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

Audit Report

Department of Corrections
Off-Site Medical Care

Report No. 18-06
June 14, 2018

EXECUTIVE SUMMARY
Nevada Department of Corrections

Objective: Improve Nevada Department of Corrections Inmate Off-Site Medical Care Management

Reviewing medical payments made to providers and reconciling to supporting medical documentation and authorization will help ensure services paid for match services rendered and were appropriate for the authorized off-site medical treatment.

NDOC sends inmates to off-site providers to receive medical care which require approved authorization by the Utilization Review (UR) Committee. NDOC's third party administrator (TPA) processes and pays medical billings but does not review or reconcile billings to UR Committee authorizations. NDOC does not review billing information because they rely on the TPA to ensure billings are correct. The TPA's system successfully vets inappropriate billings, such as double billings or Medicaid claims, but does not review for services rendered.

Billings and invoices for claims sent to NDOC's TPA for off-site medical care lack detail. NDOC is unable to determine the type of medications and other medical supplies used for treatment and if appropriate for the inmate's condition at the lowest cost option.

Performing targeted case management for off-site medical care will help NDOC monitor the inmates' progress, on-going treatment regimens, and quality of care. Neither NDOC nor its TPA perform targeted case management for inmates in hospitals to ensure appropriate care at the lowest cost option.

NDOC's Director of Nursing Services receives daily clinical reports and calls hospitals for updates on inmates during their stay in the hospital, including coordinating the inmate's discharge. NDOC does not have established protocols with hospitals for managing inmate care and does not consult with hospitals to ensure they use the least cost options for treatments or that inmates in observation status are appropriately managed.

Other states perform targeted case management while inmates are in hospitals. Oregon Department of Corrections contracted with its TPA to provide targeted case management and was able to save 20 percent on in-patient hospital costs over a two year period. This effort reduced observation days, length of stay, and increased consult on treatment options and other medical decisions for inmates in hospitals.

NDOC's structure to accomplish targeted case management is largely in place. Proactive management may require an additional senior nurse at a cost of approximately $150,000 who may be the appropriate staff to manage the UR Committee review and reconciliation process. The new senior nurse will provide continuity for managing inmate care as inmates receive authorization for off-site care, receive off-site treatment, and return to NDOC facilities for post-admittance/recovery care.

In fiscal year 2017, Medicaid paid $3.6 million for inmate hospital care. Performing targeted case management for inmates in hospitals could help reduce total Medicaid payments by up to 10 percent annually, or $360,000. Nevada's Medicaid contribution savings would be approximately $26,500. In fiscal year 2017, NDOC paid about $605,000 for in-patient hospital stays not billable to Medicaid. Performing targeted case management could help reduce costs up to 10 percent annually, or $60,000. NDOC would need to achieve an additional savings from outpatient medical care of $63,500 or approximately 1.7 percent to cover the cost of an additional senior nurse.

Ensuring in-network providers are utilized to the fullest extent possible for off-site medical services will allow NDOC to take advantage of negotiated provider rates and to define the medical requirements expected from a network provider. NDOC's two contracted Preferred Provider Organizations (PPO) do not meet all treatment requirements.[1] Off-site medical referrals are sometimes made to doctors not part of the provider network because in-network doctors are not available or the required service is not part of the provider agreement. About eight percent of off-site services were treated with out-of-network providers. Per NDOC, these out-of-network providers were the only providers willing to perform treatment for inmates.

NDOC consistently uses one out-of-network urologist in the South. This provider is willing to serve inmates on-site at rural correctional facilities. When inmates require off-site urology treatment, NDOC chooses to use this provider. NDOC paid approximately the same rate for the out-of-network urologist in the South as the in-network urologist in the North, although rates in the South are a third of rates in the North, in general. Urology services are available in the PPO in the South; NDOC has not ensured in-network providers are used for off-site urology services and is missing a potential opportunity to lower costs for off-site urological services for inmates in the South.

Fiscal year 2017 air ambulance charges were a total of $890,000. NDOC incurred additional costs as a result of billing and payment errors with one provider. The TPA had a letter of agreement to include a discounted rate with a vendor who provided a majority of air ambulance services. The vendor was not paid timely for a flight in 2014 and did not honor the discounted rate for two subsequent flights in 2017. The vendor was paid at full price, costing NDOC an additional $26,000. The PPO has recently entered into a new air ambulance contract serving the Ely and Lovelock facilities. Remaining NDOC facilities are not covered by a PPO contracted air ambulance service.

---

[1] The PPO in the North is Hometown Health. The PPO in the South is Sierra Healthcare Options.

INTRODUCTION

At the direction of the Executive Branch Audit Committee, we conducted an audit of the Nevada Department of Corrections (NDOC). Our audit focused on NDOC's inmate off-site medical care management. The audit's scope and methodology, background, and acknowledgements are included in Appendix A.

Our audit objective was to develop recommendations to:

- ✓ Improve Nevada Department of Corrections' (NDOC) inmate off-site medical care management.

Nevada Department of Corrections Response and Implementation Plan

We provided draft copies of this report to NDOC for its review and comments. NDOC's comments have been considered in the preparation of this report and are included in Appendix B. In its response, NDOC accepted our recommendations. Appendix C includes a timetable to implement our 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 NDOC 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 NDOC officials.

