Audit Report

Social Services
Community Triage Center Agreement

January 2018

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REPORT DETAILS

BACKGROUND

The WestCare Community Triage Center (CTC) was established in 2003 to alleviate the overcrowding in hospital emergency rooms and local government detention centers. CTC was operated at 930 North 4th Street until the end of December 2015, when it opened operations at a new location at 323 North Maryland Parkway in Las Vegas.

The Board of County Commissioners approved the most recent agreement to fund the CTC on August 18, 2015, known as the Agreement Relating to the Provisions of Funds for the Community Triage Center (Agreement), for a period from July 1, 2015 to June 30, 2016. Under the Agreement, the State of Nevada provides $1,005,500 from State Substance Abuse Prevention and Treatment Agency (SAPTA) grants, and local governments and hospital provide $1,726,481 in funding and $258,630 of in-kind contributions. Clark County’s portion is $456,185. The total Agreement amount is $2,990,611.

The CTC Oversight Committee monitors the Community Triage Center. Clark County provides oversight on behalf of the Southern Nevada Regional Planning Coalition. This includes analyzing and inspecting the services of WestCare’s operation of the CTC, including but not limited to inspection of WestCare’s books and records as they pertain to the Agreement. Clark County assigned the oversight to Community Resources Division, which is currently under the direction of the Social Services Department.

The Agreement requires that the CTC provide no less than 50 triage beds for inpatient mental health, substance abuse, and detoxification services to adults and youths who are homeless, and/or chronic inebriates who are not in need of emergency room care and cannot gain access to other community provided shelters. WestCare is licensed as a Non-Profit Drug and Alcohol Counseling entity. The CTC is not licensed as a mental health facility and is not a secure detoxification unit. Hospital patients who are placed on a legal hold may not be transported to the CTC until the hold is lifted in accordance with Nevada Revised Statute 433A.160 and 433A.165. Under Nevada Revised Statute 458.175, if law enforcement arrests or takes into custody a person who is found in any public place to be unlawfully under the influence of a controlled substance and unable to care for themselves, law enforcement may take them to the CTC for observation and care. Persons who are arrested or taken into custody in other than a public place must be taken to a secure detoxification unit. The CTC does not place legal holds on clients and is not a secure facility. Further, the CTC does not restrain or place clients in seclusion, and CTC clients may leave at their own will.

WestCare is to provide transportation services for referrals from Agreement participating hospitals to CTC available 24 hours a day, 7 days a week, at no additional cost to the hospital. WestCare agreed to accept self-referred clients, and those clients referred by law enforcement agencies and emergency medical service providers, as an additional means to lessen overcrowding at hospitals and detention
centers. The CTC provides monthly status reports to hospitals and local government parties. According to the Agreement, the basis of the reports is the number of persons referred and clients served. WestCare developed an in-house computer program, Clinical Data Systems, to provide financial support, patient case management, and capture data for clinical care, for all of the WestCare programs. This new system was implemented during the course of our audit period.

As a result of the Affordable Care Act expansion of parity rules (mental health and substance abuse treatment are at the same level as regular medical care), Nevada State Medicaid expanded coverage for mental health, including substance abuse disorders (drug and alcohol). WestCare was then able to bill Medicaid for clients served at the CTC for the entire Agreement period. In a memorandum issued to the CTC Oversight Committee dated April 26, 2017, WestCare proposed a credit (or rebate) to Agreement participants in the amount of $655,055 to be applied to FY17 payment. WestCare offered the credit, as participants originally understood that payments from the Agreement were the sole source of funding for CTC, and not in addition to other funding sources, such as Medicaid.

**OBJECTIVES, SCOPE, AND METHODOLOGY**

The objective of this audit was to determine whether WestCare is complying with the Community Triage Center Agreement provisions, including a review of the calculated credit. We conducted our audit procedures for the period from July 1, 2015 to June 30, 2016.

In order to achieve our objective, we interviewed CTC management and staff and performed a walkthrough of the CTC facility located at 323 North Maryland Parkway in Las Vegas. At that time, we observed triage beds and CTC operations.

