

**ADVISORY REPORT OF THE
NEBRASKA
HEALTH AND HUMAN SERVICES SYSTEM
MEDICAID PROGRAM
FOR THE FISCAL YEAR ENDED JUNE 30, 1999**

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
 MEDICAID PROGRAM
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EXECUTIVE SUMMARY

Medicaid is a large and complex program with expenditures over \$1 billion in the fiscal year ended June 30, 1999. It is essential for a program of this size to have adequate controls to ensure funds are properly disbursed and safeguarded from errors and abuse. Our review noted areas in which significant improvements could be made.

Communication within HHS and documentation of procedures could be improved. We noted many HHS staff who were knowledgeable regarding their positions and procedures; however, in some instances, procedures and information were not in writing. We also noted HHS staff were unfamiliar with the organizational structure of HHS and who to contact for information outside their own area. Our staff also had difficulties in this area and were often misdirected.

Reconciliation of accounting records and review of expenditures could be improved. We noted significant problems that would have been detected by HHS staff had they been using adequate reconciliation procedures. HHS failed to detect the double reporting of \$9.5 million in Rehabilitation Option claims. Our reconciliation of aid expenditures noted approximately \$6.2 million was paid with State funds which could have been paid with Federal funds. HHS also needs to repay \$1.45 million in Federal funds for errors in the Intergovernmental Transfer.

We found the computer systems used by HHS to be cumbersome and difficult to use. There was no comprehensive written documentation of significant computer systems used. Documentation should allow users to quickly become familiar with the system.

Nebraska's average Medicaid administrative cost per recipient was the second highest when compared to the surrounding six states. However, various HHS administrative areas were performing minimal procedures. The fraud control Surveillance and Utilization Review System unit (SURS) closed only 25 of 203 cases opened in 1999, after closing only 8% of the cases opened during 1998. Eighty percent of the 236 Medicaid nursing facilities in Nebraska had not had a field audit performed by HHS in over five years. Medicaid payments to nursing facilities totaled \$344,455,062 for the fiscal year. HHS had over \$10 million in open submittals to insurance companies for third-party liability as of June 30, 1999. However, it is unknown whether the \$10 million is accurate or collectable, and HHS did not have procedures in place to send second submittals to any of the insurance companies.

While we tested only 255 of more than 10 million claims processed during the fiscal year by HHS, we noted numerous overpayments and lack of documentation due to inadequate review processes. Twenty claims tested were paid incorrect amounts totaling a net of \$3,876. Thirty-four claims tested had inadequate support documentation on file for Medicare premium payments and pharmacy dispensing fees.

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(Concluded)

The area of contract management could be improved. Contracts did not have maximum payment amounts stated, signed or approved contracts were not on file, contracts were signed or approved after the effective date of the contracts, supporting documentation was not adequate to determine all charges were reasonable, and payments were noted that exceeded the contract limits. Supporting documentation was not adequate to determine all charges were reasonable, and overpayments were noted.

Our review process generally noted a staff that was knowledgeable in their focus of expertise; however, there are several areas where HHS should improve controls over the Medicaid Program to reduce the risk for errors and abuse. Our findings are detailed in the Comments and Recommendations Section of this report.

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BACKGROUND

The Medicaid Division administers the Nebraska Medical Assistance program (Medicaid, under Title XIX of the Social Security Act). Medical Assistance provides payments for medical services on behalf of low-income persons who are over age 65, blind or disabled, members of families with dependent children, low-income children and pregnant women, certain Medicare beneficiaries, and medically-needy individuals.

Medical care and services include: diagnostic and therapeutic services of licensed health care practitioners; inpatient and outpatient hospital care; laboratory and radiological services; prescribed drugs; prosthetic devices; audiology and speech services; family planning; and long-term services, including nursing facility services, assisted living, adult and child day health care, respite care, home health care, and other in-home support services.

In 1998, Nebraska expanded eligibility to 185 percent of poverty for pregnant women and for children 18 and younger under Title XXI (CHIPS) of the Social Security Act. This expanded program is called Kids Connection.

Preventive services are offered through the HealthCheck program for people younger than 21 (EPSDT).

The Medicaid Managed Care program requires certain recipients in Douglas, Sarpy, and Lancaster counties to enroll in a health maintenance organization or primary care case management plan for primary care services. These programs cover the entire range of Medicaid - provided services except drugs and personal care aides. The Medicaid Managed Care program requires certain recipients statewide to enroll for mental health services.

The Medicaid Program was previously administered by the Department of Social Services. Effective January 1, 1997 the Departments of Social Services, Public Institutions, Aging, Health, and the Office of Juvenile Services of the Department of Corrections, were redesigned to form the Nebraska Health and Human Services System.

MISSION STATEMENT

The mission of the Department of Health and Human Services was:

“To create and sustain a unified, accessible, caring, and competent health and human services system for each Nebraskan that maximizes local determination to achieve measurable outcomes. To this end, the State will work in partnership with communities and their public and private sector entities.”

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PROGRAM DESCRIPTIONS

The State's budgetary control is maintained at the program level. A program is an activity or goal to be accomplished with the resources provided. Resources for a program will frequently be derived from more than one fund type. The following programs are related to the Medicaid Program:

Program 344 Children's Health Insurance

The Children's Insurance Program (CHIPs) is also referred to as Kids Connection. All children under age 19 who are without health insurance coverage, and whose family income is at or below 185 percent of the federal poverty guidelines are eligible for medical services provided by this program. The start date of the program was September 1998. The state match for this program is provided from the Nebraska Health Care Trust Fund, which receives funds through an Intergovernmental Transfer.

Program 348 Medical Services

The Medicaid Program provides direct payment to providers of medical care for services rendered to eligible clients. Operational expenditures paid from this program are used for contracted administrative reviews and to operate the managed care system.

Program 349 Long-Term Care

During the 1995 legislative session, nursing facility and home health care services were moved from program 348 to a separate budget program. Individuals receiving long-term care services under the Medicaid Program have their bills paid from program 349. Administrative functions to support the implementation of the 1997 long-term care plan include estate planning, quality assurance, and assessment/service coordination.

Program 341 Administration of Public Assistance

This program provides all the supportive services administration functions for the health and human services system. This program includes support for all public assistance programs administered by the System. Disbursements and sources only as they relate to Medicaid are included in this report.

Program 421 Developmental Disability System

The Beatrice State Developmental Center (BSDC) provides 24-hour per day on-campus residential, rehabilitative, and medical services to Nebraskans with mental retardation. Medicaid funds are the primary source of federal funds received by BSDC. The state matching for Medicaid is appropriated to this program. This report is not an audit of BSDC. Disbursements and sources only as they relate to Medicaid are included in this report.