The following report contains our findings, conclusions, and recommendations.

Improve Nevada Department of Corrections Inmate Off-Site Medical Care Management

The Nevada Department of Corrections (NDOC) can improve inmate off-site medical care management by:

- Reviewing and reconciling billing and medical payments for off-site medical services;
- Performing targeted case management for inmates' off-site medical care; and
- Ensuring in-network providers are used for off-site medical services.

These improvements will allow NDOC to better manage inmate off-site medical care and could benefit the State by reduced Medicaid contributions and lower inmate medical costs. NDOC's investment in an additional senior nurse will help manage costs as well as the processes for targeted case management and the UR Committee.

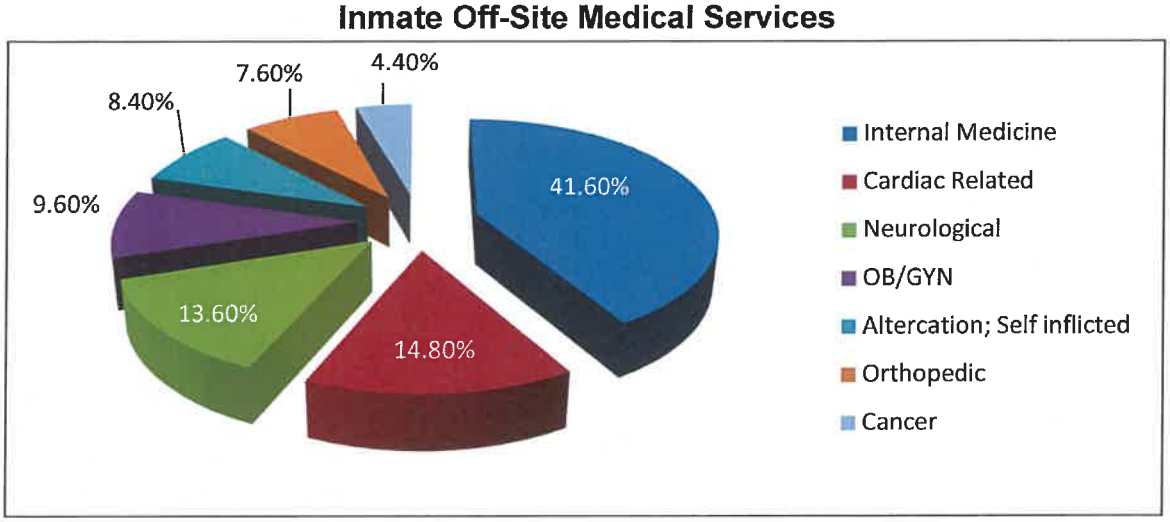
Review and Reconcile Billings and Payments for Off-Site Services

NDOC should review prison medical payments made to providers and reconcile the payments to supporting billing documentation and the authorization for off-site medical services. This process will ensure off-site medical services paid match services rendered and were appropriate for the authorized treatment of care.

Inmates Receive Wide Array of Off-Site Medical Services

In 2017, NDOC spent $11.7 million on off-site medical services for inmates. Inmates are entitled to off-site medical services when NDOC medical staff is unable to treat the inmate's medical condition. Inmates are routinely treated off-site for a wide array of conditions, including: internal medicine, cardiac related, neurological, obstetrician/gynecology, self-inflicted/altercation, orthopedic and cancer. See Exhibit I.