We obtained invoices from Clark County financial records and verified that payments were made in accordance with agreement provisions.

We obtained monthly CTC reports from Clark County Social Services. We also obtained CTC data for all CTC clients served during the period of the agreement (4,625 clients).

Our audit procedures for detailed testing included the following:

- We analyzed the data provided by the CTC for duplicates based on client number and admit date.
- We further analyzed the data for clients that did not stay overnight (zero days) and overlapping dates by client and by bed assignment.
- We performed an analysis to count the number of clients served by day.
- We compared this count, adjusted for duplicates and overlapping days by client and bed numbers, to the number of clients served on the monthly reports.
- We performed an outlier analysis to determine a normal range for length of stay. Based on the outlier analysis results, we calculated an average length of stay. This data was analyzed to recalculate the WestCare credit and conclude on the reasonableness.
We judgmentally selected 39 client records from the data provided for detail testing in order to determine the reasonableness of the accuracy of the data reported. We reviewed client and electronic files on the Clinical Data System with WestCare staff. We verified the following:

- Client was treated at the CTC
- Triage date
- Admit and Discharge dates
- Medicaid billing notations and Medicaid number
- Benefit authorization forms to determine whether the patient was insured
- Hospital referral forms to verify referral source
- Transportation forms for hospital referred clients
- Reason for length of stay longer than 7 days
- Reason for the discharge (medically cleared, against medical advice, transferred to another WestCare program).

We calculated an estimate of the credit based on Medicaid billing and collection data. CTC provided 2,388 records for clients that were billed under Medicaid. We used this data to develop an estimated credit based on the number of Medicaid paid days and the total Agreement amount divided by 50 beds and 366 days (Leap Year) in the Agreement period.

We developed a count of clients served by day from the Medicaid billing data. We compared the daily count to the available 50 beds to determine whether more clients were served than is reasonably possible (indicating that the data is potentially unreliable).

To verify the accuracy of the Medicaid data provided, we tested a representative sample of the Medicaid billing data for 2,388 records. Our representative sample size of 71 was based on a 95% confidence level, 0.5% anticipated rate of occurrence, and 5% desired precision range. To conduct our testing, we randomly selected files using a random number generator and obtained Medicaid claim forms for those stays. We then verified Medicaid numbers, dates charged, charge amounts, and that the charge code pertained to detox and substance abuse treatment for each selection.

We attempted to obtain insurance documents to verify compliance with Agreement insurance provisions.

Our review included an assessment of internal controls in the audited areas. Any significant findings related to internal control are included in the detailed results. The last day of fieldwork was October 17, 2017.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate
evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

CONCLUSION

WestCare is complying with contract terms and conditions for transport services for referred patients from hospitals to the CTC. Fifty triage beds are available for CTC clients based on observations of triage beds. Further, Clark County reasonably made payments in accordance with agreement provisions.

However, we were unable to verify that reports submitted by WestCare included accurate figures for the number of clients served. We could not determine an accurate number of clients served under the Agreement due to errors and unreliable data integrity on information maintained by WestCare.

WestCare is receiving Medicaid reimbursements for clients served at the CTC. WestCare was unable to provide us with the exact data used to calculate the credit proposed in the April 26, 2017 letter. While they did provide us with support for the calculation, we could not verify the credit amount based on uninsured client count and average length of stay. Based on the information we were able to obtain (and various assumptions), we calculated that the credit should be $1,099,670. This represents a difference of $494,115 from the WestCare calculated credit.

The CTC is reporting the number of clients served but is not reporting the number of referrals from local hospitals, law enforcement, and emergency medical response. WestCare turns away certain referrals. We were unable to determine how many referrals are turned away that could be treated at WestCare. This includes those individuals who do not require medical attention but need further assistance with detoxification and mental health that are typically sent to WestCare from local hospitals and detention centers. Since the Agreement was developed to decrease the burden on local emergency rooms, the amount of diversion is critical to measuring the success of the program.

