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We have completed an audit of the Office of the Governor, Office for Consumer Health Assistance. This audit is part of the ongoing program of the Legislative Auditor as authorized by the Legislative Commission. The purpose of legislative audits is to improve state government by providing the Legislature, state officials, and Nevada citizens with independent and reliable information about the operations of state agencies, programs, activities, and functions. The results of our audit, including findings, conclusions, recommendations, and the Office's response, are presented in this report.

We wish to express our appreciation to the management and staff of the Office for their assistance during the audit.

Respectfully presented,

Paul V. Townsend, CPA
Legislative Auditor

October 10, 2007
Carson City, Nevada

STATE OF NEVADA
OFFICE OF THE GOVERNOR
OFFICE FOR CONSUMER HEALTH ASSISTANCE

AUDIT REPORT

Table of Contents

	Page
Executive Summary	1
Introduction	5
Background	5
Scope and Objectives	6
Findings and Recommendations	7
Financial Controls Can Be Strengthened	7
General Fund Expenditures Were Funded By Hospital Assessments	8
Medicaid Not Properly Billed	9
Additional Controls Will Improve the Reliability of Performance Information	10
Consumer Savings Lacked Sufficient Documentation	10
Programming Errors Caused Inaccurate Data	11
Incomplete External Review Data	14
Appendices	
A. Audit Methodology	16
B. Response from the Office for Consumer Health Assistance	18

EXECUTIVE SUMMARY

OFFICE OF THE GOVERNOR OFFICE FOR CONSUMER HEALTH ASSISTANCE

Background

The Office for Consumer Health Assistance (Office) was created in 1999. The Office assists consumers and injured employees in understanding their rights and responsibilities under health care plans and policies, including responding to and investigating complaints regarding those plans and policies. During the 2001 Legislature, the Office for Hospital Patients was renamed the Bureau for Hospital Patients and transferred to the Office for Consumer Health Assistance. This added the responsibility of resolving disputes between patients and hospitals. The 2003 Legislature added two additional responsibilities. First, this Office provides information to consumers concerning prescription drug programs offered by manufacturers of prescription drugs or by the state. Second, the Office authorizes external review organizations to conduct reviews of final adverse determinations made by managed care organizations. In 2005, the Office received the responsibility of establishing and maintaining an Internet website which would include information regarding the purchase of prescription drugs from Canadian pharmacies.

The Office, located in Las Vegas, had eight full-time authorized positions in fiscal year 2006, and received funding from the General Fund, hospital assessments, Medicaid, and the Workers' Compensation and Safety Fund. Fiscal year 2006 expenditures totaled more than $732,000.

Purpose

The purpose of this audit was to determine if the Office's financial and administrative practices were carried out in accordance with applicable state laws, regulations, policies, and procedures. We also determined if the Office's performance information reported in the annual report was

reliable. This audit included a review of the Office's financial related activities and performance data for the 18 months ended December 31, 2006.

Results in Brief

The Office substantially complied with state laws, regulations, policies, and procedures significant to its financial administration. However, controls are needed to ensure the Office's funding sources are properly accounted for and billed. Specifically, Bureau for Hospital Patients' funds totaling more than $180,000 that were used to pay General Fund expenditures had not been reimbursed. In addition, the Office did not properly bill Medicaid for services provided to consumers. The Office did not have a written agreement regarding what services are billable and billings were based on estimated costs instead of actual costs.

Additional controls will also improve the reliability of the Office's performance information. Performance information reported in the Office's annual report was not always supported by adequate documentation. As a result, the amount of consumers' financial savings resulting from the Office's assistance could not always be verified. In addition, data programming errors caused some information in the annual report to be misstated. Finally, the annual report did not include all required information regarding external reviews of denied health services for certain insured consumers. Inaccurate performance data can affect decisions made by management and the legislature.