Exhibit I

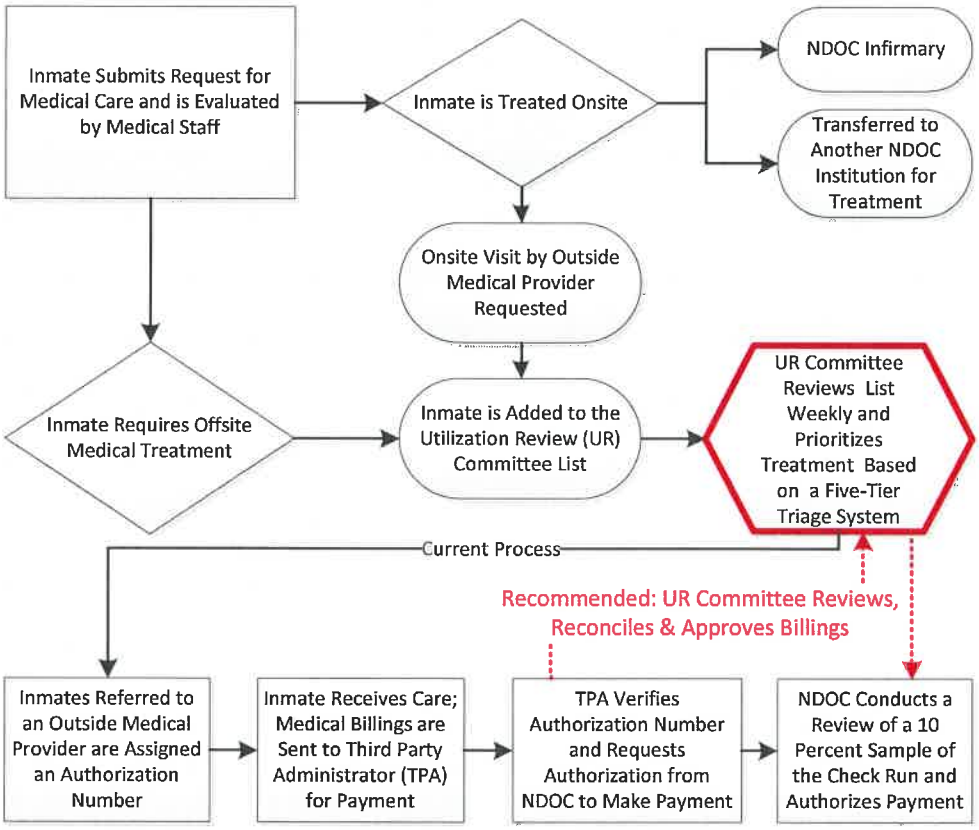


NDOC Process Determines When Off-Site Medical Services Necessary

NDOC has a process for determining when off-site medical services are necessary. Routine non-emergency medical care is provided by NDOC doctors in the correctional facilities. At times, visiting specialists conduct clinics at correctional facilities for other medical services such as, optometry care, x-rays, and other non-life threatening conditions. If an inmate needs additional or more intensive medical services, they can be authorized for off-site medical services. On occasion, emergency air ambulance services are necessary to transport inmates to a facility to receive medical services. Exhibit II shows the process for determining when an inmate will be authorized for off-site services.

Exhibit II

Inmate Medical Service Process



Off-Site Medical Care Authorizations Approved by NDOC's Utilization Review (UR) Committee

In fiscal year 2017, 476 inmates were admitted to hospitals for medical services, for an average of 40 a month, with an average length of stay of six days. Inmates receiving off-site medical services require approved authorization by NDOC's Utilization Review (UR) Committee.

The UR Committee meets weekly to determine and prioritize treatment for inmates based on a five tier triage system. (See Appendix A, Exhibit IV.) A UR committee meeting will have a minimum of three doctors, the Director of Nursing Services, the Director of Nursing Services Administrative Assistant, and the Correctional Nurses from NDOC's medical care units at Northern Nevada Correctional Center and High Desert State Prison.

NDOC's Third Party Administrator Does Not Review or Reconcile Authorized Off-Site Medical Billings and Payments

NDOC's third party administrator (TPA) does not review or reconcile inmate medical billings to what was authorized by NDOC's UR Committee. This is not part of the TPA's contracted responsibilities. However, the TPA's system flags suspected double billings, potential Medicaid claims, and miscoding.

Billings Lack Transparency

Billings from NDOC's TPA lack transparency. We reviewed billings and invoices for claims sent to NDOC's TPA for off-site medical treatment for inmates and noted a lack of detail on billings. For example, pharmaceuticals are listed as "1 unit" with no indication or explanation of drug administered. NDOC is unable to determine what kind of medications and other medical supplies being used for treatment and if appropriate for the inmate's condition at the lowest cost option.

NDOC Responsible for Oversight

NDOC is responsible for providing inmates with health care that is consistent with a level of care that would be received in the community. NDOC sends inmates to off-site providers to receive appropriate care. However, NDOC does not review billing information for services paid for inmates because they rely on the TPA to ensure billings are correct. The TPA's system for processing invoices and billing, in general, successfully vets inappropriate billings, such as double billings, Medicaid claims, and miscoding; however, the TPA does not review for appropriate services rendered.

NDOC's UR Committee should review and reconcile billings to ensure services paid for match services rendered and were appropriate for what they authorized for treatment of care. NDOC does not see provider billings the TPA pays. However, NDOC has the ability to review the explanation of billing (EOB) through the TPA's website. The EOB provides summary information of medical services rendered but does not include detailed medical notes and diagnoses information. By reviewing the medical codes on the EOB's, NDOC could reconcile billed services to authorized treatments to ensure NDOC is paying for medical services rendered and those services were appropriate. However, the EOB alone may not be sufficient for the UR Committee to perform a proper review and analysis of an inmate's treatment. It may be necessary for NDOC to have access to the TPA's billing information, which includes detailed medical notes and diagnoses information, to perform a proper review and analysis.

State Guidelines Require Supporting Documentation for Payments

State guidelines for billing and payments require review and reconciliation. Per SAM 2616 Supporting Documentation for Transactions, a department or agency should maintain documentation justifying expenditures, including original billings or other evidence documenting the state's obligation to pay the claim.

Conclusion

Reviewing medical payments made to providers and reconciling to supporting medical documentation and authorization will help ensure services paid for reconcile to services rendered and were appropriate for the authorized treatment of care.

Recommendation

1. Review and reconcile billing and medical payments for off-site medical services.

Perform Targeted Case Management for Inmates' Off-Site Medical Care

NDOC should perform targeted case management for inmates' off-site medical care, to include in-patient and out-patient services. This effort will allow NDOC to participate in on-going treatment regimens to ensure quality of care. This could benefit the state by reduced Medicaid contributions and lower inmate medical costs. NDOC's investment in an additional senior nurse will help manage costs as well as the processes for targeted case management and the UR Committee.

