS Revenue for Fiscal Year 2024



Source: Data Warehouse of Nevada.

Notes: [a] North Home revenue includes a State General Fund appropriation, beginning cash, VA per diem, cash distribution from the management company, and ARPA funds.

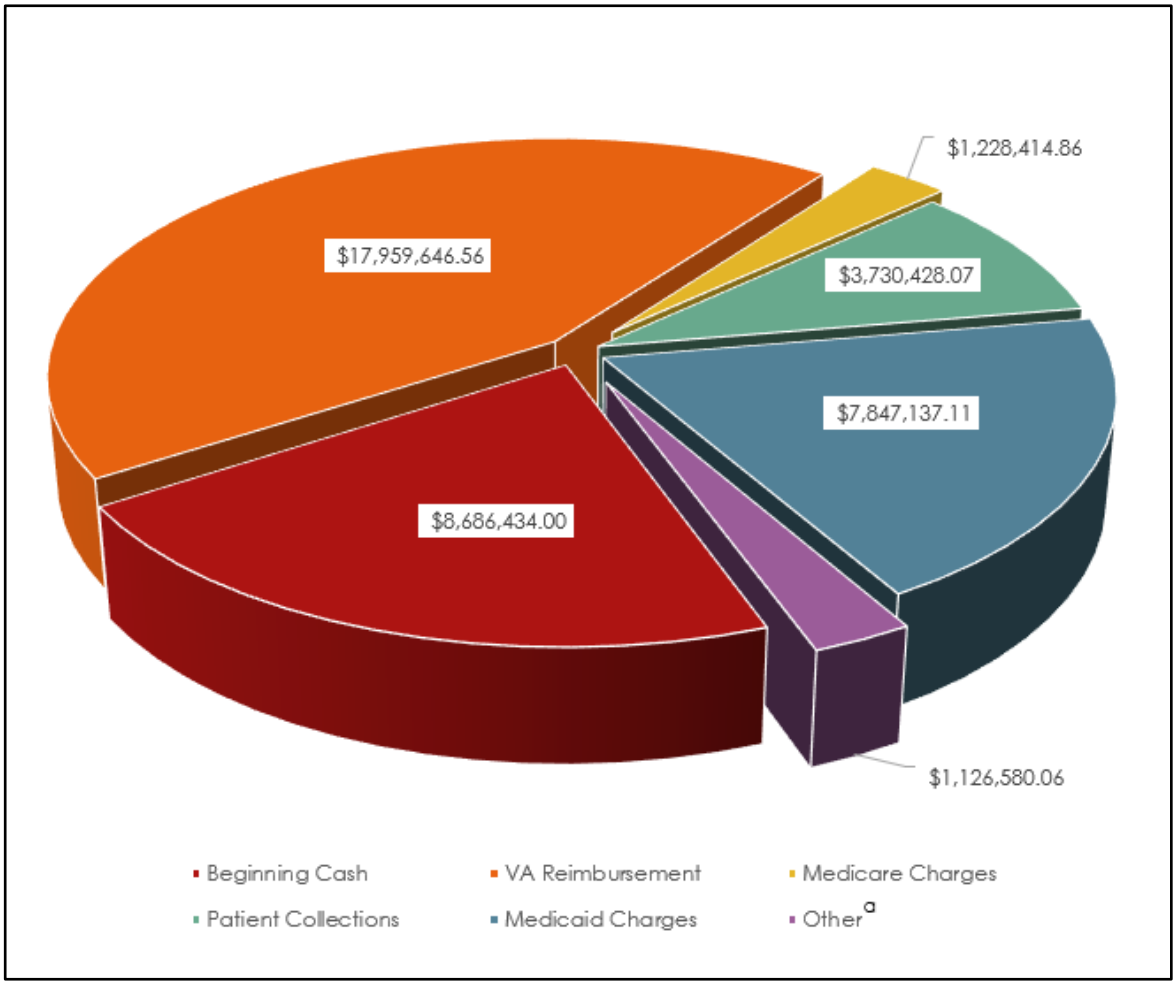
[b] Other includes Treasurer's interest distribution, gifts and donations, and license plate charges.

[c] South Home revenue is shown in Exhibit XIV.

The South Home is an award-winning, 180-bed skilled nursing facility located in Boulder City. The state-owned and operated facility serves eligible veterans, their spouses, and gold star parents. Skilled nursing care is provided 24 hours a day, 7 days a week, along with a variety of medical programs, including Alzheimer's and dementia care. Exhibit XIV shows the revenue for the South Home by funding source for fiscal year 2024.

Exhibit XIV

South Home Revenue for Fiscal Year 2024



Source: Data Warehouse of Nevada.
Note: [a] Other includes hospice charges, Clark County receipts, insurance recoveries, and ARPA funds.