Principal Findings

- Reserve funds resulting from the Bureau for Hospital Patients' (BHP) hospital assessments were used to pay General Fund expenditures in fiscal years 2004

and 2005. However, errors in the Office's year-end budget closing calculations prevented repayment of these reserve funds. As a result, Office records indicate the General Fund owed the BHP $183,569 as of June 30, 2006. Since the amount held in reserve determines the amount to assess hospitals each year, future assessments can be reduced once the amount owed has been repaid. (page 8)

- The Office did not properly bill the Division of Health Care, Financing and Policy (HCF&P) for consumer services regarding Medicaid coverage. A written agreement had not been established with HCF&P regarding what services are to be provided. Furthermore, the amounts billed were based on budgeted costs instead of actual. As a result, the Office had no assurance the amounts billed were in accordance with HCF&P and Federal requirements. (page 9)

- The amount of consumer savings reported in the Office's annual report lacked sufficient documentation. Our analysis of 5 of the largest cases and 25 selected randomly which totaled about $1.6 million, identified 3 that did not have sufficient documentation supporting the amount reported. The Office reported more than $578,000 as total savings for these three cases; however, documentation could not support approximately $362,000 of this amount. After informing management of the lack of documentation, the Office immediately contacted one of the providers and obtained sufficient documentation to support $88,000 in savings. (page 10)

- Some of the programs used to extract data from the Office's management information system contained errors. Additionally, we noted data entry errors and key information that had not been entered into the system. As a result, some of the data in the Office's 2006 annual report was misstated. For instance, the

report shows total new cases including the number of seniors and uninsured, workers' compensation, and BHP cases. The date the case was opened was used to determine the total number of cases, the number of seniors, and workers' compensation cases. However, the date closed was used to obtain the number of uninsured and BHP cases. If the Office had consistently used the date opened, it would have reported 607 BHP cases instead of 558, a difference of 9%. (page 11)

- Although the Office's 2006 annual report contained the information required in statute, it did not disclose all external reviews. The number and disposition of expedited reviews were not included. These reviews are for benefits denied by a managed care organization that may jeopardize the life or health of the consumer. (page 14)

Recommendations

This report contains six recommendations to strengthen the Office's financial and administrative controls. Three recommendations address controls to help ensure the Office's funding sources are properly accounted for and billed. In addition, we made three recommendations to improve the reliability of the Office's performance information. (page 20)

Agency Response

The Office, in response to our audit report, accepted the six recommendations. (page 18)

Introduction

Background

The Office for Consumer Health Assistance (Office) was created in 1999. The Office assists consumers and injured employees in understanding their rights and responsibilities under health care plans and policies, including responding to and investigating complaints regarding those plans and policies. During the 2001 Legislature, the Office for Hospital Patients was renamed the Bureau for Hospital Patients and transferred to the Office for Consumer Health Assistance. This added the responsibility of resolving disputes between patients and hospitals. The 2003 Legislature added two additional responsibilities. First, the Office provides information to consumers concerning prescription drug programs offered by manufacturers of prescription drugs or by the state. Second, the Office authorizes external review organizations to conduct reviews of final adverse determinations made by managed care organizations. In 2005, the Office received the responsibility of establishing and maintaining an Internet website which would include information regarding the purchase of prescription drugs from Canadian pharmacies.

The Office's mission is to allow all Nevadans access to the information they need regarding their patient rights in health care concerns, and to advocate and educate consumers and injured employees in understanding their rights and responsibilities under various health care plans, policies, and industrial insurance. The Office is committed to providing accurate, timely, and unbiased information to consumers of health care. They are also available to policy makers, legislators, community healthcare providers and government agencies, dedicated to improving the health care delivery system in Nevada.

The Office, located in Las Vegas, had eight full-time authorized positions in fiscal year 2006, and received funding from the General Fund, hospital assessments, Medicaid, and the Workers' Compensation and Safety Fund. Exhibit 1 shows the Office's funding sources and expenditures for fiscal year 2006.

Exhibit 1

Funding Sources and Expenditures
Fiscal Year 2006

Funding Sources	Amount
Appropriations	$511,159
Reversions/Balance Forward	(65,162)[(1)]
Beginning Cash	65,018
Hospital Assessments	69,115
Medicaid	92,380
Transfer from Industrial Relations	59,898
Total Funding	$732,408
Expenditures	
Personnel Services	$615,415
In-State Travel	4,946
Operating	77,640
Information Services	28,747
Other	5,660
Total Expenditures	$732,408

Source: State Accounting System.

