LA24-01

STATE OF NEVADA

Performance Audit

Department of Health and Human Services
Division of Health Care Financing and Policy

Dual Enrollments and Supplemental Drug Rebates

2022

Legislative Auditor
Carson City, Nevada

Audit Highlights

Highlights of performance audit report on the Division of Health Care Financing and Policy issued on January 12, 2023.

Legislative Auditor report # LA24-01.

Background

The mission of the Division of Health Care Financing and Policy (Division) is to: 1) purchase and provide quality health care services to low-income Nevadans in the most efficient manner; 2) promote equal access to health care at an affordable cost to the taxpayers of Nevada; 3) restrain the growth of health care costs; and 4) review Medicaid and other state health care programs to maximize potential federal revenue. The Division administers both Nevada Medicaid and Check Up programs.

Managed Care Organizations (MCOs) are contracted with the Division to provide covered medical services to recipients currently living in urban Clark County and Washoe County. In calendar year 2021, the State had three MCOs that provided medical benefits and one dental benefit administrator. MCOs are paid a monthly risk-based capitated rate for each enrolled recipient. Approximately 75% of the state's Medicaid and Check Up population receive medical benefits through an MCO.

In fiscal year 2021, the Division was primarily funded with federal grants totaling $3.7 billion and state appropriations of about $873 million. As of May 25, 2022, the Division had 314 positions authorized of which 273 positions were filled, for a vacancy rate of 13%. The Division has offices located in Carson City, Elko, Las Vegas, and Reno.

Purpose of Audit

The purpose of the audit was to determine if the Division of Health Care Financing and Policy monitored certain activities related to Managed Care Organizations' enrolled participants and drug rebate payments.

Audit Recommendations

This audit report contains 10 recommendations to reduce improper MCO capitation payments and improve the collection of MCO supplemental drug rebates.

The Division accepted the 10 recommendations.

Recommendation Status

The Division's 60-day plan for corrective action is due on April 10, 2023. In addition, the 6-month report on the status of audit recommendations is due on October 10, 2023.

Dual Enrollments and Supplemental Drug Rebates

Division of Health Care Financing and Policy

Summary

The Division does not have adequate processes in place to monitor certain MCO activities, which resulted in over $34 million in improper payments and uncollected funds. Specifically, the Division does not identify individuals concurrently enrolled in other states' Medicaid programs. Consequently, the Division made improper monthly capitation payments to MCOs because federal law does not allow an individual to be enrolled in more than one state. We conservatively estimate over $22.9 million in improper capitation payments were made during calendar years 2020 and 2021. In addition, the Division's lack of oversight related to MCOs' supplemental drug rebate payments resulted in $6.9 million dollars going uncollected for almost 2 years. Additionally, $4.2 million in rebates were invoiced to drug manufacturers by MCOs but not remitted to the State. Without action and effective oversight activities, improper capitation payments will continue and supplemental drug rebates will go uncollected.

Key Findings

The Division does not utilize available information to identify recipients enrolled in Medicaid in another state and to end related MCO capitation payments. Because payments are automatic and made each month regardless of actual medical services rendered, significant improper payments accrue when out-of-state recipients are not identified timely, and action is not taken to disenroll them from the MCO. We identified 7,092 individuals who were enrolled in a Nevada Medicaid MCO during calendar year 2020, and also enrolled in another state's Medicaid program. For 44 of 50 (88%) recipients randomly selected and tested from the population, we observed capitation payments continued an average of 12 months after the individual enrolled in another state's Medicaid program. As a result, we conservatively estimate MCOs received over $22.9 million in improper payments during calendar years 2020 and 2021. (page 6)

The Division's oversight of the supplemental drug rebate program is inadequate. During the 2019 Legislative Session, Senate Bill 378 was passed and included a provision that MCOs remit supplemental drug rebates to the State, less an administrative fee. This requirement went into effect on January 1, 2020. The Division issued a memorandum on March 27, 2019, to MCOs detailing the requirement to submit rebates less a 1% administrative fee at the end of each quarter. Despite issuing the memorandum, we found the Division took no additional action to collect or verify millions of dollars in supplemental drug rebates. While two MCOs remitted rebate payments to the State, one did not. After our inquiry to the Division on November 30, 2021, the MCO made a payment for $6.9 million in supplemental drug rebates owed. Neither the Division nor the MCO could explain why payment was not remitted, even though two other MCOs submitted supplemental drug rebate payments to the Division totaling over $7.4 million as of March 31, 2021. (page 10)

In addition, the Division did not obtain supporting documentation to ensure supplemental drug rebate payments made were accurate or timely. We requested supporting documentation and determined another $900,000 in drug rebates was collected by MCOs, but not remitted to the State. Furthermore, another $3.3 million in rebates was invoiced to drug manufactures by MCOs, but remains uncollected by the MCOs. The Division has not established formal policies and procedures over the collection and review of supplemental drug rebates, and the reconciliation of supplemental drug rebates invoiced, collected, and received by MCOs. (page 10)

The Division has not complied with requirements to audit certain MCO activities related to supplemental drug rebates. State law requires the Division perform an annual audit of each MCO, including an analysis of all claims processed to evaluate supplemental drug rebate compliance. Furthermore, MCOs are required to obtain an annual audit of internal controls to ensure the integrity of financial transactions and claims processing. The results of these audits must be posted on the Division's website. According to the Division, staff turnover impacted the Division's ability to perform and obtain audits. In addition, the Division does not have policies and procedures related to the auditing of supplemental drug rebates or internal controls. Without policies and procedures, Division staff will lack adequate guidance to ensure compliance with laws and contract provisions. (page 11)

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This report contains the findings, conclusions, and recommendations from our performance audit of the Department of Health and Human Services, Division of Health Care Financing and Policy, Dual Enrollments and Supplemental Drug Rebates. This audit was conducted pursuant to 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.