Each finding includes a ranking of risk based on the risk assessment that takes into consideration the circumstances of the current condition including compensating controls and the potential impact on reputation and customer confidence, safety and health, finances, productivity, and the possibility of fines or legal penalties.

Auditee responses were not audited and the auditor expresses no opinion on those responses.
FINDINGS, RECOMMENDATIONS, AND RESPONSES

FINDING 1 – CTC CREDIT IS UNDERESTIMATED (HIGH)

WestCare proposed a credit of $655,055 to compensate Agreement participants for Medicaid billing revenue. We estimate that the credit amount should be $1,099,670.

The Agreement was entered into on the premise that the CTC could not obtain funding from other sources for the target population. However, changes to Medicaid under the Affordable Care Act allowed WestCare to bill and receive payments from Medicaid for clients serviced under the Agreement.

WestCare began to establish processes for billing Medicaid for CTC clients in June of 2015. While this was discussed in the CTC Oversight Committee on June 24, 2015 (prior to the entering of the Agreement on August 18, 2015) the parties did not know how much revenue would be generated from Medicaid payments. The chart below shows the growing trend for Medicaid clients.

During the CTC Oversight Committee on April 26, 2017, CTC management provided an estimated credit of $655,055 for participating partners in the Agreement based on the prior year. They proposed that this credit be applied to a subsequent agreement and allocated to participants based on the contract funding formula. The CTC credit of $655,055 is based on the number of uninsured clients, the average length of stay, and a cost of $150 per day based on the contracted funding contributions.

WestCare did not provide us with the original data used to calculate the credit, as they determined the data was incorrect. WestCare did provide us with alternate client data, to be used to estimate the credit. However, we found significant errors in that data and could not use it to re-calculate the estimated credit.
Therefore, we obtained the Medicaid billing client data for the CTC in order to estimate a credit for beds available to uninsured clients. We calculated an estimate of the credit at $1,099,670 for all Agreement participants. This represents an amount of $494,115 over the amount estimated by WestCare. The calculation was based on the number of Medicaid paid days and a daily bed rate of $149.29. The daily bed rate was calculated from the Agreement amount of $2,731,981 (excluding in-kind contributions), 50 triage beds, and a 366 day year. The portion of the estimated credit for Clark County is $183,634. Based on Clark County’s funding obligation of $456,187, with a daily bed rate of $24.93. We assumed that all Agreement amounts were paid by participants and a Medicaid benefit paid day is a full use of the bed and therefore not available to uninsured clients.

In order to further verify our estimate, we performed an analysis to determine the reasonableness of the number of Medicaid paid clients served per day. Since WestCare provided the service dates and not the exact dates Medicaid paid, we determined the number of clients served by day from the first service date and then by the number of days Medicaid paid. The number of days Medicaid paid was determined by the total amount paid as Medicaid pays a flat rate. This methodology assumes that any Medicaid denial of days occurs at the end of the service period. This would affect the count of the clients serviced by day. We found that the number of Medicaid clients did not exceed the 50 available beds in any given day, providing some level of support for our estimate.

RECOMMENDATION

1. Coordinate with County Management on the appropriate direction to determine whether agreement amounts may be recovered due to WestCare receiving additional funding from Medicaid.
2. Include provisions in any future agreement for circumstances such as additional revenue sources, where funding partners are entitled to recover excess funds, or use an alternate funding model that takes this into consideration.