(1) Includes $18,779 balanced forward and $46,383 reverted to the General Fund.

Scope and Objectives

This audit is part of the ongoing program of the Legislative Auditor as authorized by the Legislative Commission, and was made pursuant to the provision of NRS 218.737 to 218.893. The Legislative Auditor conducts audits as part of the Legislature's oversight responsibility for public programs. The purpose of legislative audits is to improve state government by providing the Legislature, state officials, and Nevada citizens with independent and reliable information about the operation of state agencies, programs, activities, and functions.

This audit included a review of the Office's financial related activities and performance data for the 18 months ended December 31, 2006. The objectives of the audit were to determine if the Office's:

- **financial and administrative practices were carried out in accordance with applicable state laws, regulations, policies, and procedures, and;**
- **performance information reported in the annual report was reliable.**

Findings and Recommendations

The Office for Consumer Health Assistance (Office) substantially complied with state laws, regulations, policies, and procedures significant to its financial administration. However, controls are needed to ensure the Office's funding sources are properly accounted for and billed. Specifically, Bureau for Hospital Patients' funds totaling more than $180,000 that were used to pay General Fund expenditures had not been reimbursed. In addition, the Office did not properly bill Medicaid for services provided to consumers. The Office did not have a written agreement regarding what services are billable and billings were based on estimated costs instead of actual costs.

Additional controls will also improve the reliability of the Office's performance information. Performance information reported in the Office's annual report was not always supported by adequate documentation. As a result, the amount of consumers' financial savings resulting from the Office's assistance could not always be verified. In addition, data programming errors caused some information in the annual report to be misstated. Finally, the annual report did not include all required information regarding external reviews of denied health services for certain insured consumers. Inaccurate performance data can affect decisions made by management and the legislature.

Financial Controls Can Be Strengthened

Although the Office substantially complied with state laws, regulations, policies, and procedures significant to its financial practices, existing controls did not ensure the Bureau for Hospital Patients (BHP) was reimbursed approximately $183,000 for General Fund expenditures. These expenditures were paid by the Bureau during fiscal years 2004 and 2005. In addition, the Office did not properly bill the Division of Health Care, Financing and Policy (HCF&P) for services regarding Medicaid issues. Specifically, the Office did not have a properly executed agreement with HCF&P and the amounts billed did not reflect actual costs. As a result, the Office could not be assured the amounts billed were in accordance with policy.

General Fund Expenditures Were Funded By Hospital Assessments

Reserve funds resulting from the BHP hospital assessments were used to pay General Fund expenditures in fiscal years 2004 and 2005. However, errors in the Office's year-end budget closing documents prevented repayment of these reserve funds. As a result, Office records indicate the General Fund owed the BHP $183,569 as of June 30, 2006.

The Department of Administration, Administrative Services Division (Division), provides financial support services to the Office. These services include preparing the fiscal year-end closing documents. Since the Office has four funding sources—General Fund appropriations, Medicaid, BHP's hospital assessments, and the Workers' Compensation and Safety Fund assessments—expenditures are allocated to these sources to determine the year-end cash balances. Any remaining amount from the General Fund, Medicaid, or the Workers' Compensation and Safety Fund are reverted to the appropriate fund, while the BHP monies are carried forward to the next fiscal year.

In fiscal years 2004 and 2005, General Fund expenditures (including Medicaid) exceeded revenues by a total of $183,569. Therefore BHP reserves were used to cover the General Fund deficit since the remaining Workers' Compensation and Safety Fund monies were reverted back to the fund. Exhibit 2 shows the revenues, expenditures, and balance of each funding source for fiscal years 2004 and 2005.