This report includes 10 recommendations to help reduce improper managed care organization (MCO) capitation payments and improve the collection of MCO supplemental drug rebates. We are available to discuss these recommendations or any other items in the report with any legislative committees, individual legislators, or other state officials.

Respectfully submitted,

Daniel L. Crossman, CPA
Legislative Auditor

September 13, 2022
Carson City, Nevada

Dual Enrollments and Supplemental Drug Rebates

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Introduction

Background

The mission of the Division of Health Care Financing and Policy (Division) is to: 1) purchase and provide quality health care services to low-income Nevadans in the most efficient manner; 2) promote equal access to health care at an affordable cost to the taxpayers of Nevada; 3) restrain the growth of health care costs; and 4) review Medicaid and other state health care programs to maximize potential federal revenue. The Division works in partnership with the federal government's Centers for Medicare and Medicaid Services to assist in providing quality medical care for eligible individuals and families.

The Division administers both Medicaid and Children's Health Insurance programs in the State. Medicaid provides health care coverage for many people including low-income families with children whose family income is at or below 133% of the federal poverty level; Supplemental Social Security Income recipients; certain Medicare beneficiaries; and recipients of adoption assistance, foster care, and some children aging out of foster care. Nevada Check Up is the state's Children's Health Insurance Program that provides health care benefits to uninsured children from low-income families who are not eligible for Medicaid, but whose family income is at or below 200% of the federal poverty level. As of June 2021, 821,068 recipients were enrolled in Nevada Medicaid, and 25,363 recipients in Nevada Check Up, or an estimated 26% of Nevada's population. The Division of Welfare and Supportive Services determines eligibility for Medicaid and Check Up programs.

Managed Care Organizations (MCOs) are contracted with the Division to provide covered medical services to recipients currently living in urban Clark County and Washoe County. In calendar year 2021, the State had three MCOs that provided medical benefits and one dental benefit administrator. Approximately 75% of the state's Medicaid and Check Up

population receive medical and dental benefits through an MCO. MCOs are paid a monthly risk-based capitated rate for each eligible enrolled recipient. The Division's fiscal year 2021 MCO capitation payments totaled almost $2.3 billion. See Appendix A on page 14 for calendar years 2020 and 2021 capitation rates.

Budget and Staffing

In fiscal year 2021, the Division was primarily funded with federal grants totaling $3.7 billion and state appropriations of about $873 million. Exhibit 1 shows the Division's fiscal year 2021 revenues and expenditures.

Division Revenues and Expenditures Fiscal Year 2021 — **Exhibit 1**

Revenues	Inter-Governmental Transfers[2]	Health Care Financing and Policy Administration	Increase Quality of Nursing Care	Nevada Check Up	Nevada Medicaid	Totals
Beginning Cash	$ 3,329,364	$ 940,962	$ 3,035,719	$ -	$ 684,568	$ 7,990,613
State Appropriations	-	28,101,870	-	12,702,310	831,770,720	872,574,900
Program Taxes	10,737,359	-	38,405,411	-	-	49,142,770
Federal Grants	-	103,433,193	-	37,656,022	3,578,235,596	3,719,324,811
Licenses and Fees	-	1,240,096	-	-	-	1,240,096
Other Revenues[1]	137,330,953	324,251	38,795	2,160,944	33,699,995	173,554,938
Interagency Transfers	32,784,502	434,054	-	87,992	162,017,261	195,323,809
Total Revenues	**$184,182,178**	**$134,474,426**	**$41,479,925**	**$52,607,268**	**$4,606,408,140**	**$5,019,151,937**
Expenditures						
Personnel	$ -	$ 22,645,424	$ -	$ -	$ -	$ 22,645,424
Operating / Equipment	-	5,781,730	-	-	-	5,781,730
Medical Payments	-	4,085,708	-	46,448,048	4,564,672,597	4,615,206,353
Fiscal Agent	-	37,174,598	-	-	-	37,174,598
Program Costs	-	12,192,376	-	-	3,031,773	15,224,149
Information Services	-	730,725	-	-	-	730,725
Interagency Transfers	114,109,382	46,297,690	40,579,925	1,631,543	24,425,960	227,044,500
State Cost Allocations and Assessments	-	1,540,682	-	-	-	1,540,682
Total Expenditures	**$114,109,382**	**$130,448,933**	**$40,579,925**	**$48,079,591**	**$4,592,130,330**	**$4,925,348,161**
Differences	$ 70,072,796	$ 4,025,493	$ 900,000	$ 4,527,677	$ 14,277,810	$ 93,803,776
Less: Reversions to General Fund	-	(3,472,432)	-	(4,527,677)	(482,887)	(8,482,996)
Balance Forwards to FY 2022	**$ 70,072,796**	**$ 553,061**	**$ 900,000**	**$ -**	**$ 13,794,923**	**$ 85,320,780**

Source: State accounting system.

[1] Other revenues include county and local government reimbursements, fines, interest, and other miscellaneous revenue.

[2] Intergovernmental transfers collect funds from other state and local governmental entities to be used as state matching funds for certain Medicaid expenditures.

As of May 25, 2022, the Division had 314 positions authorized of which 273 positions were filled (13% vacancy rate). The Division has offices located in Carson City, Elko, Las Vegas, and Reno.

Federal Medicaid Assistance Percentage

The federal government provides a specified match for state Medicaid expenditures based on the Federal Medicaid Assistance Percentage (FMAP). Due to the public health emergency declared by the Secretary of the Department of Health and Human Services in response to the COVID-19 pandemic, the Families First Coronavirus Response Act was signed into law on March 18, 2020. This act temporarily increased federal funding for state Medicaid expenditures beginning January 1, 2020, and will extend until the Secretary of Health and Human Services terminates the declared public health emergency.