Costs May Be Reduced by Performing Targeted Case Management

NDOC may be able to reduce costs by performing targeted case management while inmates are in hospitals. Targeted case management for inmates in hospitals includes establishing advanced treatment protocols, proactive treatment consultation, post-admittance care, and discharge planning:

- Advanced treatment protocols would include, at a minimum, treatment directives to hospital staff for NDOC inmates, including considerations for least cost options and significant treatment decisions.
- Proactive treatment consultations would include, at a minimum, helping develop and manage treatment plans.
- Post-admittance care would include, at a minimum, evaluating the effectiveness and quality of care, and recommending treatment as necessary.
- Discharge planning would include, at a minimum, helping develop and manage the inmate's transition from the hospital to NDOC facility care.

Performing targeted case management will help NDOC manage progress, ongoing treatment regimens, and quality of care.

NDOC Does Not Perform Targeted Case Management for Inmates in Hospitals

NDOC does not perform targeted case management for inmates in hospitals. NDOC reports the Director of Nursing Services receives daily clinical reports and calls hospitals for progress updates on inmates during their stay in the hospital, including coordinating the inmate's discharge from the hospital. However, NDOC does not consult with hospitals to ensure they use the least cost options for treatments or that inmates in observations status are appropriately managed. Moreover, NDOC does not have established protocols with hospitals for managing inmate care.

NDOC's Third Party Administrator Does Not Perform Targeted Case Management for Inmates in Hospitals

NDOC's TPA does not provide targeted case management to review the inmates' medical care during their stay in the hospital to ensure appropriate care. This service is not part of the current TPA contract. Other states use their TPA to conduct targeted case management while inmates are in hospitals.[1]

Oregon Reduced In-Patient Costs by 20 Percent from Targeted Case Management

In 2010, the State of Oregon Department of Correction's (ODOC) contracted with its TPA to provide targeted case management for inmate medical services. ODOC's TPA has two nurses to monitor and ensure inmates are receiving appropriate care during their stay in hospitals. ODOC was able to save 20 percent on in-patient hospital costs over a two year period (approximately 10 percent per year) through targeted case management. This effort enabled Oregon to reduce observation days, length of stay, and consult on treatment options, and other medical decisions for inmates in hospitals.

NDOC May Require An Additional Senior Nurse

To implement targeted case management, NDOC represents it will need additional resources. The structure to accomplish targeted case management for inmates in hospitals is largely in place. Medical staff are receiving clinical reports and updates on inmate progress.

Proactive management may require an additional senior nurse. Moreover, the senior nurse may be the appropriate staff to manage the UR Committee review and reconciliation process. The new senior nurse will provide continuity for managing inmate care through the entire process as inmates receive authorization for off-site care, receive off-site treatment, and return to the NDOC facilities for post-admittance/recovery care. The additional senior nurse will free time for NDOC's Director of Nursing and other staff who currently work inmate hospital issues part-time to focus on priorities elsewhere.

We estimate the cost to NDOC for an additional senior nurse to complete the targeted case management process and coordinate the UR Committee process will be approximately $150,000 annually.

[1] Oregon and Colorado.

In-Patient Hospital
Potential Savings

Nevada's Medicaid contribution varies for the inmate population. Currently, 15 percent of the inmate population qualifies under the 65/35 percent federal/state match (inmates 65 years of age and older; most women); 85 percent of the inmate population qualifies under the Affordable Care Act's 97.5/2.5 percent federal/state match (newly eligible).

In fiscal year 2017, Medicaid paid $3.6 million for inmate hospital care. By performing targeted case management for inmates in hospitals similar to ODOC, NDOC could help reduce total Medicaid payments by up to 10 percent, or $360,000.[2] Under current ratios, Nevada's Medicaid contribution savings would be approximately $26,500.[3]

In fiscal year 2017, NDOC paid about $605,000 for in-patient hospital stays not billable to Medicaid. By performing targeted case management similar to ODOC, NDOC could help reduce costs up to 10 percent, or $60,000.

Out-Patient
Potential Savings

In fiscal year 2017, NDOC spent $3.8 million on out-patient medical care, excluding in-patient hospital stays.[4] Given the estimated potential savings from Medicaid, NDOC would need to achieve an additional savings from outpatient medical care of $63,500 or approximately 1.7 percent to cover the cost of an additional senior nurse.[5] Moreover, targeted case management should achieve additional benefits from inmates' quality of care.

NDOC Responsible for Inmate Quality of Care

NDOC is responsible for providing inmates with health care that is consistent with a level of care that would be received in the community. NDOC does not include targeted case management for inmates in hospitals to ensure medical services are appropriate. NDOC believes targeted case management is an elevated level of care over the community standard.

---

[2] Total NDOC Medicaid Payments FY 2017 = $3,596,410.50
Total Medicaid Contribution Savings = $3,596,410.50 * 10 Percent = $359,641.50 ~ $360,000

[3] Nevada Medicaid Savings for 15 percent inmate population at 35 percent contribution = $359,641.50 * 15 percent * 35 percent = $18,881.16 ~ $18,900
Nevada Medicaid Savings for 85 percent inmate population at 2.5 percent contribution = $359,641.50 * 85 percent * 2.5 percent = $7,642.37 ~ $7,600
Total Nevada Medicaid Savings = $18,900 + $7,600 = $26,500

[4] Outpatient Hospital Stay and Same Day Surgery Center Visit

[5] $150,000 (Cost of Senior Nurse) - $86,500 (Hospital Savings) = $63,500 (Savings to be Achieved in Out-Patient Costs)

Unless NDOC contracts with the TPA to assume and provide targeted case management, NDOC's medical division should perform targeted case management to ensure inmate medical services are appropriate.