MANAGEMENT RESPONSE

1. The agreement with WestCare requires that the agency provide a centrally located drop-off triage center of no less than 50 beds for those mentally ill and chronic inebriates who are not in need of emergency room care. During the audit period, WestCare received reimbursements from Medicaid in addition to the funding contributed by the local government and hospital partners to support services for these 50 beds. There is no indication that WestCare provided services for more than the 50 beds during the period. County Management agrees with the audit assessment that WestCare should credit the county for $1,099,670. Based on this audit, County Management will work with WestCare and the CTC Oversight Committee to determine how this amount may be recovered, perhaps by being applied toward costs incurred outside of the contract period since July 1, 2016. WestCare would need to provide a financial report that shows the total costs of services and total revenues for the period in order to establish that value. County Management will also work with the CTC Oversight Committee to create a monitoring plan for WestCare or any other agency that provides these services.
2. All future interlocal agreements with WestCare or any other contracting agency that provides these services will include provisions for circumstances such as additional revenues from sources like Medicaid. Future agreements will specify how any excess funds will be recovered and used. Future agreements may also specify how the partnership deals with budget shortfalls. County Management will engage with the CTC Oversight Committee and WestCare to review the existing version of the interlocal agreement in relation to how effectively the agreement language requires alignment of the scope of work and budget, and how clearly the language requires specific financial tracking and reporting to the funding partners. As part of this work, the group will clarify the expectations for financial reporting, including such reports as quarterly income statements. All changes to the interlocal agreement will be reviewed by legal counsel.
FINDING 2 – MONTHLY REPORTS ARE BASED ON INACCURATE DATA (HIGH)

The Agreement requires WestCare to submit monthly status reports to the participants. We obtained client data from the CTC and compared the number of clients served to the totals reported in the months of October 2015, December 2015, February 2016, April 2016, May 2016, and June 2016. The data provided by WestCare did not agree to the monthly reports. We found discrepancies ranging from 33 clients underreported to 145 clients over-reported per month. The CTC client served count does not include clients who did not stay for the day, or zero day clients. We also excluded zero day clients.

We judgmentally selected 39 patient files to verify whether WestCare provided accurate data. We found the following errors:

<table>
<thead>
<tr>
<th>Error Type</th>
<th>Number of Errors</th>
<th>Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients that did not participate in CTC program</td>
<td>3</td>
<td>Clients from another program operating in the same building coded as CTC client.</td>
</tr>
<tr>
<td>Duplicates</td>
<td>5</td>
<td>Data conversion errors from State of Nevada System.</td>
</tr>
<tr>
<td>Duplicates</td>
<td>1</td>
<td>Data entry error, with client intake record entered twice.</td>
</tr>
<tr>
<td>Transport Form Missing for Hospital Referrals</td>
<td>6</td>
<td>Transport forms not fully implemented.</td>
</tr>
<tr>
<td>Medicaid Number</td>
<td>5</td>
<td>Medicaid number not associated with client service dates and incomplete information. Medicaid process not fully implemented.</td>
</tr>
<tr>
<td>Triage Only</td>
<td>1</td>
<td>Another program participant was triaged at CTC and counted as client.</td>
</tr>
<tr>
<td>Admit Date Incorrect</td>
<td>1</td>
<td>Data entry error.</td>
</tr>
<tr>
<td>Incorrect Discharge Date</td>
<td>2</td>
<td>The discharge date for CTC is not captured in a reportable form. The discharge date is the last WestCare program attended by client.</td>
</tr>
<tr>
<td>Bed Numbers</td>
<td>5</td>
<td>Bed numbering is not fully implemented.</td>
</tr>
<tr>
<td>Incorrect Referral Source</td>
<td>1</td>
<td>Potential data corruption on data conversion from the State of Nevada system.</td>
</tr>
</tbody>
</table>

We believe the nature of some of these errors could indicate that the errors were pervasive during the period of the Agreement.

RECOMMENDATION

1. At this time, the County has not entered into another Agreement for these services. Should a similar contract be executed in the future, Social Services should contact the Audit Department to request an audit of contract effectiveness.
1. The services provided through the CTC are designed to divert clients from local jails and emergency departments with the objective of reducing unnecessary use of these facilities while providing inpatient mental health, substance abuse and detoxification services. Collecting and assessing data such as the number of clients served, from which entity they were referred or if they were self-referred, how they were served, the length of service, and the frequency of service, the cost of the services provided for each time they are referred, and the cost reasonableness of these services is critical to measuring the effectiveness of the program. Having this data that refers directly to the CTC, even if the client goes on to other WestCare programs, is important to determining program effectiveness. County Management advocates that the interlocal agreement should contain a clear itemized list of the measures that WestCare or any other contracting agency is required to record. County Management also advocates for a review of WestCare’s newly implemented record keeping and tracking systems to determine whether these systems are adequate to collect information required. Any future agreements must contain a clause that requires addressing any inadequacies with systems designed to collect data. County Management will contact the Audit Department to request an audit of contract effectiveness prior to executing a similar contract in the future. Following this audit of contract effectiveness, County Management will collaborate with the CTC Oversight Committee to create a regular monitoring plan for WestCare’s or any other agency’s operation of a CTC.
FINDING 3 – MONTHLY REPORTS DO NOT INCLUDE NUMBER OF REFERRALS TURNED AWAY (HIGH)