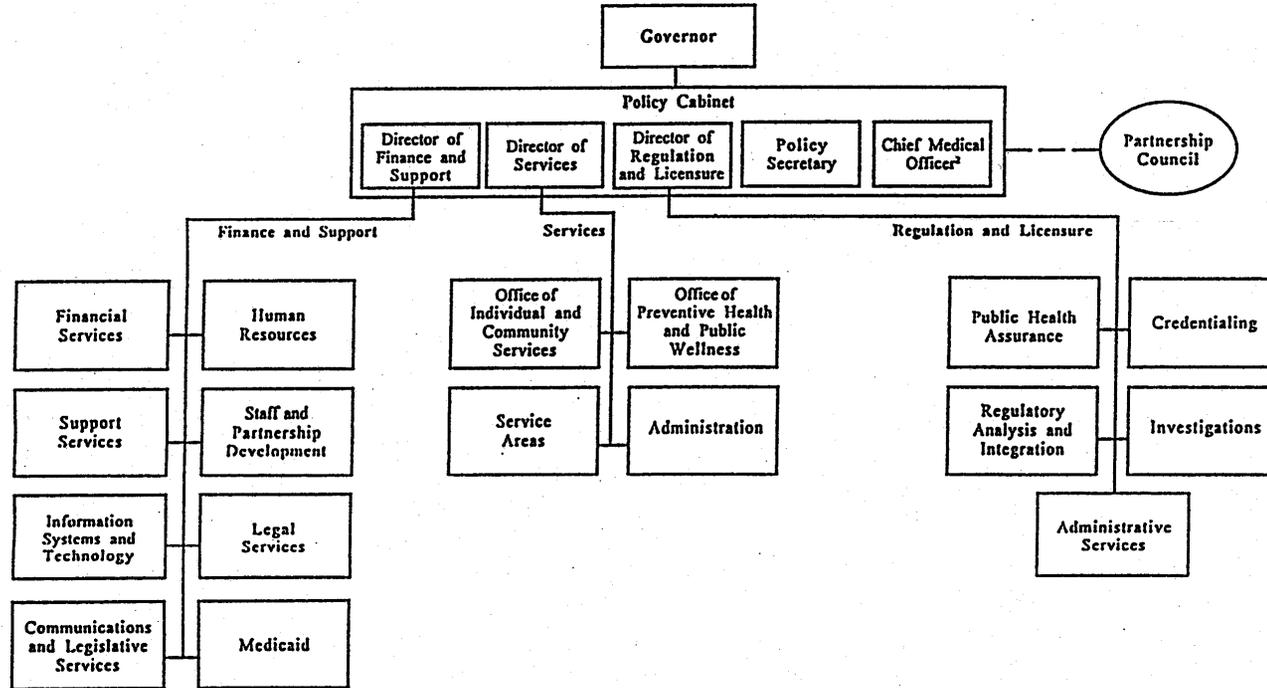
Program 424 Developmental Disability

This program provides funds to purchase community-based services for individuals with developmental disabilities. Disbursements and sources only as they relate to Medicaid are included in this report.

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ORGANIZATIONAL CHARTS

Nebraska Health and Human Services System



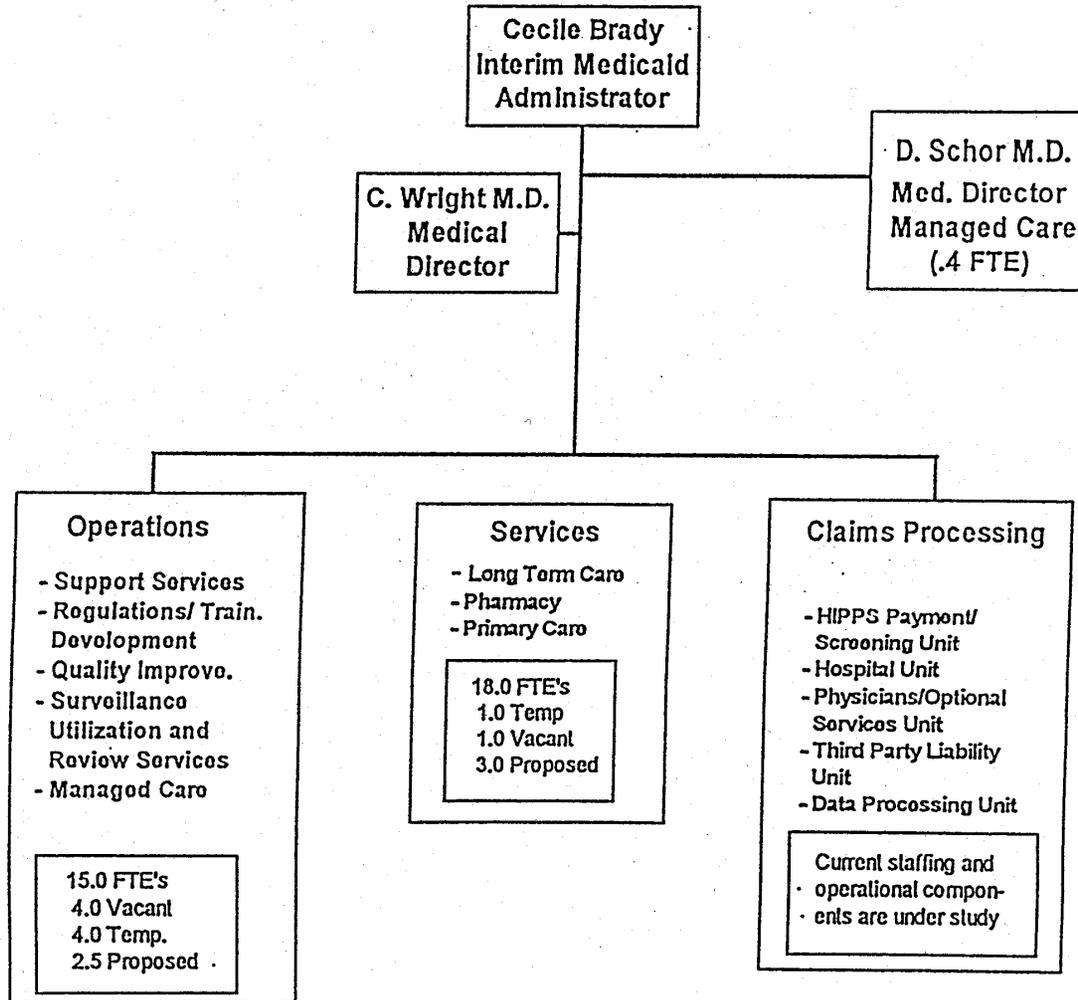
¹ Source: Nebraska Department of Health and Human Services Finance and Support.

² A chief medical officer is appointed if the director of regulation and licensure is not a licensed physician.