Acknowledgments

We express appreciation to the Department of Veterans Services' management and staff, and the Governor's Finance Office, Budget Division for their cooperation and assistance throughout the audit.

Contributors to this report included:

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Administrator

Marty Schaefer, CPA
Executive Branch Auditor

Appendix B

Nevada Department of Veterans Services
Response and Implementation Plan

JOE LOMBARDO
Governor

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October 10, 2024

Craig Stevenson
Administrator, Division of Internal Audits
Governor's Finance Office, Nevada
c.stevenson@finance.nv.gov

Re: NDVS Response to SNSVH Audit Recommendations

Dear Administrator Stevenson

The Nevada Department of Veterans Services (NDVS) would like to thank you and your team for your assistance with helping us to improve. NDVS is committed to implementing these recommendations and improving our processes and services.

Below is the anticipated timetable for implementing the audit recommendations.

Recommendation	Time Frame
1. Submit Applicable Past Due Debts to the State Controller for Collections	6 months
2. Pursue Updated MOU with the State Controller's Office	6-9 months
3. Record Accounts Receivable in Accordance with GAAP	6 months
4. Revise Admission Application to Include Medicaid Information	6 months
5. Submitting the Medicaid application at the start of the admission process and training staff on updated admission processes	6 months
6. Seek a BDR to join the Nurse Licensure Compact	If not possible in 2025 Legislative Session would be submitted in 2027 Legislative Session

1. **Submit Applicable Past Due Debts to the State Controller for Collections**
NDVS will reach out to the State Controller's Office and set the process for the submittal of past due debts as recommended. In addition, staff will be trained on the process to ensure continuity moving forward.

2. **Pursue Updated MOU with the State Controller's Office.**
   NDVS will reach out to the State Controller's Office and share the recommendations provided in the audit and work on a new comprehensive MOU. Taking into account the impact to both offices of the new state financial system coming online and the upcoming legislative session NDVS anticipates it may take up to 9 months to accomplish this change; however, the department is committed to implementation as quickly as possible.

3. **Record Accounts Receivable in Accordance with GAAP.**
   NDVS will work with the audit team and State Controller's Office to ensure the Accounts Receivables are recorded as outlined. Finance staff will be trained on the Office of the State Controllers Policies and Procedure regarding accounts receivable.

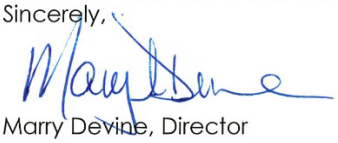
4. **Revise Admission Application to Include Medicaid Information**
   NDVS will review the recommendation and examples provides and revise the admission application to include written information regarding the Medicaid process in addition to the information currently being provided verbally with the goal of providing greater clarity to the applicant and families/guardians related to the process, rules and obligations associated with the Medicaid application process.

5. **Submitting the Medicaid application at the start of the admission process and training staff on updated admission processes.**
   NDVS will review and refine the Medicaid application process to achieve greater efficiency in the submission of these applications. Training will be provided to admissions, social workers, fiscal and any other team members as necessary to ensure all have the tools necessary to meet this recommendation.

6. **Seek a BDR to join the Nurse Licensure Compact.**
   As the deadline for agency BDR submissions has passed NDVS will research to see if it is possible to submit a request for the upcoming legislative session. If it is not possible to submit a BDR for the 2025 session, NDVS will submit a request for the 2027 legislative session for consideration.

Please do not hesitate to reach out to me should you require any additional information. Thank you.

Sincerely,



Marry Devine, Director
"Serving Nevada's Heroes"

Appendix C

Timetable for Implementing Audit Recommendations

In consultation with the Nevada Department of Veterans Services (NDVS), the Division of Internal Audits categorized the recommendations contained within this report into two separate implementation time frames (i.e., *Category 1* – less than six months; *Category 2* – more than six months). NDVS should begin taking steps to implement all recommendations as soon as possible. The target completion dates are incorporated from Appendix B.

Category 1: Recommendations with an anticipated implementation period less than six months.

Recommendation	Time Frame
1. Submit applicable past due debts to the State Controller for collections.	April 2025
3. Record accounts receivable in accordance with GAAP.	April 2025
4. Revise admission application to include Medicaid information.	April 2025
5. Submit Medicaid application at start of admission process and train staff on updated admission processes.	April 2025

Category 2: Recommendations with an anticipated implementation period exceeding six months.

Recommendation	Time Frame
2. Pursue an updated MOU with the State Controller's Office.	July 2025
6. Seek a BDR to join the Nurse Licensure Compact.	July 2025

The Division of Internal Audits shall evaluate the actions taken by NDVS concerning the recommendations within six months from the issuance of this report. The Division of Internal Audits must report the results of its evaluation to the Executive Branch Audit Committee and NDVS.