WestCare refuses to accept certain clients from Agreement participants. Monthly progress reports required by the Agreement are based on the number of clients served and do not include the number of referrals elsewhere.

According to WestCare, their computer system provides a date when a refusal first occurred, but does not include subsequent refusal dates. Therefore, there was no way for us to determine the number of times a patient was turned away from the WestCare data.

The Agreement scope of services to be provided by WestCare, Section 3(B)(vii) states that separate reporting of activities contain the number of persons who are referred to WestCare from hospitals, detention centers, police drop-offs, hospitals, and other locations.

The number of referrals that are turned away are not included in clients served counts and would not be reported. Agreement requirements are not met for providing counts on the number of referrals from Agreement participants in monthly reporting. Knowing the number of referrals is significant in assessing whether referrals are successfully diverted from emergency rooms and detention centers to address overcrowding due to drug or alcohol intoxication or persons with mental health conditions not requiring medical attention.

The Agreement does not clarify the criteria CTC should use when declining to accept clients. However, we believe it is an important metric to evaluate the impact of the contract on local emergency rooms.

RECOMMENDATION

1. Include specific language regarding WestCare’s rights to turn away referrals in any future agreement.
2. Require the CTC to report the number and reason for any referrals that are turned away.

MANAGEMENT RESPONSE

1. County Management will include in any future agreement language that specifies WestCare’s rights to turn away referred clients. This language will be drafted for approval by all funding partners and will take in account any local, state or federal regulations that might prohibit a client’s being turned away. County Management will work with the CTC Oversight Committee to create a monitoring plan for client turn-aways with the goal of helping the funding partners and the CTC service provider (WestCare or other) with feedback on how to improve the referral process.
2. Any future agreements will require record-keeping related to the number of referred clients who were turned away and the reasons for their being turned away. The agreement will specify information that must be included in the records, including but not limited to number of times a client has been turned away, from which entity the client was referred each time, the reason
the person was turned away for each incident, and the type of other service provider to which the person was referred in order to help determine whether clients are being sent back to jails, emergency departments or other entities from which the program is meant to divert them. County Management will work with the CTC Oversight Committee to create a monitoring plan for client turn-aways with the goal of helping the funding partners and the CTC service provider (WestCare or other) with feedback on how to improve the referral process.
AUDIT REPORT RESPONSE
LAS VEGAS COMMUNITY TRIAGE CENTER
OPERATED BY WESTCARE, NV INC.

AUDIT CONDUCTED BY
CLARK COUNTY SOCIAL SERVICES

December 15, 2017

Richard E. Steinberg
President/CEO
WestCare Foundation, Inc.

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Executive Vice President
WestCare Foundation, Inc.
WestCare Response to Clark County Social Services Audit Report
On the Community Triage Center Agreement
December 15, 2017

Background
WestCare began operating the Las Vegas Community Triage Center (CTC) December 2002 in response to concerns identified by the Southern Nevada Mental Health Task Force and the Southern Nevada’s Regional Planning Coalition’s (SNRPC) Task Force on Emergency Room Overcrowding and the Regional Planning Coalition’s Chronic Public Inebriate Task Force. The original proposed budget to operate a 50 bed CTC was $3,812,833.