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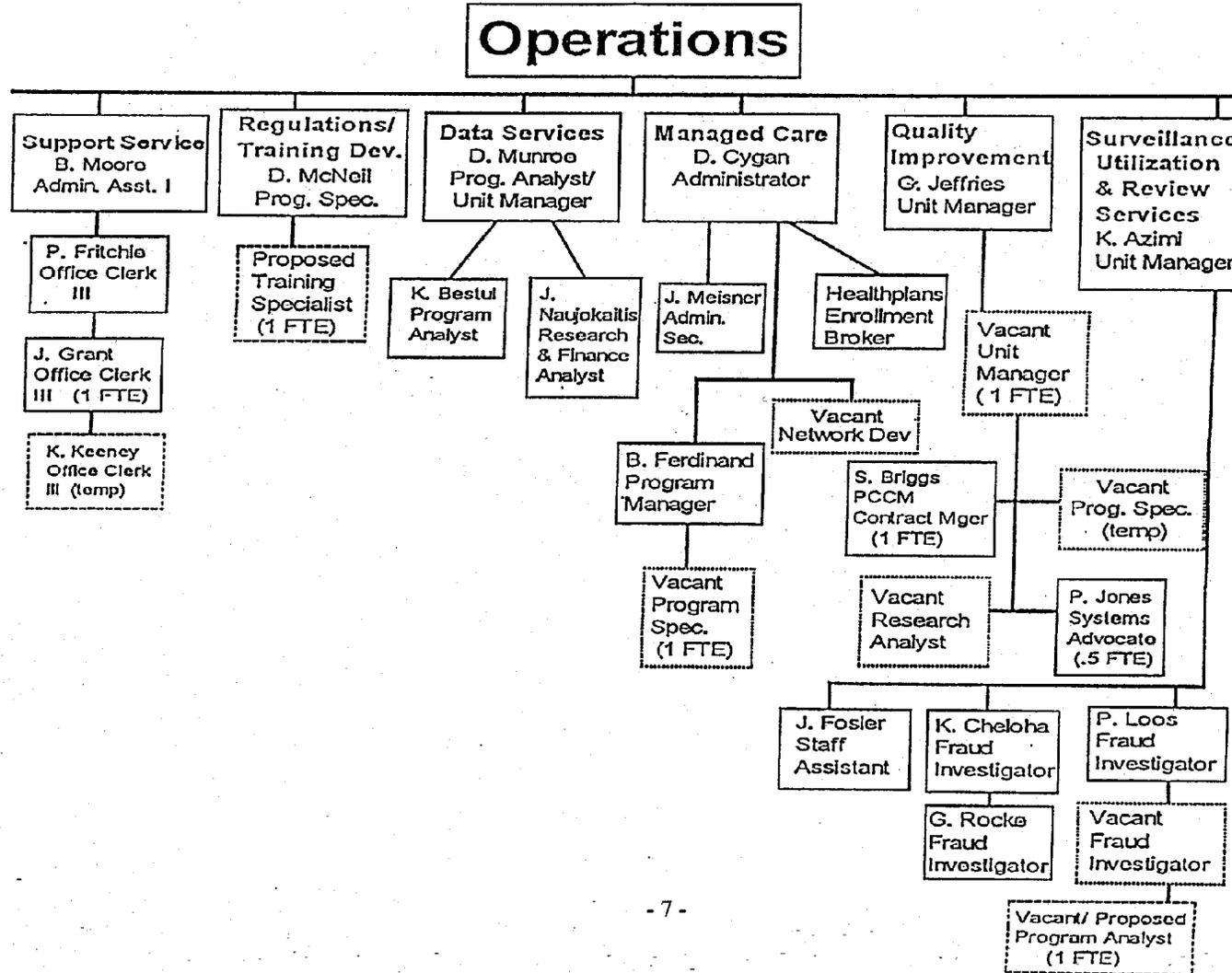
ORGANIZATIONAL CHARTS

MEDICAID DIVISION



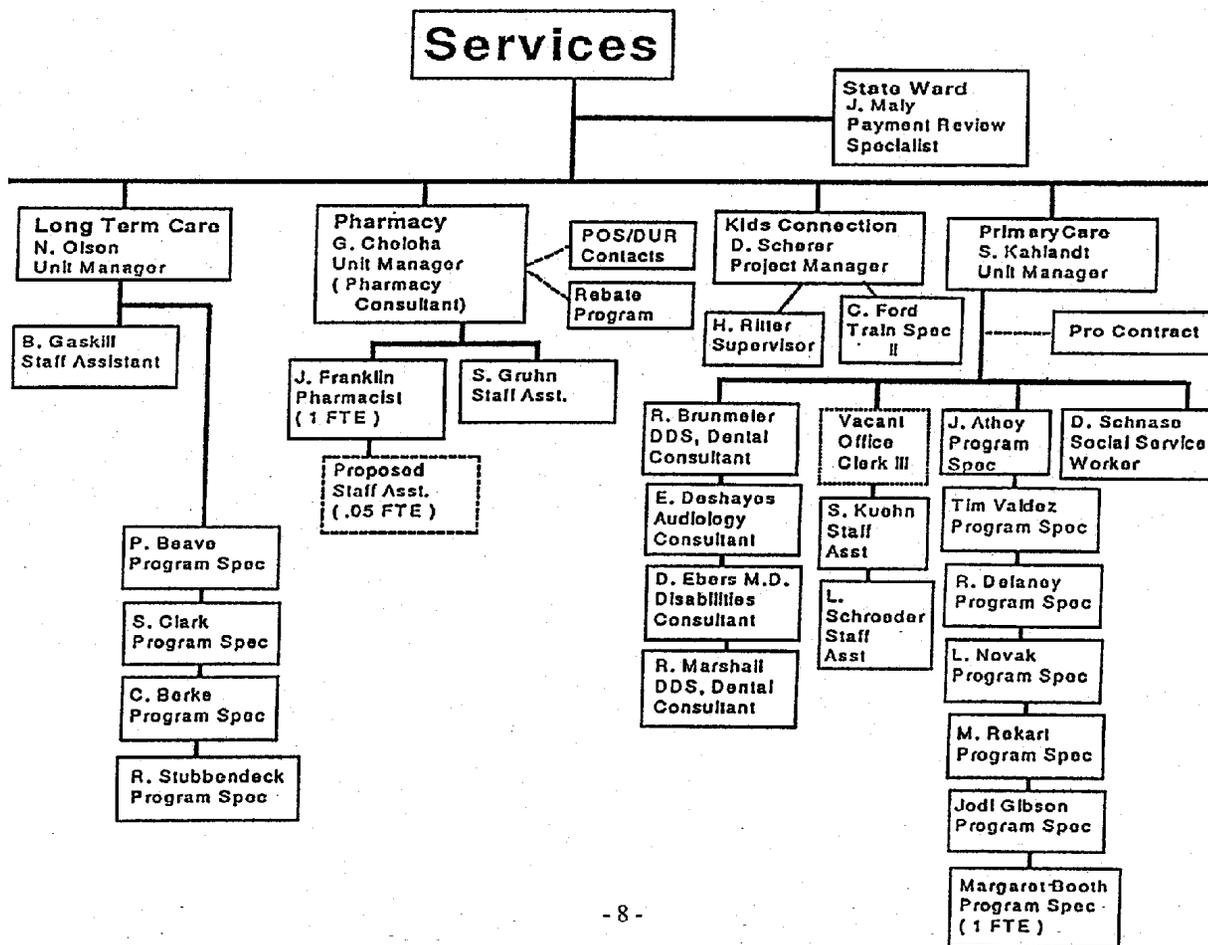
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ORGANIZATIONAL CHARTS



NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
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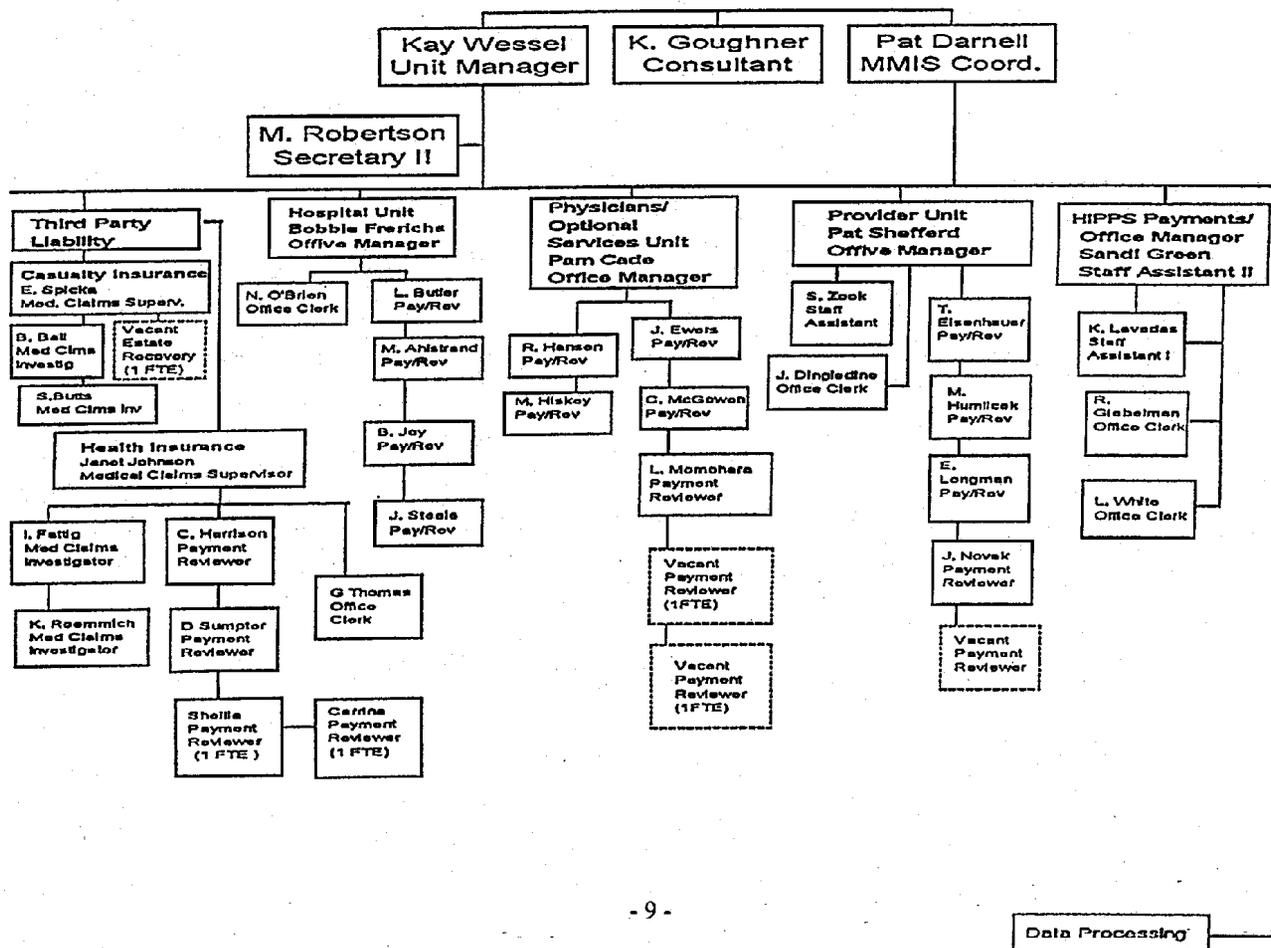
ORGANIZATIONAL CHARTS



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Claims Processing



NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
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Common Abbreviations and Acronyms

BSDC	Beatrice State Developmental Center
CFR	Code of Federal Regulations
CHIPs	Children's Health Insurance Program (Kids Connection, Title XXI)
DAS	Department of Administrative Services
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
FTE	Full-Time Equivalent
HCFA	Health Care Financing Administration (Federal Regulatory Agency)
HHS	Nebraska Health and Human Services System
ICF-MR	Intermediate Care Facility - Mentally Retarded
IGT	Intergovernmental Transfer
MIPS	Medicaid in Public Schools
MMIS	Medicaid Management Information System
NAC	Nebraska Administrative Code
NAS	Nebraska Accounting System
NFOCUS	Nebraska Family On-Line Client User System
SFY	State Fiscal Year
SURS	Surveillance and Utilization Review System
TPL	Third Party Liability

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Dr. Richard Raymond, Interim Director
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Dear Dr. Raymond:

We have studied the policies and procedures related to the Nebraska Health and Human Services System – Medicaid Program for the fiscal year ended June 30, 1999. Our study was made under the authority of State Statute Section 84-304, R.R.S. 1999, which authorizes the examination of agency records. This advisory report provides the results of that study and is intended for the information of the Nebraska Health and Human Services System; however, this report is a matter of public record and its distribution is not limited.

Our study included disbursements in Program 344 Children's Health Insurance, Program 348 Medical Assistance, and Program 349 Long-Term Care. Our study also included Medicaid - related disbursements in Program 341 Administration of Public Assistance, Program 421 Developmental Disability System, and Program 424 Developmental Disability.

As a result of our study of the Medicaid Program, we noted certain issues which the Nebraska Health and Human Services System should consider relative to those procedures. These issues are included in the Comments and Recommendations section of our report.

Pat Reding, CPA

June 5, 2000

Pat Reding
Audit Manager

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SUMMARY OF COMMENTS

During our study of the Nebraska Health and Human Services System – Medicaid Program, we noted certain matters involving the internal control and other operational matters that are presented here. Comments and recommendations are intended to improve internal controls, ensure compliance, or result in operational efficiencies.

1. Significant Deficiencies in Accounting Procedures
2. Information Management Systems Documentation
3. Nursing Facility Field Audits
4. Supporting Documentation for Aid Payments
5. Incorrect Amounts Paid to Providers
6. Aged and Disabled Waiver Payments
7. Accounts Receivable –TPL
8. Contractual Service Payments
9. Payments for Bedholding
10. Nursing Facility Rates
11. Nursing Home Adjustments
12. Performance Measures Not Developed
13. Claims Processing
14. Surveillance and Utilization Review Subsystem
15. Temporary Employees

More detailed information on the above items is provided hereafter. It should be noted this report is critical in nature since it contains only our comments and recommendations on the areas noted for improvement.

Draft copies of this report were furnished to HHS to provide them an opportunity to review the report and to respond to the comments and recommendations included in this report. All formal responses received have been incorporated into this report. Where no response has been included, HHS declined to respond. Responses have been objectively evaluated and recognized, as appropriate, in the report. Responses that indicate corrective action has been taken were not verified at this time.

We appreciate the cooperation and courtesy extended to our auditors.

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COMMENTS AND RECOMMENDATIONS

1. Significant Deficiencies in Accounting Procedures

During our audit, we noted significant deficiencies in the controls over the recording and reporting of Medicaid disbursements.

HHS does not have reconciliation procedures to ensure aid payments reported agree to expenditures.

Our reconciliation noted Rehabilitation Option claims were included twice on the federal report. The expenditures were reported both in Physician Services and in Clinic Services. The double reporting occurred for the period April 1998 through December 1999. The amount over-reported during fiscal years ended June 30, 1998 and June 30, 1999 was \$1,274,768 and \$9,524,931, respectively. The amount over-reported during the period July 1, 1999 through December 31, 1999 was \$4,395,162. There were no questioned costs as a result of the error; however, authorizations to spend federal monies may have been affected. HHS made a correction to the March 2000 report after our auditors discovered the error.

Our reconciliation of aid expenditures reported to NAS records noted approximately \$6.2 million was paid with State funds which could have been paid with Federal funds. HHS prepares the federal report using total expenditures, without regard to funding source, and multiplies by the applicable federal percentage to report the breakdown between Federal and State funds. HHS indicated this was a timing difference and federal grants were reconciled when closed (the 1997 grant was not closed as of May 2000). However, no reconciliation is performed to ensure the funding reported agrees to the source used. Therefore, the State could overspend State funds.

Administrative costs reported are not reconciled to the accounting records. HHS utilizes a Cost Allocation Plan to assign administrative costs to benefiting programs. Each quarter the Plan is executed and the administrative costs are reported in total. The amount reported does not agree with actual expenditures paid by Medicaid funds. No formal adjustment is made to the accounting records. An HHS accountant reviews the Grant Project Status report and charges costs to programs based on knowledge of the system; however, there are no written procedures and no documentation to support choices made. We also noted adjustments to payroll funding and adjustments for negative grant balances with little or no written documentation.

During our review, HHS was adjusting the Cost Allocation Plan numbers due to an error involving certain disbursements that were not charged to the proper program. The error first occurred when the Plan was amended in 1997 for the HHS Partnership reorganization and continued through 1999. HHS was revising all four quarters for State fiscal year 1998 and all four quarters for fiscal year 1999. Various programs were affected, and adjustments are needed to federal reports. The correction for Medicaid is an over-claim of \$5,706,035 for 1998 and an under-claim of \$3,774,648 for 1999.