Conclusion

Performing targeted case management for inmates' in-patient and out-patient medical care will help NDOC monitor the inmates' progress, on-going treatment regimens, and quality of care. This effort could benefit the State by reduced Medicaid contributions and lower inmate medical costs. NDOC's investment in an additional senior nurse will help manage costs as well as the processes for targeted case management and the UR Committee.

Recommendation

2. Perform targeted case management for inmates' off-site medical care.

Ensure In-Network Providers are Used for Off-Site Medical Services

NDOC should ensure in-network providers are used to the fullest extent possible for off-site medical services. This effort will allow NDOC to take advantage of negotiated provider rates. This will also allow NDOC to define the medical requirements expected from a network provider.

NDOC's Contracted Preferred Provider Organizations (PPO) Do Not Meet All Treatment Requirements

NDOC's two contracted Preferred Provider Organizations (PPO) do not meet all treatment requirements inmates may have.[6] Consequently, off-site medical referrals are sometimes made to doctors who are not part of the provider network because in-network doctors are not available or the required service, such as air ambulance transport, is not part of the provider agreement.

In-Network Doctors Not Always Used

Our sample noted 16 non-emergency instances, or about eight percent, where inmates were treated with out-of-network providers and may have been able to be treated with in-network providers. Per NDOC, these out-of-network providers were the only providers willing to perform treatment for inmates.

Both NDOC and ODOC report doctors are reluctant to treat inmates. To help ameliorate this challenge, NDOC states they take inmates to the doctors' offices through the back door usually before or after business hours to get treatment to avoid interaction with other patients. Consequently, it is difficult to recruit and retain providers and it is necessary to use out-of-network providers.

NDOC Choice of Provider Drives Doctor Selection in the South

NDOC consistently uses one out-of-network urologist in the South. NDOC states this provider is willing to serve inmates on-site at rural correctional facilities, such as Ely and conservation camps. Consequently, when these inmates require off-site urology treatment, NDOC chooses to take inmates to this same provider.

[6] The PPO in the North is Hometown Health. The PPO in the South is Sierra Healthcare Options.

NDOC paid approximately the same rate for the out-of-network urologist in the South as the in-network urologist in the North.[7] Urology services are available in the PPO in the South; however, NDOC has not ensured in-network providers are used for off-site urology services.

The PPO in the South stated their rates are 60-70 percent of billed charges. Our review showed, in general, rates in the South are a third of rates in the North.[8] However, we were unable to determine if the in-network rate in the South is comparable to the out-of-network rate paid in the South for urological services because NDOC, the TPA, nor the PPO could provide rate information. Moreover, there was not historical billing data for a urologist in the South because NDOC represents doctors in the PPO in the South will not treat inmates. NDOC is missing a potential opportunity to lower costs by managing off-site urological services for inmates.

Lack of In-Network Guaranteed Rate for Air Ambulance Services Led to Higher Costs

We reviewed all air ambulance charges in fiscal year 2017. There were a total of 24 air ambulance claims totaling $890,000. NDOC incurred additional costs as a result of billing and payment errors with one provider.

The majority (60 percent) of air ambulance services were provided by one vendor based in Salt Lake City, Utah. The TPA had a letter of agreement with the vendor that included that included discounted rate for services. The vendor was not paid in a timely manner for a flight that occurred in 2014. After protracted discussions about the outstanding payment, the vendor did not honor the discounted rate. Subsequently, two flights provided by the Utah air ambulance service were billed and paid at full price, costing NDOC an additional $26,000.

A contract with the Utah air ambulance service was negotiated at the guaranteed rate of three times the Medicare rate from October 2016 through March 2017. This contract resulted in air ambulance service costs of approximately $70,000 discounted to $23,500 per flight for this vendor.[9]

The PPO has recently entered into a new air ambulance contract serving the Ely and Lovelock facilities. However, the remaining NDOC facilities are not covered by a PPO contracted air ambulance service.

---

[7] Urology treatments include an ultrasound, biopsy, and associated care.

[8] We sampled 197 billings for inmate off-site medical services in fiscal year 2017. Based on our sample, in general, rates in are three times higher in the North.

[9] Medicare rate is based on costs of approximately = $4,700 (Basic rate) + $3,100 (Mileage rate) = $7,800 x 3 = $23,400.

Conclusion

Ensuring in-network providers are utilized to the fullest extent possible for off-site medical services will allow NDOC to take advantage of negotiated provider rates and to define the medical requirements expected from a network provider.

Recommendation

3. Ensure in-network providers are utilized for off-site medical services.

Appendix A

Scope and Methodology, Background, Acknowledgements

Scope and Methodology

We began the audit in February 2018. In the course of our work, we interviewed staff and discussed processes inherent to Nevada Department of Corrections' (NDOC) responsibilities. We reviewed NDOC records for fiscal years 2015 through 2017, applicable Nevada Revised Statutes and other state guidelines. We also surveyed other states, comparing management of inmate medical services.

This audit included a compilation and detailed analysis of multiple data sets, including NDOC medical records, third party administrator (TPA) billing and claims information. We also conducted interviews and discussions with TPA staff and Oregon Department of Corrections officials.

We concluded field work and testing in May 2018.