Local funding for the CTC is provided via an established inter-local agreement between WestCare Nevada, Inc., and the local government parties defined as Clark County, City of Las Vegas, City of Henderson, City of North Las Vegas and 15 area hospital parties as defined in the agreement dated August 18, 2015 known as the Agreement Relating to the Provisions of Funds for the Community Triage Center. Additional funding is provided from the State of Nevada’s Department of Health and Human Services. The Agreement serves as a fixed price contract for providing general operating costs for providing CTC services.

The proposed budget was designed to provide the basic operating costs for a 50 bed facility to provide triage services for approximately 4,000 patients annually. The identified triage services included an assessment of mental health and substance abuse as well as providing social model and medically supported detoxification services, psychiatric evaluations and the administration of limited psychiatric medication and case management services to assist with follow-up medical, psychiatric and substance abuse treatment as needed and transport services to pick up patients at local hospitals or other locations as needed and transport them to the CTC or other identified care.

A reporting requirement was included in the Agreement Relating to the Provision of Funds for the Community Triage Center which established the funding agreement between the local government parties and the hospital parties as the mechanism to establish service requirements, oversight, billing and program data. The required reporting elements indicated in the Agreement are tracked through WestCare’s Clinical Data System and reported each month to the inter-local funding partners. There is no requirement in the FY16 Agreement to track the number of people who are “turned away” or not admitted to the CTC and this information is not currently tracked in the Clinical Data System.

The inter-local funding for the CTC remained constant at $3.8 million annually until 2008, when a downturn in the economy forced a reduction in funding support to approximately $2.8 million annually. WestCare has never requested a rate increase from the inter-locals during the 15 year history of the CTC while inflation over this same period has increased 25%.
Patient Protection and Affordable Care Act Impact on CTC Agreement

In 2015, DHHS began implementing the Affordable Care Act, moving from service reimbursement through federal block grants into Medicaid managed care reimbursement for certain services. With the Affordable Care Act implementation, service providers were encouraged to apply for Medicaid numbers and enter into contracts with managed care companies for eligible participants. The language in the Agreement Relating to the Provision of Funds for the Community Triage Center included a paragraph describing the impact of the Patient Protection and Affordable Care Act on funding under this agreement. The paragraph read: “All parties hereto acknowledge and agree that the implementation of the Patient Protection and Affordable Care Act (the “Act”) may allow certain services provided under this Agreement to be billed through third-party insurance. Although the impact and application of the Act is unknown at this time, it is understood among the parties that the Agreement may be amended by written agreement by all parties hereinaf to reflect any changed circumstance or billing structure as a result of the Act.”

In FY16, WestCare added a monthly reporting element identifying the amount of billing reimbursed by third-party payers and Medicaid. WestCare is not aware of any adjustment to the FY16 Agreement that changed the identified billing structure or amendments that identified a change in billing requirements or reporting requirements. When the FY17 draft Agreement was circulated, the City of Henderson representative questioned why there were no adjustments to the Agreement based on the addition of Medicaid billing by WestCare. As a result of this, the Agreement remained inchoate. However, in the best interest of those we serve, WestCare has continued to provide services under the implied contract anticipating a revised agreement as had been done in many previous years when the agreement had been slow to be signed, often not being fully executed until mid-way through the fiscal year.

By March 2017, WestCare had not received a revised draft or finalized Agreement. Communication between WestCare and the Oversight Committee deteriorated over concerns regarding potential increased revenues from Medicaid. In April of 2017 WestCare Senior Management presented a revised proposal to the Committee that would adjust the current funding plan for the CTC Agreement by shifting from fixed service agreement fees to cost reimbursement for the those patients lacking the ability to pay for eligible services either through self-pay, insurance or Medicaid.

The WestCare proposal identified the number of patients covered by Medicaid or other insurance for both FY16 and FY17. Since FY17 was over half way through the year, WestCare proposed that a rebate or credit in funding be applied to FY16 and deducted this amount from the FY17 standard Agreement amount of $2.8 million. The remaining amount could then be paid to WestCare. This would decrease the FY17 funding amount by approximately 50% or more depending on final end of the year numbers.
Response to Audit Report Finding

Finding 1. CTC Credit Is Underestimated
The issue of WestCare receiving Medicaid funding was discussed and Medicaid reimbursement amounts were reported to the CTC Oversight Committee. WestCare never received any directions from the Committee to alter or adjust the billing based on the addition of Medicaid payments. The Agreement was never amended to address adjustments based on the addition of Medicaid funding which would eventually replace the State’s portion of their funding obligation. The poor communication between WestCare and the Oversight Committee regarding this matter led to the erosion of the Committee meetings and lack of trust between the Oversight Committee and WestCare.