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1. Significant Deficiencies in Accounting Procedures (Continued)

As noted in our advisory report on Nursing Facilities Intergovernmental Transfers (see Appendix C), the proportionate share pool incorrectly included \$905,210 in fiscal year 1999 and \$452,605 in fiscal year 1998. This amount was properly paid to a nursing facility per HHS regulations; however, it was also distributed in the pool and transferred to the Nebraska Health Care Trust Fund. Therefore, federal funds were charged twice and the \$1,450,104 received by the Trust Fund, plus accumulated interest, should be reimbursed to the Federal government.

State Statute Section 81-3007(3)(d) R.R.S. 1999 states the Department of Health and Human Services Finance and Support has the responsibility to “Develop and manage a consistent accounting, contracting, disbursement, and fiscal compliance system.” Good internal control requires a plan of organization, procedures, and records designed to provide reliable records. This includes adequate reconciliation procedures to ensure all costs are properly recorded and reported. Title 45 CFR 74.21(b)(1) requires financial management systems to provide for: accurate and complete disclosure of financial results; records that adequately identify the source and application of funds; effective control and accountability for all funds; written procedures; and accounting records that are supported by source documentation.

Without adequate controls, there is an increased risk for loss or misuse of funds.

We recommend HHS implement adequate control procedures to ensure funds are properly recorded and reported. Written procedures should be developed. HHS should implement reconciliation procedures to ensure errors are discovered and corrected in a timely manner. Procedures should include a reconciliation of reported amounts to the Medicaid Management Information System and to the Nebraska Accounting System. Quarterly adjustments should be performed after the Cost Allocation Plan is completed. We further recommend these issues be resolved with the appropriate federal agency, and that all necessary corrections be made in a timely manner.

HHS RESPONSE: THE DEPARTMENT AGREES THAT NO WRITTEN PROCEDURES EXIST FOR THE RECONCILIATION PROCESSES. HOWEVER, HHS-FINANCE & SUPPORT EXPLAINED TO THE AUDITORS THE OTHER PROCESSES THAT ALLOW FOR DETECTION OF INCORRECT AMOUNTS.

THE DEPARTMENT DOES NOT AGREE WITH THE FINDING THAT \$6.2 M WAS PAID WITH STATE FUNDS WHICH SHOULD HAVE BEEN FEDERAL. THE DEPARTMENT PROVIDED SEVERAL ITEMS OF EXPLANATION AND ILLUSTRATION TO SUPPORT THIS. AS WAS EXPLAINED, A POINT IN

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1. Significant Deficiencies in Accounting Procedures (Concluded)

TIME (6-30-99) USED BY THE AUDITORS WAS ONLY THREE QUARTERS OF THE FEDERAL FY GRANT AND DID NOT ALLOW FOR THE FOURTH QUARTER REPORTING AND ALL FUNDS AND ADJUSTMENTS TO BE POSTED AGAINST THIS YEAR.

THE DOUBLE REPORTING OF \$9.5 MILLION IN REHAB OPTION CLAIMS OCCURRED ON HCFA-64 QUARTERLY REPORTS. NO FEDERAL OR STATE DOLLARS WERE EXPENDED. THIS REPORTING ERROR WAS CORRECTED ON THE HCFA-64 REPORT FOR THE JANUARY-MARCH 2000 QUARTER.

THE UNDER AND OVERCLAIMED AMOUNTS ARE TOTAL PROGRAM COSTS NOT THE FFP. THE 1998 AND 1999 AMOUNTS FOR THE AUDITOR'S AMOUNTS ARE (\$3,130,085) AND \$1,055,583 RESPECTIVELY. WE HAD PROVIDED UPDATED NUMBERS FOR 1999 BUT THEY WERE NOT INCLUDED IN THE FINDING. WITH THE UPDATED NUMBERS THE UNDER CLAIMED AMOUNT IS ONLY \$2,408 FFP.

THE DEPARTMENT AGREES THAT THEY CLAIMED INTERGOVERNMENTAL FUNDS TWICE DURING THE PERIODS IN QUESTION. WE ARE IN THE PROCESS OF DETERMINING THE ACTUAL INTERGOVERNMENTAL TRANSFER AMOUNT FOR BOTH PERIODS IN QUESTION SINCE ESTIMATES WERE USED. THE AMOUNTS WILL BE ADJUSTED.

AUDITORS' RESPONSE: BASED ON THE DOUBLE REPORTING OF \$9.5 MILLION FOUND BY OUR AUDIT STAFF AND OTHER ITEMS NOTED, WE DISAGREE THAT HHS PROCESSES ARE ADEQUATE TO DETECT INCORRECT AMOUNTS. FURTHERMORE, THE CASH MANAGEMENT PRACTICES WHICH ALLOW FOR VARIANCES IN MILLIONS OF DOLLARS BETWEEN FEDERAL AND STATE RESOURCES WITHOUT TIMELY RECONCILIATIONS IS UNACCEPTABLE.

THE FINDING INCLUDES THE MOST CURRENT NUMBERS FURNISHED DURING FIELDWORK. CHANGES TO THE 1999 COST ALLOCATION UNDERCLAIM WERE NOT VERIFIED AT THIS TIME. HOWEVER, THE ISSUE REMAINS THAT AMOUNTS REPORTED WERE INCORRECT FOR AT LEAST TWO YEARS, AND CONSIDERABLE HHS STAFF TIME WAS NEEDED TO CORRECT ERRORS WHICH SHOULD HAVE BEEN DETECTED IN A TIMELY MANNER.

2. Information Management Systems Documentation

Good internal control requires a plan of organization, procedures, and records designed to safeguard assets and provide reliable records. Good internal control includes documentation of information management systems.

Nebraska Health and Human Services utilizes Information Management Systems to manage the Medicaid program. Significant systems used to manage the Medicaid Program include the Medicaid Management Information System (MMIS), Nebraska Family On-Line Client User System (NFOCUS), and the CICS1 System. We noted there was no comprehensive, organized, written documentation, which included definitions of the fields and codes used in these systems. During testing we conducted, multiple staff had to be contacted to determine field definitions and to determine what the codes meant.

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2. Information Management Systems Documentation (Concluded)

We recommend written documentation be developed to support the Information Management computer systems. This should include instructions to access, field definitions, and coding documentation.

HHS RESPONSE: THE DEPARTMENT AGREES THAT NO ALL-INCLUSIVE WRITTEN DOCUMENTATION FOR THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) EXISTS, DUE TO LIMITED STAFF RESOURCES. TRAINING ON INDIVIDUAL APPLICATIONS IS PROVIDED TO NEW EMPLOYEES AND ON AN "AS NEEDED" BASIS. MAJOR ENHANCEMENTS TO THE MMIS WILL INCLUDE USER DOCUMENTATION AS A STANDARD DELIVERABLE.

3. Nursing Facility Field Audits

HHS reported \$334,455,062 in Medicaid payments to nursing facilities for fiscal year ended June 30, 1999. A field audit has not been performed for 188 of 236 (80%) of nursing facilities in the past five years. Of the 188, there were 59 without a field audit in the past ten years. There is an increased risk for errors, abuse, and overpayments to occur without periodic audits.

We visited six nursing facilities and compared various data reported to the facilities' records. For one facility, we noted one of four lines tested on the cost report did not agree with supporting documentation. The Other Nursing cost reported was overstated by \$8,590. The last HHS field audit of this facility was 1987. HHS regulations do not allow an audit more than five years after the end of the report period.