See Exhibit 2 for the Nevada FMAP and increased FMAP rates due to Families First Coronavirus Response Act for fiscal years 2020 and 2021.

Nevada Base and Enhanced FMAP Rates Fiscal Years 2020 and 2021 **Exhibit 2**

State Fiscal Year	Medicaid Base	Enhanced CHIP[1]	ACA[2] Enhanced CHIP	Newly Eligible[4]
2020	64.17%	74.92%	89.29%	91.50%
2020 FFCRA[3]	67.27%	77.09%	91.46%	91.50%
2021	63.46%	74.42%	77.30%	90.00%
2021 FFCRA	68.11%	77.68%	80.55%	90.00%

Source: Division budget presentation to the Assembly Committee on Ways and Means on February 26, 2021.

[1] Children's Health Insurance Program (CHIP) gets an enhanced federal matching rate added to the base Medicaid FMAP rate.

[2] Affordable Care Act of 2010 (ACA) Enhanced CHIP ended in September 2020.

[3] Families First Coronavirus Response Act.

[4] Newly Eligible is expanded coverage for certain adult groups under the ACA.

Public Assistance Reporting Information System

The Public Assistance Reporting Information System (PARIS) is a free data-matching service for states that helps ensure the integrity of public assistance programs through detecting and deterring improper payments. The PARIS Interstate Match is

accomplished by matching recipients of public assistance to other states to identify if recipients are receiving duplicate benefits in two or more states. The PARIS matching program is overseen by the federal government. PARIS matches are performed quarterly in February, May, August, and November of each year. Nevada's participation in submitting program enrollment data for PARIS matching is required by the Social Security Act as a condition of receiving Medicaid funding for automated data systems. This Act also requires states to have an eligibility determination system that provides for data matching through PARIS or any successor system, including matching with medical assistance programs operated by other states.

Medicaid Drug Rebate Program

The Medicaid Drug Rebate Program was created through the Omnibus Reconciliation Act of 1990, to help reduce overall costs of prescription drugs bought under the Medicaid program due to the creation of federally managed prescription drug rebate agreements with drug manufactures. Drug manufactures who want their drugs covered under Medicaid must enter into a national rebate agreement with the Secretary of the United States Department of Health and Humans Services. Under this agreement, they must rebate a specified portion of the Medicaid payment for the drug to the states, who then share a portion of the drug rebates collected with the federal government based on the FMAP. The amount of rebates collected from each drug is mandated by federal law.

Senate Bill 378 (Chapter 616, Statutes of Nevada) was passed in the 2019 Legislative Session and went into effect on January 1, 2020. This bill requires drug manufactures serving Nevada Medicaid to pay additional rebates for specific drugs to be included on the State Medicaid Preferred Drug Lists. The supplemental drug rebate program provides for Nevada-specific rebates for both fee-for-service and MCO programs. MCOs are required to enter into supplemental drug rebate agreements and to submit 100 percent of all rebates to the State, less an administrative fee.

Scope and Objective

The scope of our audit covered the systems and practices in place during calendar years 2020 and 2021. Our audit objective was to:

- Determine if the Division of Health Care Financing and Policy adequately monitored certain activities related to Managed Care Organizations' enrolled participants and drug rebate payments.

This audit is part of the ongoing program of the Legislative Auditor as authorized by the Legislative Commission and was made pursuant to the provisions of Nevada Revised Statutes 218G.010 to 218G.350. 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 operations of state agencies, programs, activities, and functions.

Insufficient Monitoring of Managed Care Organization Enrollment and Certain Drug Rebate Collections

The Division does not have adequate processes in place to monitor certain MCO activities, which resulted in over $34 million in improper payments and uncollected funds. Specifically, the Division does not identify individuals concurrently enrolled in other states' Medicaid programs. Consequently, the Division made improper monthly capitation payments to MCOs because federal law does not allow an individual to be enrolled in more than one state. We conservatively estimate over $22.9 million in improper capitation payments were made during calendar years 2020 and 2021. In addition, the Division's lack of oversight related to MCOs' supplemental drug rebate payments resulted in $6.9 million dollars going uncollected for almost 2 years. Additionally, $4.2 million in rebates were invoiced to drug manufacturers by MCOs but not remitted to the State. Without action and effective oversight activities, improper capitation payments will continue, and supplemental drug rebates will go uncollected.

Action Needed to Reduce Improper Capitation Payments

The Division does not utilize available information to identify recipients enrolled in Medicaid in another state and to end related MCO capitation payments. Because payments are automatic and made each month regardless of actual medical services rendered, significant improper payments accrue when out-of-state recipients are not identified timely and action is not taken to disenroll them from the MCO.

For 44 of 50 (88%) recipients tested that were enrolled first in Nevada, monthly capitation payments continued an average of 12 months after the individual enrolled in another state. As a result, we conservatively estimate MCOs received over $22.9 million in

improper payments during calendar years (CY) 2020 and 2021 because recipients should have been disenrolled from Nevada Medicaid and MCOs. Although the federal government has provided a resource for states to help reduce improper capitation payments due to concurrent enrollment and requires its use, the Division has not taken action to use it. Proper oversight of MCO enrollment is key to ensuring unnecessary capitation payments are not made.

Using the Public Assistance Reporting Information System (PARIS) Interstate Match data from February, May, and August 2020 quarterly reports, we identified 7,092 Nevada Medicaid recipients who were actively enrolled with a MCO during CY 2020, but also had concurrent enrollment in another state's Medicaid program. We focused on individuals enrolled in Nevada Medicaid first, as subsequent Medicaid enrollment in another state indicates a change of residency out of Nevada. Since these individuals likely no longer live in the State and have chosen to enroll in another state's Medicaid program, they are no longer eligible for Nevada Medicaid.