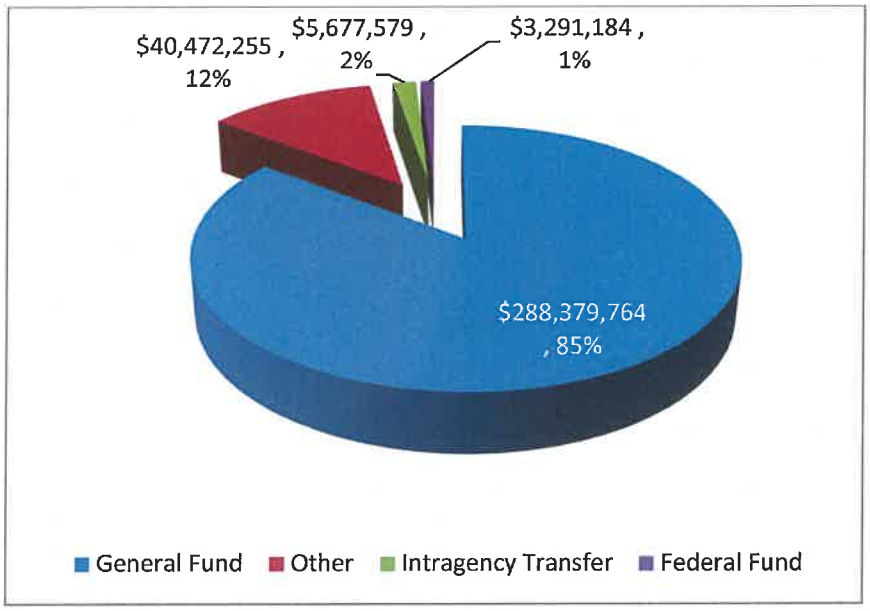
We conducted our audit in conformance with the *International Standards for the Professional Practice of Internal Auditing.*

Background

NDOC improves public safety by ensuring a safe and humane environment that incorporates proven rehabilitation initiatives that prepare individuals for successful reintegration into Nevada's communities. NDOC's budget for fiscal year 2018 was approximately $338 million. Exhibit III summarizes NDOC's funding sources for fiscal year 2018.

Exhibit III

Nevada Department of Corrections Funding Sources
Fiscal Year 2018



Source: 2018 Legislatively Approved Budget
Table Note: Other includes balance forward from prior year and appropriations.

NDOC is responsible for providing inmates with health care that is consistent with a level of care that would be received in the community. NDOC's Medical Division's fiscal year 2018 budget is $45.7 million. NDOC's Medical Division oversees the delivery of health services. NDOC officials indicated that inmates often have significant health care needs when they enter NDOC facilities. NDOC contracts with Hometown Health to use their provider network that offers negotiated discounted rates as well as contracts with outside health care providers for specialist services and certain testing and treatments such as remote electrocardiogram readings and clinical laboratory services. The providers treat inmates in correctional facilities or at off-site locations such as hospitals or other medical facilities.

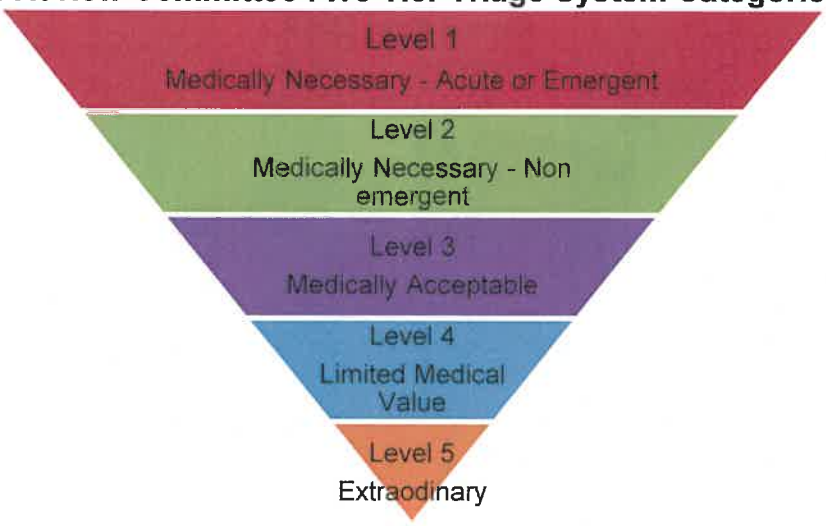
Additionally, NDOC contracts with Hometown Health as its TPA to process billings and make payments to providers based on negotiated rates which are typically based on an agreed upon percentage above the Medicare rates or those rates that were negotiated with the TPA. Moreover, some providers have a written agreement with the TPA to stipulate payment rates. When there is no provider agreement, NDOC, via the TPA, pays all billed amounts.

Utilization Review Committee Triage System

Exhibit IV shows NDOC's Utilization Review Committee five tier triage system and categories of care. This system helps the committee makes decisions about appropriate treatments for inmates, including off-site medical services.

Exhibit IV

Utilization Review Committee Five Tier Triage System Categories of Care



Level 1: Medically Necessary-Acute or Emergent – Medical conditions that are immediate, acute, or emergent in nature which have a likelihood of rapid deterioration. Example: Myocardial infarction, severe trauma, hemorrhage.