Exhibit 2

Funding Source Balances
Fiscal Years 2004 and 2005

	FY 04			FY 05		
Description	**Revenues**	**Expenditures**	**Balance**	**Revenues**	**Expenditures**	**Balance**
General Fund	$ 456,308	$ 504,043	$ (47,735) [1]	$ 382,952	$ 463,393	$ (80,441) [2]
Medicaid	$ 18,634	$ 71,782	$ (53,148) [1]	$ 63,269	$ 65,514	$ (2,245) [2]
BHP	$ 289,008	$ 75,183	$ 213,825	$ 247,941	$ 100,237	$ 147,704
Workers' Compensation	$ 188,291	$ 46,542	$ 141,749	$ 190,656	$ 47,170	$ 143,486

Source: State Accounting System and Office records.

(1) Total shortfall of $100,883 (47,735 + 53,148) paid for with BHP funds.

(2) Total shortfall of $82,686 (80,441 + 2,245) paid for with BHP funds.

An error in the Division's calculations used to close the fiscal year 2005 budget resulted in understating the amount of BHP's reserve funds carried forward to fiscal year 2006. As a result, no General Fund appropriations were applied to the debt. Instead, the Office reverted $46,383 to the General Fund in fiscal year 2006. According to Division staff, this reversion could have been applied to the amount owed to the BHP if the error had been detected.

Since the amount held in reserve determines the amount to assess hospitals each year, future assessments can be reduced once the amount owed has been repaid. Therefore, controls should be implemented to ensure the BHP reserve is replenished as soon as possible and funding sources are sufficient to cover expenses.

Medicaid Not Properly Billed

The Office did not properly bill the Division of Health Care, Financing and Policy (HCF&P) for services provided to Medicaid clients. Specifically, the Office did not have a written agreement with HCF&P establishing what services are to be provided. Furthermore, the amounts billed were based on budgeted costs instead of actual. As a result, the Office had no assurance that the amounts billed were in accordance with Medicaid requirements.

The Office employs skilled medical personnel that assist consumers with Medicaid related issues. Pursuant to federal regulations, the costs associated with assisting these consumers can be recovered through Medicaid reimbursements. The federal financial participation rate is based upon the actual percentage of time spent assisting consumers. However, the Office calculates the amount to bill Medicaid during the budget process using projected hours and bills HCF&P annually for these estimates. Furthermore, federal regulations require a written agreement with HCF&P in order to obtain the federal financial participation rate. The federal financial participation rate is 50% and could be as high as 75% if the Office meets specific criteria classifying them as skilled professional medical personnel. Despite federal requirements, the Office did not have a written agreement with HCF&P. An agreement will help ensure the Office is accurately billing in compliance with federal regulations.

Since the Office tracks staff hours charged to each Medicaid client, it is possible to obtain the actual time and costs incurred and bill Medicaid accordingly. However, a

written agreement should be established to ensure billed charges are in compliance with HCF&P and Federal policies.

Recommendations

1. Ensure the amount owed to the Bureau for Hospital Patients from the General Fund is properly paid back.
2. Execute an interlocal contract with the Division of Health Care, Financing and Policy regarding Medicaid billing provisions.
3. Ensure Medicaid billings are based on the actual time spent working on these cases.

Additional Controls Will Improve the Reliability of Performance Information

Performance information reported in the Office's annual report was not always supported by adequate documentation and was not always accurate. First, the amount of consumer savings reported in the annual report lacked sufficient documentation. Additionally, we identified programming errors in the Office's management information system. These errors resulted in some data being misstated. Finally, the annual report did not disclose expedited reviews of health benefits denied by managed care organizations. These reviews can be for denied benefits that may jeopardize the life or health of the consumer. State guidelines indicate performance measurement is crucial to the overall management of programs, since it is a tool of self-assessment, goal-setting, and progress monitoring. Thus, reporting inaccurate performance data can affect decisions made by management and the legislature.

Consumer Savings Lacked Sufficient Documentation

One of the Office's key performance measures is the amount of consumer savings. These savings are the amount the consumer would have had to pay for health care or the loss of workers' compensation benefits without the Office's intervention.[1] Our analysis of 5 of the largest cases and 25 selected randomly which totaled about $1.6 million, identified 3 that did not have sufficient documentation supporting the

[1] Total consumer savings reported in the 2006 annual report was $7.03 million.

amount reported. The Office reported more than $578,000 as total savings for these three cases; however, documentation could not support approximately $362,000 of this amount.