Our estimate of improper payments may be higher compared to other years due to the COVID-19 pandemic and the increased demands on social services. Because of the severity and magnitude of the pandemic, a public health emergency was declared and states received an increase to their federal assistance percentage. As a condition of increased federal assistance, states were not allowed to automatically disenroll individuals from Medicaid that no longer met eligibility requirements. Therefore, the State curtailed activities to identify and disenroll individuals no longer eligible. However, per federal guidance during the public health emergency, the Division was still allowed to disenroll individuals if they enrolled in another state's Medicaid program during this time.

Improper Capitation Payments Identified

From the population of 7,092 MCO recipients, we randomly selected a sample of 50 and found MCO providers received monthly capitation payments during the time the recipient was concurrently enrolled for 44 of the 50 tested. On average, these

monthly capitation payments during the time the recipient was concurrently enrolled occurred for 12 months after enrollment in another state's Medicaid program.

From our analysis of the sample of 44 concurrently enrolled recipients, we calculated total MCO medical and dental improper capitation payments to be $92,322 for calendar year 2020 and $69,692 for 2021. Using statistical principals to project improper capitation payments to the population of 7,092 MCO recipients with concurrent enrollment, we conservatively estimate the Division's improper capitation payments exceeded $13 million in CY 2020 and $9.9 million in CY 2021. At a 90% confidence level, the confidence interval is plus or minus $3 million for both years.

Exhibit 3 below shows an example of five individuals on the PARIS data match that had concurrent enrollment in other states' Medicaid programs. As shown, the number of months and the capitation payment amount significantly affect the improper payment for each identified recipient. Improper payment months can differ depending on whether a recipient's eligibility is assessed during a redetermination process, or the individual notifies Medicaid after enrolling in another state Medicaid program.

Examples of Concurrently Enrolled Recipients **Exhibit 3**

Recipient	Enrollment Dates	Enrollment State	Nevada Enrollment End Date	Number of Improper Months in CY 2020[2]	Monthly Capitation Amount	Total Improper Payment in CY 2020
1	10/01/2018	NV	5/31/2020	5	$685.63	$3,428.15
	11/01/2019	CO				
2	10/04/2019	NV	4/30/2021	5	$296.57	$1,482.85
	7/20/2020	HI				
3	9/01/2017	NV	N/A[1]	10	$622.06	$6,220.60
	2/01/2020	MI				
4	8/13/2019	NV	N/A[1]	11	$376.39	$4,140.29
	12/01/2019	UT				
5	5/05/2017	NV	N/A[1]	12	$89.74	$1,076.88
	11/01/2019	FL				

Source: PARIS and the Division's Medicaid Management Information System.
[1] Recipients were still enrolled in Nevada Medicaid as of November 2021.
[2] The number of improper capitation payments begins one month after the stated enrollment date in another state program, or January 2020 based on our audit scope.

Laws Provide for Eligibility Termination for Concurrently Enrolled Recipients

Federal law 42 CFR 435.403(j)(3) and the Medicaid State Plan do not allow a Medicaid recipient to be enrolled concurrently with another state Medicaid program, as a recipient can only be a resident of one state at a time. Once a Medicaid recipient enrolls in another state program, they no longer qualify as a Nevada resident for eligibility purposes. In addition, federal law allows a state to terminate Medicaid eligibility if a state confirms that a recipient has been determined eligible in another state. In these instances, the state is not required to provide advance notice of termination; however, federal law does require a state to seek additional information from the recipient before terminating eligibility, and to not base its decision only on PARIS information.

The Division does not utilize the PARIS information to identify recipients enrolled in multiple states. Additionally, the Division does not have a process or policies and procedures to identify improper capitation payments related to these recipients and recover improper payments. Other states we reviewed have documented processes for performing this type of analysis.

The Division's contracts with MCOs provide for the monitoring of capitation payments and the recovery of improper payments.

These contracts state that recipient eligibility determinations, along with managed care program enrollment, are the responsibility of the Division and the Division of Welfare and Supportive Services. Finally, contracts contain a provision that allows the Division to adjust capitation payments or recover improper capitation payments for up to 3 years. As defined in the contracts, improper payments include fraud, waste, abuse, and errors on the part of the Division.

Supplemental Drug Rebate Program Oversight Is Inadequate

The Division does not actively monitor or perform required audits of its supplemental drug rebate program to ensure the timely collection and accurate payment of drug rebates by MCOs. As a result, one MCO failed to pay the Division collected rebates for almost 2 years, which resulted in a lump sum payment of over $6.9 million after we performed an analysis and inquired about the unpaid rebates. Despite this payment and those made by other MCOs, records show another $4.2 million in rebates invoiced to drug manufacturers by the MCOs was not remitted to the State. Without adequate oversight of MCOs' supplemental drug rebate programs, rebates intended to help offset prescription drug program costs could be lost.

During the 2019 Legislative Session, Senate Bill 378 was passed. This bill requires the Division's contracts with MCOs to include a provision that MCOs pay the Division the entire amount of any rebates received for the purchase of prescription drugs, less an administrative fee. Additionally, MCOs must disclose any information relating to rebates collected and paid. The requirement to submit rebates went into effect on January 1, 2020.

The Division issued a memorandum to MCOs on March 27, 2019, detailing the requirement to submit rebates less a 1% administrative fee at the end of each quarter. Furthermore, the Division indicated MCOs were to provide a comprehensive reconciliation of pharmacy rebates invoiced and received with each payment.