Title 42 CFR 447.253(g) states, "The Medicaid agency must provide for periodic audits of the financial and statistical records of participating providers." Title 471 NAC 12-011.09 requires providers to maintain financial records, supporting documentation, and all pertinent records related to the cost report for a minimum of five years. Financial records must be accurate and sufficiently detailed to substantiate the data reported.

We recommend HHS perform field audits on a timely basis. We further recommend HHS resolve the discrepancy noted at the facility tested.

HHS RESPONSE: THE DEPARTMENT AGREES THAT TITLE 42 CFR 447.253 DOES STATE, "THE MEDICAID AGENCY MUST PROVIDE FOR PERIODIC AUDITS OF THE FINANCIAL AND STATISTICAL RECORDS OF PARTICIPATING PROVIDERS." BUT IT DOES NOT STATE THAT FIELD AUDITS ARE MANDATORY TO FULFILL THIS REQUIREMENT. BASED ON AVAILABLE STAFFING LEVELS, THE DEPARTMENT HAS DEVELOPED A COST REPORT FORM AND A DESK AUDIT PROCESS THAT FULFILLS THE REQUIREMENTS OF CFR 447.253. THE DESK AUDIT

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3. Nursing Facility Field Audits (Concluded)

PROCESS IN MANY CASES EXAMINES DETAILED TRIAL BALANCES, ADJUSTING JOURNAL ENTRIES AND ACTUAL SOURCE DOCUMENTATION. IN FACT, ALL FACILITIES ARE DESK AUDITED. THEREFORE, 100% OF THE PROVIDERS REPORTING TO THE DEPARTMENT HAVE BEEN AUDITED.

ALSO, PLEASE NOTE THAT THE MOST RECENT STATEWIDE SINGLE AUDIT BY KPMG FOR THE FISCAL YEAR ENDING JUNE 30, 1999 CONTAINED NO MENTION OF NOT MEETING THE REQUIREMENTS OF CFR 447.253. THE AUDITORS FOR KPMG REVIEWED MANY OF THE DESK AUDITS AND FOUND THAT 'DETAILED REVIEWS' WERE BEING PERFORMED. THE AUDITORS FROM KPMG WERE APPARENTLY SATISFIED THAT THE AUDIT UNIT WAS MEETING THE REQUIREMENTS SET FORTH IN CFR 447.253.

THE AMOUNT OF THE ESTIMATED OVERPAYMENT IN THE DRAFT IS IN ERROR. THE MEDICAID OVERPAYMENT WAS \$2,509.43, NOT \$8,590. WE WILL WORK WITH THIS PROVIDER AND THE STATE AUDITORS TO EXPLAIN ANY DIFFERENCES.

4. Supporting Documentation for Aid Payments

Good internal control requires procedures designed to provide reliable records. It also requires expenditures have adequate supporting documentation on file. This ensures processed claims are for legitimate purposes and paid at the proper amount.

During our review of 155 Medicaid Management Information System (MMIS) claim lines of coding we noted the following:

- HHS was unable to provide supporting documentation as to how many Medicaid clients are enrolled in the Medicare Buy-In program. HHS paid Medicare part B premiums for eligible Medicaid clients. The Health Care Financing Administration (HCFA) billed Medicaid for these clients on a monthly basis. During our testing for one month, HHS paid HCFA \$885,578 for part B premiums. Without adequate supporting documentation for the number of clients enrolled in the Medicare Buy-In, the Department could pay inaccurate premium amounts to HCFA.
- Two claims did not have adequate documentation to support the clients' exemptions from co-pay status. The services the clients received required a co-pay of \$2 and \$3. However, the recipients were listed on NFOCUS and MMIS as being exempted from co-pay. A client must meet one of seven criteria to be co-pay exempt. HHS was unable to furnish documentation that supported the clients' exemptions from co-pay status. This could result in Medicaid overpaying on claims when a client should be required to share the cost of the services received.

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4. Supporting Documentation for Aid Payments (Continued)

- Supporting documentation for determining the amount of pharmacy dispensing fees was not available. During our testing of 33 drug claims, we noted the pharmacy dispensing fee ranged from \$3.09 to \$4.91. Dispensing fees were originally set by a state survey. The dispensing fees have been adjusted by the State Pharmacist as conditions warrant. However, HHS could not furnish the survey or documentation for adjustments made to each pharmacy's dispensing fee. Without supporting documentation, each pharmacy's specific dispensing fee could not be justified.
- One claim had duplicate client profiles in NFOCUS and MMIS. The caseworker entered client information for a pregnancy into NFOCUS using an unborn child profile. When the child was born a second profile was created instead of updating the existing unborn profile. Therefore, two profiles were created for one individual. The NFOCUS and MMIS databases may not be reliable when the client's information is located in two separate profiles.

Without proper internal controls over supporting documentation, the risk of loss or misuse of Medicaid funds increases.

We recommend HHS:

- Develop procedures to maintain supporting documentation to verify billing amounts are correct.
- Review procedures to update client information in NFOCUS.
- Develop procedures to identify the specific criteria which allows the client to be exempt from co-pay status.
- Maintain supporting documentation to verify pharmacy dispensing fees.

HHS RESPONSE: THE AGENCY COMPLETED SYSTEM WORK DURING JULY 1999 TO SUMMARIZE THE DATA COMING BACK FROM HCFA ON THE CLIENTS THE AGENCY IS BUYING IN FOR. THE AGENCY DOES HAVE A SUMMARY OF THE CLIENTS BEING SENT TO HCFA BUT IT IS NOT BROKEN DOWN IN A MANNER THAT PROVIDES EASY COMPARISON TO THE INCOMING DATA. THE BUY-IN SYSTEM IS GOING TO BE REWRITTEN DURING THE LATE SUMMER OR EARLY FALL; WE WILL BREAK DOWN THE OUTGOING DATA SO THAT IT IS EASY TO COMPARE TO THE HCFA DATA.

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4. Supporting Documentation for Aid Payments (Concluded)

THE AGENCY RUNS LISTINGS OF UNBORN CHILDREN WHERE THE BIRTH IS OVERDUE AND IF THE SCENARIO IS FOUND WHERE A SEPARATE PROFILE HAS BEEN CREATED, ONE PROFILE IS PLACED IN A CLOSED STATUS. ALTHOUGH AN HHSS EMPLOYEE DID NOT FOLLOW CORRECT PROCEDURES, THESE SITUATIONS DO NOT RESULT IN MISSPENT DOLLARS.

THERE ARE SITUATIONS WHEN THE CASEWORKER TAKES CASE ACTIONS THAT HAVE NO BEARING ON THE CLIENT'S COPAYMENT STATUS DURING THE MIDDLE OF A MONTH, THESE ACTIONS CHANGE THE COPAYMENT STATUS FROM COPAY REQUIRED TO NOT REQUIRED. THE AGENCY WILL INVESTIGATE THESE SITUATIONS AND WRITE A SYSTEM INVESTIGATIVE REPORT TO ADDRESS THIS ISSUE IF APPROPRIATE.

5. Incorrect Amounts Paid to Providers

Good internal control requires claims be reviewed prior to payment to ensure the amount is correct. In addition, procedures should be established to prevent duplicate paid claims.