Exhibit 3 shows the reported savings, the documented savings, and the undocumented savings for the three cases lacking documentation. The majority of undocumented savings is from a workers' compensation case. In this instance, the Office claimed future long-term disability payments without confirming the benefits had been officially approved by the insurance company.

Exhibit 3

Cases Lacking Savings Documentation
2006

	Case Type	Reported Savings	Documented Savings	Undocumented Savings
Case #1	Hospital and Lab Billings	$292,476	$204,312	$ 88,164
Case #2	Workers' Compensation Benefits	255,789	3,279	252,510
Case #3	Provider Billing	29,875	8,566	21,309
	Totals	**$578,140**	**$216,157**	**$361,983**

Source: Office records.

After informing management of the lack of documentation, the Office immediately contacted the health care provider for Case #1 and obtained sufficient documentation to support the reported savings. However, additional documentation was not available for the remaining two cases.

Our last audit of the Office for Hospital Patients (currently the BHP) noted similar problems with supporting documentation. Therefore, the Office needs to ensure sufficient documentation is obtained when reporting consumer savings.

Programming Errors Caused Inaccurate Data

The Office's management information system contains all consumer information. Queries (a programming tool) are used to extract the data for reporting performance information. However, some of these queries contained programming errors. In addition, we noted data entry errors and key information that had not been entered into the system. As a result, some of the data in the Office's 2006 annual report was misstated.

Pursuant to NRS 223.575 and 223.580, the Office must submit an annual report to the Governor and the Legislature which addresses the Office's activities. We reviewed 14 queries that provided data for the 2006 report. Of these 14 queries, 12 had programming errors and incomplete data. Although most errors did not have a significant effect on the data's reliability, three queries contained variances exceeding 5%. Some of the errors we noted included:

- **inconsistent use of the dates a case was opened and closed,**
- **required data not always entered into the system,**
- **duplicate counting of cases, and**
- **incorrect methodology.**

Opened vs. Closed Date

The date a case was opened or closed is a key criteria in the Office's system for extracting certain data. However, the Office has not established written procedures addressing what data should be obtained based on these dates. As a result, our analysis of the reporting process indicated the inconsistent use of these criteria. For instance, an exhibit in the Office's annual report shows total new cases in calendar year 2006 including the number of seniors and uninsured, workers' compensation, and BHP cases. The date a case was opened was used to determine the total number of cases, the number of seniors, and workers' compensation cases. However, the date closed was used to obtain the number of uninsured and BHP cases. If the Office had consistently used the date opened, it would have reported 607 BHP cases instead of 558, a difference of 9%.

Data Entry Errors

We also identified information that was not accurate because of data entry errors. The data entry errors were the result of staff not entering all required information. For instance, two measures identified the types of assistance provided by the Office and the types of complaints received. Our analysis identified 61 cases with missing information. As a result, we could not reconcile our results to the Office's since the missing data had been reallocated to the various categories, and the total cases reported agreed with the total cases opened—not the total cases closed. Therefore, the data reported for the types of assistance and complaints was overstated by more than 100 cases.

Duplicate Case Counts

When reporting the activity for workers' compensation cases, the Office identifies two categories—medical care and benefit payments. However, in addition to these two categories, the staff record workers' compensation activity in a third category—cases that involve both medical care and benefit payments. Our analysis identified 123 of these cases. Instead of reporting this dual category separately, the cases are reported as a medical case and a benefit case. Therefore, these cases were reported twice and overstated the total number of workers' compensation cases by 18%.

Incorrect Methodology

One of the Office's performance measures in the annual report and the Governor's Executive Budget is the percentage of cases resolved within 60 days. The Office's methodology for determining this measure does not result in accurate information. Since the measure is based on working days, staff must calculate the number of days it took to resolve the case and then enter the days into the system. This data is then extracted at the end of the year to determine the percentage of cases resolved within 60 days. However, we identified two problems with the Office's process. First, the Office determines the number of cases resolved after 60 days and then subtracts these cases from the total cases opened during the year. As a result, the Office overstates this measure since all cases opened during the last 60 working days of the year are deemed to be resolved within 60 days. Second, we found more than 100 closed cases in which the number of days open was not entered into the system. Although the Office reported 94% of the cases were resolved within 60 days in the annual report and 93% in the Executive Budget, the actual amounts are unknown because of the missing data and incorrect methodology.