Level 2: Medically Necessary – Non Emergent – Medical conditions that are not immediately life threatening, but which without care, the health of the inmate would not be maintained without significant risk or further deterioration which might be life-threatening. Example: Diabetes, asthma, hypertension, cancer, pregnancy.

Level 3: Medically Acceptable – Not Always Necessary – Medical conditions that do not significantly interfere with the inmate's ability to function in their current living situation. Example: Corneal transplant, joint replacement, hearing aids.

Level 4: Limited Medical Value – Medical conditions in which treatment provides little or no medical value. Example: Tattoo removal, cosmetic surgeries.

Level 5: Extraordinary – Interventions which involve the life of another individual or are considered investigational. Example: Organ transplant.

Acknowledgments

We express appreciation to NDOC staff for their cooperation and assistance throughout the audit.

Contributors to this report included:

Warren Lowman
Executive Branch Audit Manager

Ashwini Prasad, CPA, CIA, CGMA
Executive Branch Auditor

Craig Stevenson, MBA
Executive Branch Auditor

Appendix B

Nevada Department of Corrections
Response and Implementation Plan

Northern Administration
5500 Snyder Ave.
Carson City, NV 89701
(775) 887-3285

Southern Administration
3955 W. Russell Rd.
Las Vegas, NV 89118
(702) 486-9912

State of Nevada
Department of Corrections

Brian Sandoval
Governor

James Dzurenda
Director

John Borrowman
Deputy Director
Support Services

May 24, 2018

RECEIVED
MAY 24 2018
DIVISION OF INTERNAL AUDITS

Steve Weinberger, Administrator
State of Nevada, Governor's Finance Office
Division of Internal Audits
209 East Musser Street, Suite 302
Carson City, Nevada 89701

Mr. Weinberger,

Thank you for the opportunity to meet with your audit team in pursuit of improving the Nevada Department of Correction's (NDOC) inmate off-site medical care management. Your audit team was courteous, professional and accomodating. Your audit team met with our staff in Carson City and spent time field testing documents and processes in Reno with the agency's Third Party Administrator (TPA). NDOC is in receipt of the audit team's report and agrees with pursuing all three of the recommendations.

The report provides three recommendations where NDOC can improve the medical administration of medical services to confirm if services and payments for services were necessary and correct. By allocating resources to perform the recommendations, NDOC could potentially improve the quality of care through continuity of care and protocols. The report does not conclude that any billing or payment through the third party administrator was incorrect, that any service by an outside medical provider was unnecessary or inappropriate, or that in-network providers would have provided all necessary medical services. The report also does not conclude NDOC should have referred any more or less medical conditions for treatment by an outside medical provider.

The following provides comparisons of NDOC to the correctional departments in the referenced states and compares NDOC to other Nevada agencies. The audit report compares NDOC's medical services to the correctional departments in Oregon and Colorado. Per an October 2017 Pew report measuring each state's medical spending per inmate, Nevada is ranked 47th lowest cost in the nation, only spending more than Alabama and Louisiana (Note: only 49 states were ranked as New Hampshire did not provide data for the study.). Oregon is ranked 7th and Colorado is ranked 21st in the nation in medical spending per inmate. Below is a table summarizing the medical spend on inmates for Nevada, Oregon and Colorado department of corrections for the two state fiscal years in the 2017-19 biennium:

State	Inmate Population (approximate)	Medical Division Positions	Legislatively Approved Budget	Per Inmate/Per Month Costs	National Ranking
Nevada	14,000	288.62	$92.5 million	$275	47th
Oregon	14,700	349.37	$249.3 million	$706	7th
Colorado*	14,204	387.50	$207.6 million	$609	21st

*Using only inmates in a DOC institution

For additional perspective, the NDOC compared its medical spending in SFY17 to other state agencies (albeit that serve potentially healthier populations) and found NDOC ranked the lowest on a per member per year comparison. The table below provides a summary comparison of total spending per budget account to total members/inmates in SFY17:

Nevada State Agency	Total Spent in SFY17	Population	Annual Cost/Member
NDOC	$49,865,978	13,716	$3,636
PEBP (1)	$358,223,701	70,000	$5,117
PEBP (2)			$6,996
DHCFP (newly eligible)			$5,808

1. Calculations based solely on PEBPs 2017 budget expenses
2. Calculation is per member per month cost from PEBP: $451 medical + $59 prescription + $73 PPO = $583 x 12 months = $6,996

Recommendation #1:

Review and reconcile billing and medical payments for off-site medical services

NDOC agrees with the recommendation to provide additional review and reconciliation of medical billings for off-site medical services to ensure the appropriate services were provided and billed, but does not agree the NDOC Utilization Review (UR) Panel is the appropriate resource to complete this action. The NDOC would propose to assign this task to the new Director of Nursing position recommended for targeted case management (recommendation #2).

The UR Panel is comprised of institutional practioners, the Medical Director, and the Quality Assurance Specialist IV. The UR Panel meets once a week to review the medical needs of inmates that are being recommended for outside medical care by NDOC's internal providers. The UR Panel meets for 2-4 hours depending on the number of outside medical referrals being considered. The institutional practioners are unable to provide medical treatment to inmates while carrying out the duties of the UR Panel. Adding the task of reviewing and reconciling medical billings will further reduce the number of hours NDOC's medical providers spend treating inmates. The NDOC does not believe this is best use of the medical providers' time. Having a new Director of Nursing position dedicated to work with the UR Panel and reconcile the medical billings to the authorized medical services would be reasonable, cost effective, and provide the desired continuity.