The Executive Summary report provided to the Oversight Committee on April 3, 2017 was intended to be a preliminary proposal to stimulate further dialogue and to work together to find a way forward. WestCare recognizes the existing provision within the Agreement to conduct an audit, but also encouraged the process so that trust might be regained though this process. The audit review also provided a good insight into the data needed to develop a new set of deliverables and expectations to re-establish a productive relationship.

While the number of patients with no payer source identified by the auditor is slightly different than those presented in the April report, WestCare concurs with the numbers presented in the Audit report as being accurate. The current Agreement does not specify billing provisions based on a daily bed rate and the invoices are not based on a bed fill rate or services tied to an individual. WestCare agrees with the recommendation that a new Agreement based on a daily rate for non-revenue generating clients might be a better method for billing now that WestCare is receiving Medicaid.

Finding 2. Monthly Reports Are Based On Inaccurate Data
The required reporting elements identified in the Agreement are tracked through WestCare’s Clinical Data System. WestCare recognizes that the data that would have been useful in providing the information the Auditor was seeking was insufficient to adequately provide corrected the data the Auditor was seeking. However, the system was never designed to capture data in this format.

The Auditor was given open access to and spent time with the WestCare Software Team Director and architect of the Clinical Data System reviewing the data system. The discrepancies noted and errors in reporting can be corrected and the system further developed to capture additional information and produce accurate reports should a contract be executed in the future. WestCare would welcome further interaction with Clark County Social Services Audit team to ensure appropriate Information could be accurately reported.
Finding 3. Monthly Reports Do Not Include Number of Referrals Turned Away
The CTC Executive Summary data report, which was a report developed for reporting to the Oversight Committee, does include the number of referrals from local hospitals, law enforcement and emergency medical response. The FY16 admission referrals indicated in this report are 649 from hospitals, 38 from Metro and 87 from emergency medical.

Currently, the system is not designed to track how many times a single client is turned away from CTC services for referrals to a higher level of care. The system could be modified to do so if this element was included in a future Agreement.

Conclusion
There are many complex issues involved in the overall conversion to Medicaid including: the addition of increased medical services at the Maryland Parkway CTC, the difficulty finding and enrolling eligible individuals that are homeless, step down services at the 4th CTC and increased level of medical care and medical staff and administrative staff required to meet the emerging integrated needs and the Managed Care requirements. The cost of operating the CTC has significantly increased and now WestCare is faced with the same dilemma that spawned the existence of the CTC; how to cost effectively deliver crises triage, detox and stabilization services in a lower cost setting than hospitals or jails and how the CTC service provider is compensated for uncompensated care?

Approximately 35 to 50 percent of the CTC patients remain uninsured (Medicaid or other provider). The population that WestCare is serving is amongst the most difficult to enroll and keep enrolled in the Medicaid system. WestCare, with the state, has hired enrollers and trained additional enrollers but despite many strategies there remains many eligible but not enrolled as well as ineligible clients that are served on a daily basis at WestCare. WestCare has continued to provide needed services in good faith in this community for approximately 1,700 to 2,500 people without a payer source in FY17 and FY18. WestCare is interested in continuing to provide service for this population at a reasonable compensation rate, but cannot sustain the losses that have been experienced.

WestCare is supportive of a new Agreement that identifies new data elements for better client tracking and measuring performance outcomes. WestCare is also supportive of a new Agreement based on a fee structure to cover costs for patients with no other funding source. The eligible but not enrolled population, can and are being serviced at this time. Our hopes are that we can come to an agreement to continue to serve this population and avoid the chance that there will be no alternate but the streets of Southern Nevada.