State guidelines indicate that the performance data must be reliable and that agencies should develop written procedures on how the performance measures are computed. However, the Office's policies do not adequately address what performance information should be reported and the procedures needed to ensure the information is reliable.

Incomplete External Review Data

Although the Office's 2006 annual report contained the information required in statute, it did not disclose all external reviews. These reviews, which are authorized by the Office, allow a consumer insured by a managed care organization (MCO) the opportunity to appeal denied benefits. In the event the consumer or their physician believes the denial may have serious medical consequences, they may request an expedited review. However, the Office has not established sufficient reporting procedures for the MCO's. As a result, the number and disposition of the reviews reported in the annual report did not include expedited reviews.

One of the Office's statutory responsibilities includes assisting consumers with an external review of final adverse determinations made by managed care organizations. The Office assigns these reviews to external review organizations and tracks the final dispositions. However, reviews which require immediate attention are not handled by the Office. Instead, the MCO selects an approved external review organization directly from the Office's website. These reviews are expedited if the consumer or physician provides proof that failure to proceed quickly may jeopardize the life or health of the consumer.

NRS 695G.310 requires the managed care organizations to report the number of external review requests and outcomes annually to the Office. In addition, NRS 695G.271 requires an MCO to notify the Office as soon as possible when an external review organization has been assigned to conduct an expedited review. However, MCO's are not notifying the Office when expedited reviews are conducted or identifying reviews expedited in their annual reports. Since these reviews are a critical component of the assistance provided to consumers, the Office needs to establish a process that will help ensure compliance with the reporting requirements.

Recommendations

4. Obtain adequate documentation before reporting consumer savings.
5. Review and revise system data extractions to help ensure performance information is complete and accurate.

6. Revise the managed care organization reporting procedures to help ensure all expedited reviews are included in the annual report.

Appendices

Appendix A
Audit Methodology

To gain an understanding of the Office for Consumer Health Assistance, we interviewed staff and reviewed statutes, regulations, policies, and procedures significant to the Office's operation. We also reviewed the Office's financial information, prior audit reports, budgets, legislative committee minutes, and other information describing activities of the Office. Furthermore, we documented and assessed the Office's internal controls.

To determine if the Office's financial and administrative practices were carried out in accordance with applicable state laws, regulations, policies, and procedures, we determined if the Office had taken an annual property and equipment inventory during fiscal year 2006. We then tested the accuracy of the inventory list by verifying the existence of assets that had a high risk of loss or misuse. Next, we verified hospital assessments were properly billed and paid by randomly selecting 15 fiscal year 2007 assessments for compliance testing. We also randomly selected five fiscal year 2006 hospital assessment refunds to ensure amounts were accurate and given to the appropriate hospital. We then met with Health Care, Financing and Policy personnel to determine if the Office's charges for Medicaid services were appropriate. Additionally, we reviewed the accuracy of the Office's funds carried forward and reverted at year-end.

Next, we randomly selected 20 expenditure transactions and tested each for proper recording, approval, and compliance with laws, regulations, policies, and procedures. The sample included travel and contract-related expenditures, which were also tested for compliance requirements specific to those transactions. In addition, we randomly selected a total of 12 transactions recorded in fiscal years 2005, 2006, and 2007 to verify they were recorded in the correct fiscal year. We also reviewed the five largest credit entries to expenditures to determine their propriety.

To verify that the Office complied with applicable personnel and payroll laws, regulations, and policies, we randomly selected two pay periods and verified the payroll transactions were processed correctly. We also verified the Office's classified employees had work performance standards established and received timely performance evaluations. Additionally, we reviewed the unclassified employees leave activity for additional compliance requirements.