During our review of 155 Medicaid Management Information System (MMIS) claim lines of coding we noted the following errors in nine claims:

- One ventilator care claim was underpaid \$589. The provider submitted a claim for 31 days of care. The effective rate at the time of care was \$470 per day. However, HHS had not updated the effective rate in MMIS and paid this claim at \$451 per day. Of 155 MMIS claims selected, one ventilator care service was tested.
- One podiatry service claim was overpaid \$11. The procedure code for this service did not have a unit value at the time the claim was paid. When a general procedure code does not have a unit value, MMIS kicks the claim out for a payment specialist to review and pay at 70% of the submitted amount. The payment specialist paid 100% of the submitted amount. The total claim amount was \$38. Of the 155 MMIS claims tested, one podiatry service claim was selected.
- One Physician Services claim was paid \$3 for a procedure code that had not been covered since January 1994.
- Two Physician Services claims were paid for \$25 for clients who had third party insurance at the time of the service but had not informed HHS of the insurance. HHS has not yet billed the third party insurer for these services.
- One Managed Care claim was overpaid by \$4. The contracted rate for this client's demographics was \$146 per month. HHS paid \$150 each month of fiscal year 1999. Five Managed Care Medical/Surgical capitated rates were selected for testing.

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5. Incorrect Rates Paid to Providers (Concluded)

- One nursing home claim was overpaid by \$11. The client had excess income. Individuals who are medicaid eligible but have excess income (spenddown) shall obligate the excess amount for medical care before payment for medical services can be approved. Per NFOCUS, the client had a spenddown amount of \$921; however, HHS reduced the claim by only \$910.

Without proper internal control over claims processing, the risk of loss or misuse of funds increases. During fiscal year 1999 HHS processed approximately 10 million claim lines of coding and paid approximately \$730 million in aid through MMIS.

We recommend HHS implement procedures to ensure claims are paid at the proper amount and prevent duplicate claim payments. We further recommend the errors noted be corrected.

HHS RESPONSE:

- A. THE AGENCY HAS TAKEN CORRECTIVE ACTION.
- B. WE AGREE THAT A MANUAL ERROR OCCURRED; A PROCEDURE CODE HAS BEEN AUTOMATED EFFECTIVE APRIL 1999 TO ELIMINATE MANUAL ERRORS.
- C. WE AGREE THAT PROCEDURE CODE 36415 IS OBSOLETE; HOWEVER, THE SERVICE IS STILL COVERED UNDER A DIFFERENT CODE NUMBER AND WAS PAID CORRECTLY. THE AUDIT COMMENT QUESTIONS A \$3 PAYMENT OUT OF A NEARLY BILLION DOLLAR BUDGET.
- D. THE INSURANCE RECOVERY PROCESS IS CONTINUALLY BEING IMPROVED. THE PROCESS INCLUDES BILLING THIRD PARTIES AFTER MEDICAID PAYMENT WHEN A MINIMUM DOLLAR AGGREGATION PER RECIPIENT HAS BEEN REACHED; RECOVERY OF COSTS BELOW THIS MINIMUM LEVEL IS NOT WARRANTED BASED ON THE COST OF THE COLLECTION EFFORT.
- E. WE DISAGREE WITH THIS FINDING. THE \$150.07 FIGURE WAS THE FINAL CONTRACTED RATE; THE \$146 FIGURE WAS AN INITIALLY PROPOSED RATE, NEVER FINALIZED.
- F. WE AGREE. THE SPENDDOWN CHANGED BY \$11 DURING THE CLAIMS PROCESSING PERIOD. A MONTHLY REPORT IDENTIFIES SUCH CHANGES. STAFFING LEVELS AFFECT OUR ABILITY TO FOLLOW UP.

AUDITORS' RESPONSE: AS INDICATED ABOVE, WE NOTED ERRORS IN 9 OF 155 CLAIMS TESTED. HHS PROCESSED APPROXIMATELY 10 MILLION CLAIM LINES OF CODING AND PAID APPROXIMATELY \$730 MILLION IN AID THROUGH MMIS. WE ARE NOT SIMPLY QUESTIONING A \$3 PAYMENT, BUT RATHER, WE ARE CONCERNED WITH THE CONTROLS AND PROCEDURES WHICH ALLOWED ERRORS IN 6% OF THE MMIS CLAIMS TESTED.

6. Aged And Disabled Waiver Payments

The Aged and Disabled (AD) waiver was established to allow the client to remain at home instead of being placed in a nursing facility. To be enrolled in the AD waiver, the client must

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6. Aged And Disabled Waiver Payments (Continued)

not exceed a monthly waiver cap. This cap is used to ensure waiver payments are more cost effective than placement in a nursing facility. The client may receive services once a provider agreement has been established. This agreement defines the provider, the type of service, and the number of units the client may receive. The AD waiver payments for the year were approximately \$14,000,000 and the waiver served approximately 2,537 clients.

During our testing of provider payments for seventeen AD waiver clients, we noted the following:

- Eight of seventeen clients tested exceeded the monthly waiver cap by a total of \$7,051. During the year tested, the client could exceed the monthly waiver cap with the verbal permission of HHS Central Office staff. HHS did not require any further documentation to support the client's exception to the waiver cap.
- One provider was underpaid \$24. The client had excess income. Individuals who are eligible for Medicaid but have excess income (spenddown) shall obligate the excess amount for medical care before payment for medical services can be approved. The provider submitted the claim for three months of chore services. Per NFOCUS, the client had a spenddown amount of \$488 for the first two months and \$500 for the third month; however HHS reduced the provider's claim by \$500 for each of the three months.
- One provider exceeded the provider authorization on three separate claims. Each of these exceptions also caused the clients to exceed the monthly waiver cap.
 1. For one client, the provider was authorized 20 hours/week of RN care at a rate of \$31/hour. The provider submitted a claim for one month of 98 hours of RN care and was overpaid \$558.
 2. For another client, the provider was authorized for 81 hours/month of RN care at a rate of \$32/hour and 18 hours/month of LPN care at a rate of \$22/hour. The provider submitted a claim for one month of 99 hours of RN care and was overpaid \$180.
 3. For the same client, the provider submitted a claim for another month for 94 hours of RN care and was overpaid \$130.

If the waiver cap is exceeded on a consistent basis, this may be an indication the client might be better cared for in a nursing facility. It may also signal that financially the waiver is not in the best interest of the State. Total AD waiver payments tested were \$48,926.

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6. Aged And Disabled Waiver Payments (Concluded)

We recommend HHS:

- Document all approvals to exceed the monthly waiver cap.
- Review waiver cap expenditures to ensure clients are not continually exceeding the cap.
- Ensure the units of services paid agree to the provider agreements.
- Verify the client's spenddown on NFOCUS to ensure the proper claim amount is paid.

HHS RESPONSE: THE WAIVER IS EVALUATED ON AN AGGREGATE BASIS, NOT PER INDIVIDUAL CLIENT COSTS. HHS HAS CERTIFIED TO HCFA THAT THE AGGREGATE EXPENDITURE DOES NOT EXCEED THE AGGREGATE CAP. IN THE MOST CURRENT WAIVER PROGRAM YEAR, THE AVERAGE PER CLIENT WAIVER EXPENDITURE WAS \$11,179, COMPARED TO \$22,280 AVERAGE PER CLIENT NURSING FACILITY EXPENDITURE.

7. Accounts Receivable – TPL

Good internal control over receivables requires periodic billings of outstanding accounts, review of payments for completeness, and an aging of receivables in order to determine collectability. In some instances HHS initially paid for Medicaid benefits and then generated post-payment billings to obtain reimbursement from other payors, such as insurance companies.

During our review of Medicaid TPL, we noted HHS did little monitoring of submitted claims due from third party insurance companies. HHS submitted billings of suspected TPL's and accepted any payments received. HHS did not investigate and verify whether the insurance company Explanation of Benefits (EOB) was the proper amount due to HHS. Also, HHS did not send out any second notice claims, and did not review accounts receivable or perform and maintain an aging of the receivables.