Despite issuing the memorandum, we found the Division took no additional action to collect or verify millions of dollars in supplemental drug rebates. While two MCOs remitted rebate

payments to the State, one did not. After our inquiry to the Division on November 30, 2021, the MCO made a lump sum payment of over $6.9 million in supplemental drug rebates owed. Neither the Division nor the MCO could explain why payment was not remitted, even though two other MCOs submitted supplemental drug rebate payments to the Division totaling over $7.4 million as of March 31, 2021.

In addition, the Division did not obtain supporting documentation to ensure supplemental drug rebate payments made were accurate or timely. We requested supporting documentation and determined another $900,000 in drug rebates was collected by MCOs from drug manufactures, but not remitted to the State. Furthermore, another $3.3 million in rebates was invoiced to drug manufactures by the MCOs, but this remains outstanding as the MCOs indicated it has not been collected from drug manufacturers.

The Division has not established formal policies and procedures, nor does it perform reconciliations or review documentation of supplemental drug rebates invoiced, collected, and received by MCOs. Finally, the Division does not have a process to ensure drug rebates are submitted timely, or that fines or penalties are assessed for late payments.

Because the Division does not actively monitor supplemental drug rebates, it has little assurance MCOs are properly invoicing, collecting, and paying the required amounts timely and accurately. Since MCOs do not retain these rebates, there is little incentive for them to track and ensure rebates are paid timely to the State. Furthermore, the State's efforts to reduce prescription drug costs, which was the intent of Senate Bill 378, is hindered when rebates and any interest they would generate remain uncollected.

Required Audits Not Performed

The Division has not complied with requirements to audit certain MCO activities related to supplemental drug rebates. Senate Bill 378 requires the Division to perform an annual audit of each MCO, including an analysis of all claims processed to evaluate supplemental drug rebate compliance. Furthermore, MCOs are

required to obtain an annual audit of internal controls to ensure the integrity of financial transactions and claims processing. The results of these audits must be posted on the Division's website.

The Division amended its MCO contracts effective January 1, 2022, to include provisions that help ensure compliance with statutes. Current contracts also require annual audits by the Division and by an independent accountant. These audits will review compliance with any contractual obligations and federal and state requirements. Furthermore, contracts give the State or its designee the right to review and audit information related to supplemental drug rebates. Finally, contracts provide for mutual cooperation and grant auditors full access to relevant information.

According to the Division, staff turnover impacted the Division's ability to perform and obtain audits specified in Senate Bill 378. In addition, the Division does not have policies and procedures related to the auditing of MCOs' supplemental drug rebates or internal controls. Without policies and procedures, Division staff will lack adequate guidance to ensure compliance with laws and contract provisions.

Recommendations

1. Develop policies and procedures to regularly review PARIS data and identify MCO recipients with concurrent enrollment in another state. Work with the Division of Welfare and Supportive Services to disenroll ineligible recipients.
2. Develop policies and procedures to identify, calculate, and recover improper capitation payments from MCOs for concurrent enrollments, as applicable.
3. Develop controls to ensure the timely collection of supplemental drug rebates.
4. Amend existing MCO contracts to include fines and penalties for untimely or nonpayment of supplemental drug rebates to encourage timely payments.
5. Develop policies and procedures to obtain and review adequate supporting documentation for supplemental drug rebates.

6. Develop procedures to reconcile MCO supplemental drug rebate amounts invoiced to drug manufactures, collected by the MCOs, and received by the Division. Ensure procedures include monitoring and obtaining payment for drug rebate amounts invoiced by MCOs to drug manufacturers that have not been received.
7. Perform a reconciliation of MCO supplemental drug payments from January 1, 2020, to the present, and request payment for rebate amounts collected by MCOs but not paid.
8. Establish a program and develop policies and procedures to ensure annual audits of MCOs' prescription drug services are conducted as required by Senate Bill 378, including the invoicing, collecting, and payment of supplemental drug rebates.
9. Develop policies and procedures to ensure MCOs obtain audits of their internal controls as required by Senate Bill 378. Procedures should include the monitoring and review of audits by the Division.
10. Post the results of audits performed by the Division or independent auditors to the Division's website in compliance with law.

Appendix A

Managed Care Organization Capitation Rates by Region, Category, and Age Group — Composite Estimates Calendar Years 2020 and 2021

Nevada Region	Category	Age Group	CY 2020 (January 1, 2020–August 31, 2020, Capitation Rates)	CY 2020 (September 1, 2020–December 31, 2020, Capitation Rates)[1]	CY 2021 Capitation Rates
Northern	TANF/CHAP[2]	Under 1	$536.47	$504.82	$488.61
Northern	TANF/CHAP	Child 1 – 2	98.90	93.72	101.47
Northern	TANF/CHAP	Child 3 – 14	75.84	72.43	84.77
Northern	TANF/CHAP	Female 15 – 18	132.33	127.29	138.31
Northern	TANF/CHAP	Male 15 – 18	102.74	98.66	110.34
Northern	TANF/CHAP	Female 19 – 34	255.97	245.68	260.30
Northern	TANF/CHAP	Male 19 – 34	165.22	159.01	179.46
Northern	TANF/CHAP	Female 35 and Over	468.24	451.25	433.67
Northern	TANF/CHAP	Male 35 and Over	386.62	372.33	402.65
Northern	Check Up[3]	Under 1	199.22	187.42	199.13
Northern	Check Up	Child 1 – 2	101.76	96.69	106.80
Northern	Check Up	Child 3 – 14	77.80	74.46	82.31
Northern	Check Up	Female 15 – 18	123.51	118.96	126.87
Northern	Check Up	Male 15 – 18	97.75	94.09	99.35
Northern	Expansion[4]	Female 19 – 34	271.39	260.97	297.02
Northern	Expansion	Male 19 – 34	370.55	357.11	377.34
Northern	Expansion	Female 35 and Over	619.09	596.24	633.77
Northern	Expansion	Male 35 and Over	$662.98	$635.81	$666.72