As with PEBP and DHCFP, the NDOC Medical Division contracts for TPA services, including payment of all claims for outside medical services. The report did not identify any concerns with the payments that were authorized and paid. But the report highlighted the medical billing claims viewable remotely using the software's user interface did not provide enough detail to clearly identify the specific medical supplies being used for medical treatment and if they were the most cost effective option. The NDOC confirmed with the TPA that the detail provided in the medical claims received from outside providers for payment were consistent with the industry standard. Changing the level of detail on the medical billing claims would be outside of the industry standard and would require each medical provider to change their customary billing practice and possibly require a TPA software system modification. It is also unclear if an industry billing code is available

to discriminate among the pricing for each available treatment option, including differences in drug pricing, to generate a cost savings to the department. The NDOC will request a separate bid component for enhanced remote billing claim detail to both the TPA and preferred provider organzation RFPs as both contracts will expire on June 30, 2019. The isolated bids will be analyzed for the cost-benefit ROI.

Recommendation #2:
Perform targeted case management for inmates' off-site medical care

NDOC agrees with this recommendation and will include an enhancement decision unit in the 2019-21 biennium budget asking for the additional Director of Nursing position to provide targeted case management (as defined in the report). The new position will cost approximately $146,000 per year and could save the state approximately $150,000 in General Funds per year ($123,500 saved in NDOC's budget and $26,500 saved in Medicaid's budget).

NDOC currently provides some of the targeted case management duties (as defined in the report), including preparing the emergency room provider for the arrival of an inmate, receiving daily clinical reports and monitoring the services provided to inmates once admitted to a hospital, and preparing and coordinating the medical needs of the inmate once discharged from the hospital. The NDOC medical staff does not have the current capacity to initiate and ensure advanced treatment protocols are in place for both in-patient and out-patient services or to recommend treatment plans to outside medical providers for inmates under the outside medical provider's care to ensure the inmate is receiving the community standard of care in the most cost effective manner. NDOC verified PEBP and DHCFP do not provide this scope of targeted case management. The new Director of Nursing position will be able to establish relationships with outside medical providers throughout the state and provide a service that is above the community standard of care.

The report points out the Oregon Department of Corrections was able to save ten percent for in-patient hospital costs for inmate medical services each year for two years when it contracted with a TPA to provide targeted case management services in 2010. The NDOC would note the Affordable Care Act became law on March 23, 2010 and the majority of the provisions came into effect in January 2014. The Affordable Care Act and Medicaid Expansion has allowed inmates to become eligible for medicaid when admitted to a hospital so this expenditure (and potential savings) is no longer within the NDOC medical budget. While the agency believes there are potential cost savings by performing targeted case management (as defined in the report), the rates for out-patient services are negotiated by the contracted preferred provider organizations and the rates for in-patient services and medical products are primarily directed by Medicaid. Savings may be generated by recommending more cost effective medical product options, recommending treatment plans for outside medical providers to consider, and potentially reducing the length of stay during admissions to reduce custody coverage expenditure.

Recommendation #3:
Ensure in-network providers are utilized for off-site medical services

NDOC agrees with this recommendation and will draft the RFP to pursue the preferred provider networks with the best performing providers to meet the needs of the inmate population.

The report states the NDOC and the Oregon Department of Corrections have providers in their contracted networks that are reluctant to treat inmates or provide on-site services. Unless required in statute for emergency

services, a provider may refuse to provide services to inmates. Having qualified providers in the contracted network does not guarantee those providers will agree to provide services to inmates. In order to provide quality healthcare, the NDOC has exhausted the provider list in the network for some services and has had to utilize providers who are not in the contracted networks. NDOC will continue to monitor the situation to use in-network providers when a provider is available to ensure the state is getting the most cost effective option while providing the medical community standard of care to inmates.

The providers on a network change throughout the course of a contract. NDOC has experienced this with not only medical providers but also with emergency transporation providers. Preferred provider organization networks do not typically have contracts with air ambulance providers. When a medical emergency exists at a correctional institution, the NDOC must provide the necessary medical treatment to the inmate and use whatever vendor is able to provide the service, regardless of whether or not there is a contract with a vendor on the network. Fortunately, a new contract was just negotiated with MedX AirOne, which can serve Lovelock Correctional Center and Ely State Prison.

NDOC appreciates the opportunity to discuss the recommendations in this report with the Executive Branch Audit Committee and pursue potential solutions to better manage medical care for inmates as well as reduce expenditures where applicable.

Thank you,

J R Borrowman 5/24/18

John Borrowman
NDOC Deputy Director, Support Services

Appendix C

Timetable for Implementing Audit Recommendations

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

Category 2: Recommendations with an anticipated implementation period of more than six months.

Recommendations	Time Frame
1. Review and reconcile billing and medical payments for off-site medical services. (page 6)	Oct 2020
2. Perform targeted case management for inmates in hospitals. (page 10)	Oct 2020
3. Ensure in-network providers are utilized for off-site medical services. (page 13)	Jul 2019

The Division of Internal Audits shall evaluate the action taken by NDOC concerning report 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 NDOC.