To determine if the Office's performance information is reliable, we reviewed the Office's statutory reporting requirements and its annual report to verify if these requirements were met. We then determined the reliability of the Office's automated management information system by tracing information from 10 consumers noted in files to and from the system. Next, we analyzed system queries to determine if they produced the Office's desired results and accurate information. We also selected 5 cases with the largest reported savings and randomly selected 25 cases with reported savings during calendar year 2006, to ensure the documentation supported the amount reported and the savings resulted from the Office's assistance.

Our audit work was conducted from February to July 2007, in accordance with generally accepted government auditing standards.

In accordance with NRS 218.821, we furnished a copy of our preliminary report to the Director of the Office for Consumer Health Assistance. On September 27, 2007, we met with agency officials to discuss the results of our audit and requested a written response to the preliminary report. That response is contained in Appendix B, which begins on page 18.

Contributors to this report included:

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Appendix B

Response from the Office for Consumer Health Assistance

STATE OF NEVADA

OFFICE OF THE GOVERNOR

CONSUMER HEALTH ASSISTANCE

Bureau for Hospital Patients
555 E. Washington Avenue, Suite 4800
Las Vegas, Nevada 89101
Telephone: (702) 486-3587 • Fax: (702) 486-3586

JIM GIBBONS
Governor

VALERIE M. ROSALIN, RN
Director

October 4, 2007

Paul V. Townsend, CPA
Legislative Auditor
401 S. Carson Street
Carson City, NV 89701-4747

Dear Mr. Townsend:

We have reviewed the recommendations stated in the preliminary audit report dated October 1, 2007 and respectfully submit our response. First I would like to thank you and your staff for your graciousness, this has been a positive experience for me and the staff. We've been able to examine our operations through another's eyes enabling us to make corrections as required.

1. Ensure the amount owed to the Bureau for Hospital Patients from the General Fund is properly paid back.

   This recommendation has been accepted per M. Keating, Administrative Services – Budget Division

2. Execute an interlocal contract with the Division of Health Care, Financing and Policy regarding Medicaid billing provisions.

   Contact with DHCFP, Mike Wilden, Chuck Duarte has been initiated to draw up the contract. (Diane Comeaux, ASO IV 775-684-3621)

3. Ensure Medicaid billings are based on the actual time spend working on these cases.

   This recommendation has been accepted per M. Keating, Administrative Services – Budget Division

1

(NSPO Rev. 7-06) L-4

4. Obtain adequate documentation before reporting consumer savings.

    - Policy # 03.100.20,I, section 2 through 4 has been developed. (Copy of Policy enclosed)
    - Desk Manuals updated to secure that each Quality Assurance Specialist understands the requirements per the Agency Policy and Procedure Manual.
    - The MA will review file for savings documentation before entering into the database.

5. Review and revise system data extractions to help ensure performance information is complete and accurate.

    GovCHA has instituted the program recommendations provided by LCB Audit, Grant Dintiman, CPA.

6. Revise the managed care organizations reporting procedures to help ensure all expedited reviews are included in the annual report.

    We are sending a notice to the MCOs' and insurers that fall under the ERO laws requesting all information on ER's both expedited and standard. (Copy of letter enclosed) Also, we are requesting that the DOI place a notice on their website.

Again thank you for the opportunity to improve our operations and align them with the requirements of the State of Nevada.

Sincerely,

Valerie M. Rosalin, RN, BSN, MSHSA, CPUR
Director

Enclosure(s)

cc: Governor Jim Gibbons
Andrew K. Clinger, Director
Department of Administration

2

Office for Consumer Health Assistance
Response to Audit Recommendations

Recommendation Number		Accepted	Rejected
1	Ensure the amount owed to the Bureau for Hospital Patients from the General Fund is properly paid back.	X	
2	Execute an interlocal contract with the Division of Health Care, Financing and Policy regarding Medicaid billing provisions.	X	
3	Ensure Medicaid billings are based on the actual time spent working on these cases.	X	
4	Obtain adequate documentation before reporting consumer savings.	X	
5	Review and revise system data extractions to help ensure performance information is complete and accurate.	X	
6	Revise the managed care organization reporting procedures to help ensure all expedited reviews are included in the annual report.	X	
	TOTALS	6	0