Appendix A

Managed Care Organization Capitation Rates by Region, Category, and Age Group — Composite Estimates Calendar Years 2020 and 2021 (continued)

Nevada Region	Category	Age Group	CY 2020 (January 1, 2020–August 31, 2020, Capitation Rates)	CY 2020 (September 1, 2020–December 31, 2020, Capitation Rates)(1)	CY 2021 Capitation Rates
Southern	TANF/CHAP	Under 1	$629.70	$592.37	$614.73
Southern	TANF/CHAP	Child 1 – 2	114.07	108.46	122.30
Southern	TANF/CHAP	Child 3 – 14	90.76	86.91	98.84
Southern	TANF/CHAP	Female 15 – 18	133.22	127.86	141.57
Southern	TANF/CHAP	Male 15 – 18	109.77	105.62	108.94
Southern	TANF/CHAP	Female 19 – 34	273.12	261.20	263.91
Southern	TANF/CHAP	Male19 – 34	148.54	142.67	162.35
Southern	TANF/CHAP	Female 35 and Over	479.33	461.07	467.70
Southern	TANF/CHAP	Male 35 and Over	395.08	380.46	432.56
Southern	Check Up	Under 1	226.61	212.68	226.13
Southern	Check Up	Child 1 – 2	124.05	118.17	130.70
Southern	Check Up	Child 3 – 14	98.05	94.02	101.93
Southern	Check Up	Female 15 – 18	157.21	151.28	155.01
Southern	Check Up	Male 15 – 18	109.23	105.33	126.93
Southern	Expansion	Female 19 – 34	269.11	258.56	267.79
Southern	Expansion	Male 19 – 34	298.15	287.90	287.29
Southern	Expansion	Female 35 and Over	628.07	605.47	623.55
Southern	Expansion	Male 35 and Over	$690.22	$664.64	$665.05

Source: Division MCO capitation rate reports.

(1) Adjusted capitation rates due to the budget cuts during the COVID-19 pandemic.

(2) TANF/CHAP includes Nevada's legacy low-income children and caretaker adults who were eligible for Medicaid prior to the Affordable Care Act expansion; the Child Health Assurance Program (CHAP) covers children and pregnant women, while Temporary Assistance for Needy Families (TANF) covers caretaker adults at lower income levels.

(3) Check Up category is Nevada's Child Health Insurance Program.

(4) Expansion category is for the newly eligible (adults without children ages 19 thru 64) under the Affordable Care Act.

Note: These rates are estimated composite rates across MCOs and do not consider the varying contracted rates for administrative costs and premium tax.

Appendix B
Audit Methodology

To gain an understanding of the Division of Health Care Financing and Policy (Division), we interviewed staff, reviewed state and federal laws, regulations, and policies and procedures significant to the Division's operations. We also reviewed financial information, prior audit reports, budgets, legislative committee minutes, and other information describing the Division's activities. Furthermore, we documented and assessed the Division's controls related to Medicaid managed care recipient enrollment and supplemental drug rebates.

Our audit included a review of the Division's internal controls significant to our audit objective. Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved. Internal control comprises the plans, methods, policies, and procedures used to fulfill the mission, strategic plan, goals, and objectives of the entity. The scope of our work on controls related to Medicaid managed care recipient enrollment and supplemental drug rebates included the following:

- Design of control activities (Control Activities); and
- Performance of monitoring activities (Monitoring).

Deficiencies and related recommendations to strengthen the Division's internal control systems are discussed in the body of this report. The design, implementation, and ongoing compliance with internal controls is the responsibility of agency management.

To assess the reliability and reasonableness of recipient and claims data stored in the Medicaid Management Information System (MMIS), we randomly selected 25 recipients out of the 881,958 total recipients from calendar year 2020 data we received from the Division of Welfare and Supportive Services (DWSS) and searched each

individual in MMIS. We then randomly selected 20 out of 160,975 fee-for-service recipients and 20 out of 705,699 MCO recipients from data extracted from MMIS calendar year 2020 enrollment and searched each individual in the DWSS' recipient enrollment system. For claims testing, we randomly selected 25 out of 6,784,499 fee-for-service claims, 10 out of the 37,170 fee-for-service Children's Health Insurance Program claims, and 25 out of 5,930,442 MCO and 10 out of 145,062 MCO Children's Health Insurance Program encounter claims, from claim data extracted from the MMIS system from the 1st and 4th quarters of calendar year 2020 respectively, and searched each claim in the MMIS system. We then traced 28 MCO medical records and 30 fee-for-service medical records from the 1st and 4th quarters of calendar year 2020 combined, to recipient data in MMIS and to the extracted MMIS, MCO, and fee-for-service claim data. The medical records were judgmentally selected by the Division based on the first Surveillance Utilization Review Unit provider cases that had their medical records pulled. We determined the data was reliable for our testing purposes.

To determine if Medicaid recipients were concurrently enrolled in other states, we used the federal PARIS February, May, and August calendar year 2020 interstate match data. We identified recipients that enrolled in Nevada first before they enrolled in another state's Medicaid program. We then matched the Social Security numbers of the Medicaid recipients from each of the PARIS reports to the calendar year 2020 enrollment data received from the DWSS. Next, we matched them to MCO recipients in calendar year 2020 to identify the individuals that were enrolled with a MCO. We then reviewed and removed any duplicates. In total, we identified 7,092 recipients who had concurrent enrollment in another state after first enrolling in Nevada. For testing purposes, we used the earliest enrollment date in which the individual enrolled in another state.

Next, we selected a random sample of 50 from the 7,092 concurrently enrolled recipients and reviewed MMIS data regarding medical and dental capitation payments. We then calculated the improper payments up to the recipient's Medicaid eligibility end date reported in MMIS, or November 2021 if there was no previous end date. If a recipient was found to have encounter claims paid by the MCO, we excluded those months in our calculation of improper payments.

To calculate our estimate of improper capitation payments in calendar years 2020 and 2021 to the population, we used professional judgment and statistical principles to extrapolate a yearly amount. For calendar year 2020, the amount was extrapolated at a 90% confidence level, resulting in a level of precision of plus or minus $3 million (24.26%) of the $13 million. For calendar year 2021 improper capitation payments, the amount was extrapolated at a 90% confidence level, resulting in a level of precision of plus or minus $3 million (29.70%) of $9.9 million.

To determine if MCOs paid supplement drug rebates owed to the Division, we requested the amount of invoiced and collected supplemental drug rebates required per Senate Bill 378, as well as the administrative fee retained, directly from each MCO. We then requested from the Division all amounts that have been paid to the Division by each of the three MCOs from January 1, 2020, to the last reporting period of March 31, 2021, and related supporting documentation. For each MCO, we then determined what the Division received, and calculated the balance still owed to the State. In addition, to verify required audits are not performed, we confirmed with Division management.

We used nonstatistical audit sampling for our audit work, which was the most appropriate and cost-effective method for concluding on our audit objective. Based on our professional judgment and review of authoritative sampling guidance, we believe that nonstatistical sampling provided sufficient, appropriate audit evidence to support the conclusions in our report. Although we used nonstatistical audit sampling, the results of our random sample regarding PARIS data allowed us to use statistical principles to project the results to the population.

Our audit work was conducted from July 2020 to February 2022. 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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

In accordance with NRS 218G.230, we furnished a copy of our preliminary report to the Administrator of the Division of Health Care Financing and Policy. On August 12, 2022, we met with agency officials to discuss the results of the audit and requested a written response to the preliminary report. That response is contained in Appendix C, which begins on page 20.

Contributors to this report included:

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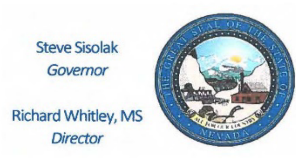
Appendix C
Response From the Division of Health Care Financing and Policy

Steve Sisolak
Governor

Richard Whitley, MS
Director



DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
Helping people. It's who we are and what we do.

Suzanne Bierman, JD MPH
Administrator

August 18, 2022

Daniel L. Crossman, CPA
Legislative Auditor
Legislative Counsel Bureau
401 S. Carson St.
Carson City, NV 89701

Dear Mr. Crossman:

In response to the letter and draft audit report provided by the Legislative Counsel Bureau (LCB) dated August 1, 2022, the Nevada Division of Health Care Financing and Policy (DHCFP) accepts all recommendations. Below, each recommendation is listed followed by discussion regarding how DHCFP plans to address or implement each recommendation contained in the report.

DHCFP provides this written response to the 10 recommendations as follows:

1. Develop policies and procedures to regularly review PARIS data and identify MCO recipients with concurrent enrollment in another state. Work with the Division of Welfare and Supportive Services to disenroll ineligible individuals.

   Response: The Division agrees with this recommendation.

   Under federal law, the Medicaid eligibility function is the sole responsibility of the Single State Agency. See 42 CFR 431.10(3). In Nevada, the Department of Health and Human Services (DHHS) is the "Single State Medicaid Agency" per NRS 422A.338(2), and the Division of Welfare and Supportive Services (DWSS) at DHHS is delegated this responsibility and function pursuant to the state's federally approved Medicaid State Plan. To support the resources necessary to perform the eligibility function and maintain the eligibility system, DHCFP allocates Medicaid funds under Title XIX and XXI of the Social Security Act to the Division of Welfare and Supportive Services (DWSS) pursuant to an interlocal agreement.

   The PARIS data matching process is a function of eligibility verification as outlined in our federally approved State Verification Plan. Matches returned in the PARIS data matching process are unverified until DWSS completes its investigation and properly notices the member as required by the Centers for Medicare & Medicaid Services (CMS). Once eligibility has been terminated by DWSS, DHCFP will disenroll the members from the MCOs and adjust the capitation payments accordingly.

   Additionally, DHCFP will work with DWSS to streamline and shorten the timeframe between the quarterly PARIS matching process, the state's notification to members, and closure of eligibility to reduce the occurrence of improper payments in the Managed Care program. DHCFP will also develop policies and procedures to receive the results of

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the PARIS data match from DWSS and utilize DHHS' Office of Analytics to conduct oversight and monitor the eligibility of identified recipients to ensure these cases are being verified and, when necessary, formally terminated by DWSS.

2. Develop policies and procedures to identify, calculate, and recover improper capitation payments from MCOs for concurrent enrollments, as applicable.

   Response: The Division agrees with this recommendation.

   DHCFP will develop policies and procedures to identify, calculate, and recover improper payments to MCOs, as applicable, for verified concurrent enrollments, upon the closure of Medicaid eligibility by DWSS.

3. Develop controls to ensure the timely collection of supplemental drug rebates.

   Response: The Division agrees with this recommendation.

   DHCFP will develop internal controls to ensure timely collection of supplemental drug rebates, including developing policies and procedures for its MCOs regarding DHCFP expectations for timely collection and monitoring of supplemental drug rebates.

4. Amend existing MCO contracts to include fines and penalties for the untimely or nonpayment of supplemental drug rebates to encourage timely payments.

   Response: The Division agrees with this recommendation.

   Currently, DHCFP believes it has sufficient authority in its current contract with MCOs to impose a fine or penalty on MCOs for not submitting timely payments of supplemental drug rebates upon request by DHCFP. Under section 7.15.2 of the current contract, if a Managed Care Plan is noncompliant with any requirement in the contract, which includes submission of rebate-related payments, DHCFP may require the MCO to agree to a corrective action plan and impose related penalties and sanctions as needed for continued noncompliance with the contract requirements. DHCFP will use this contractual authority to the extent necessary to encourage and enforce MCOs to submit future supplemental drug rebate payments owed to the state.

5. Develop policies and procedures to obtain and review adequate supporting documentation for supplemental drug rebates.

   Response: The Division agrees with this recommendation.

   The DHCFP will develop policies and procedures to obtain and review adequate supporting documentation for supplemental drug rebates to extent permissible under state law and in accordance with the state's contract with MCOs.

6. Develop procedures to reconcile MCO supplemental drug rebate amounts invoiced to drug manufactures, collected by the MCOs, and received by the Division. Ensure procedures include monitoring and obtaining payment for drug rebate amounts invoiced by MCOs to drug manufacturers that have not been received.

   Response: The Division agrees with this recommendation.

   DHCFP will develop policies and procedures for reconciliation of MCO supplemental drug rebate amounts invoiced to drug manufactures, collected by the MCOs, and received by the Division. DHCFP will also review documentation

for supplemental drug rebates invoiced, collected, and received by MCOs in addition to developing procedures for monitoring and obtaining payment for drug rebates invoiced by MCOs to drug manufacturers that have not be received.

7. Perform a reconciliation of MCO supplemental drug payments from January 1, 2020, to the present, and request payment for rebate amounts collected by MCOs but not paid.

   Response: The Division agrees with this recommendation.

   DHCFP will establish a process to reconcile MCO supplemental drug payments from January 1, 2020 to the present to the extent feasible. This includes requesting payment for rebate amounts collected by MCOs but not paid under the prior contract period (i.e., from 2020 through 2021).

8. Establish a program and develop policies and procedures to ensure annual audits of MCOs' prescription drug services are conducted as required by Senate Bill 378, including the invoicing, collecting, and payment of supplemental drug rebates.

   Response: The Division agrees with this recommendation.

   During the last procurement for the current contract period (2022-2025), DHCFP added several provisions to the state's contract with MCOs to support compliance with Senate Bill 378. See Sections 7.4.2.11.14 and 7.4.2.12.4 of the State-and-MCO Contract. DHCFP is in the process of developing policies and procedures to ensure proper monitoring and oversight of new requirements for MCOs for the current contract period. This includes developing policies and procedures for the requirement that MCOs conduct annual audits of prescription drug services and drafting guidance for MCOs regarding DHCFP's expectations for when these reports must be submitted in addition to procedures for invoicing, collecting, and payment of supplemental drug rebates.

9. Develop policies and procedures to ensure MCOs obtain audits of their internal controls as required by Senate Bill 378. Procedures should include the monitoring and review of audits by the Division.

   Response: The Division agrees with this recommendation.

   As stated above in response to recommendation #8, DHCFP will develop policies and procedures for the requirements included in the State's current contract with MCOs, including ensuring DHCFP obtains, reviews, and monitors these audits submitted by MCOs.

10. Post the results of audits performed by the Division or independent auditors to the Division's website in compliance with law.

    Response: The Division agrees with this recommendation.

    DHCFP will be working to conduct the audits required by Senate Bill 378 in addition to posting the results on its website in accessible format as required by state law. The reporting process will follow the protocol being used for annual supplemental rebate agreement reporting which is accessible on the Division's website here.

Should you have any questions or require additional information, you may contact Russ Steele at (775) 830-3627.

Sincerely,

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Suzanne Bierman
Suzanne Bierman (Aug 17, 2022 11:52 PDT)
Suzanne Bierman, JD MPH
Administrator

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Division of Health Care Financing and Policy's Response to Audit Recommendations

	Recommendations	Accepted	Rejected
1.	Develop policies and procedures to regularly review PARIS data and identify MCO recipients with concurrent enrollment in another state. Work with the Division of Welfare and Supportive Services to disenroll ineligible individuals	X	
2.	Develop policies and procedures to identify, calculate, and recover improper capitation payments from MCOs for concurrent enrollments, as applicable	X	
3.	Develop controls to ensure the timely collection of supplemental drug rebates	X	
4.	Amend existing MCO contracts to include fines and penalties for untimely or nonpayment of supplemental drug rebates to encourage timely payments...	X	
5.	Develop policies and procedures to obtain and review adequate supporting documentation for supplemental drug rebates	X	
6.	Develop procedures to reconcile MCO supplemental drug rebate amounts invoiced to drug manufactures, collected by the MCOs, and received by the Division. Ensure procedures include monitoring and obtaining payment for drug rebate amounts invoiced by MCOs to drug manufacturers that have not been received..	X	
7.	Perform a reconciliation of MCO supplemental drug payments from January 1, 2020, to the present, and request payment for rebate amounts collected by MCOs but not paid.....	X	
8.	Establish a program and develop policies and procedures to ensure annual audits of MCOs' prescription drug services are conducted as required by Senate Bill 378, including the invoicing, collecting, and payment of supplemental drug rebates	X	
9.	Develop policies and procedures to ensure MCOs obtain audits of their internal controls as required by Senate Bill 378. Procedures should include the monitoring and review of audits by the Division...	X	
10.	Post the results of audits performed by the Division or independent auditors to the Division's website in compliance with law	X	
	TOTALS	10	