During the fiscal year ending June 30, 1999 HHS submitted numerous claims to insurance companies. Of these fiscal year 1999 claims, 5,140 were still outstanding at June 30, 1999 totaling \$10,600,454. During the fiscal year, HHS did collect \$5,506,856 from TPL.

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7. Accounts Receivable – TPL (Concluded)

We recommend HHS verify the propriety of EOB amounts received. In addition, we recommend HHS review accounts receivable related to TPL for collectability, perform an aging of the receivables, and send out second collection notices.

HHS RESPONSE: THIS AREA DOES MERIT AN ADDITIONAL REVIEW AS STAFFING ALLOWS. HOWEVER, THE TOTAL OF \$10,600,454 IS THE GROSS AMOUNT AND OVERSTATES ANY POTENTIAL MONIES DUE TO THE STATE. THE DEPARTMENT CONTINUES TO MAKE COMPUTER SYSTEM CHANGES TO REDUCE THE AMOUNT OF MANUAL INTERVENTION CURRENTLY REQUIRED FOR COST AVOIDANCE AND ROLL-UP RECOVERY. DURING THE AUDIT PERIOD, PERSONNEL RESOURCES WERE DIRECTED TO Y2K MODIFICATION EFFORTS. IN PART DUE TO THESE EFFORTS IN FY 1999 AND THE AVAILABILITY OF PERSONNEL RESOURCES, THE TPL RECOVERY IMPROVED FROM \$5.65 MILLION IN FY 1999 TO \$11.76 MILLION IN FY 2000. ADDITIONALLY, IMPROVEMENTS MADE TO THE TPL RECOVERY PROCESS SHOW AN INCREASED PROPORTION OF ACTUAL RECOVERIES COMPARED TO ATTEMPTED RECOVERIES. THE DEPARTMENT HAS ANALYZED PHARMACY CLAIMS SUBMITTED TO BE RECOVERED AND ACTUALLY RECOVERED WHICH SHOWS BY CALENDAR YEAR, 9.7% RECOVERY FOR 1998, 40.5% RECOVERY FOR 1999 AND 75% RECOVERY FOR FIRST QUARTER 2000.

8. Contractual Service Payments

Good internal controls include a plan of organization, procedures, and records designed to safeguard assets and provide reliable financial records. Good internal control records include adequate supporting documentation and written contract terms to support the claim. Without adequate supporting documentation, HHS cannot properly review the claim for services rendered and determine whether the payment is reasonable and necessary. Good internal control procedures include verifying that all documents are properly reviewed and processed. Without these controls, there is an increased risk of loss or misuse of funds.

During our testing of Medicaid-related administrative expenses, we noted the following:

- Two documents tested did not have adequate supporting documentation on file for escort services. The documents totaled \$339,896. Escort services are available to clients enrolled in Managed Care mental health/substance abuse. The provider negotiates and obtains medically necessary transportation and escorts for those clients enrolled in Managed Care mental health/substance abuse. The client may travel out of the state for necessary services. Transportation can range from cab to airline services.

HHS had a spreadsheet on file from the provider for services rendered. The spreadsheet lists the client's name, recipient number, provider number, service date, and the paid amount. The spreadsheet did not detail the type of transportation provided

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8. Contractual Service Payments (Continued)

or distance the client and escort traveled. Also, HHS did not review the claims to ensure the proper amount was billed for transportation services. HHS had a contract that states the provider may provide escort services. However, the contract did not stipulate the type of transportation and amount that would be paid to the provider for these services.

- A contract to establish rates was overpaid by \$125,107. HHS entered into a contract totaling \$582,000 with an actuary service to research and establish capitated rates for managed care, and had paid the actuary a total of \$707,207. Also, HHS paid \$2,108 during a four-month period in contract travel/delivery expenses. The documentation on file was an invoice that listed the charge as travel/delivery expense. No detailed documentation was attached to the invoice detailing the charge as a delivery or travel expense or to determine whether the charges were reasonable. The contract stated HHS may be billed separately for travel/delivery services. However, the contract did not specify the maximum travel and delivery expenses the department would reimburse the contractor.
- HHS overpaid \$15,000 for computer maintenance and support services. HHS was billed and paid \$15,000/month for these services. The contracted compensation for the computer services was \$12,500/month.
- HHS entered into seven contracts for computer services related to the MMIS. A general contract with the vendor was used. Work orders stipulated which vendor staff would be used, the vendor staff rates to be paid, and the time period the vendor's staff would be used. However, our review noted neither the contract nor the work orders included a total amount to be paid or a limit on the hours to be worked. In addition, we noted one work order was not on file, 11 work orders were not signed by HHS, and two rates paid did not agree to the vendor rates listed in the work orders. During the fiscal year ending June 30, 1999, HHS paid a total of \$4,456,830 to these seven vendors.
- Fourteen HHS contracts or contract amendments tested were signed after the effective date of the contract/amendment. One contract was signed 16 months after the contract's effective date.
- One HHS contract tested was never signed or approved, but services were provided, and HHS made payments on the contract.

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8. Contractual Service Payments (Continued)

We recommend HHS require supporting documentation, including signed contracts, to verify claims are reasonable and necessary. HHS should document within the contract the type of service and rates to be provided. In addition, we recommend HHS compare claims to contract terms before approving payments.

HHS RESPONSE:

- A. THE SUPPORTING DOCUMENTATION IS AVAILABLE UPON REQUEST FROM THE CONTRACTOR. THE CONTRACT SPECIFIES THE AVAILABILITY OF THIS AND OTHER FINANCIAL INFORMATION TO THE DEPARTMENT. EXAMPLES OF THE BACK-UP INFORMATION ARE AVAILABLE.

THE SERVICE DOES NOT INCLUDE REIMBURSEMENT FOR TRAVEL. THE PAYMENT IS FOR THE TIME AND EXPENSES OF THE ATTENDANT.

STARTING JANUARY 1, 2000, ESCORT SERVICES WERE NEGOTIATED INTO THE MONTHLY CAPITATION RATE AND WILL NOT BE INVOICED SEPARATELY.

- B. WE DISAGREE THAT OVERPAYMENT OCCURRED. THE CONTRACT WITH THE ACTUARIAL RATE SETTING FIRM WAS REVIEWED IN PERSON WITH AUDITOR STAFF WHO AGREED THERE WAS NO GAP OR OVERPAYMENT. STAFF HAVE AGAIN REVIEWED THE CONTRACT, AMENDMENTS, AND EXTENSION FOR THE AUDIT PERIOD AND HAVE NOT IDENTIFIED THE CITED OVERPAYMENT.

THE CONTRACTOR HAS AGREED TO PROVIDE ADDITIONAL DETAIL FOR TRAVEL AND COURIER EXPENSES.

THE DEPARTMENT'S CURRENT POLICY IS TO STATE A SPECIFIED OR MAXIMUM CONTRACT PRICE.

- C. WE AGREE THE BILLED AND PAID AMOUNT WAS INCORRECT. THE OVERCHARGE HAS BEEN CREDITED.

- D. WE AGREE. IN SEPTEMBER 1998 A THOROUGH REVIEW OF ALL CONTRACTS/WORK ORDERS WAS COMPLETED BY HHS F&S MMIS STAFF. PROCEDURES WERE ESTABLISHED, DOCUMENTED, AND COMMUNICATED TO BOTH HHS F&S AND IMS. SINCE SEPTEMBER 1998, COMPUTER SERVICE CONTRACTS/WORK ORDERS HAVE BEEN PROPERLY EXECUTED ACCORDING TO PROCEDURES ESTABLISHED.

REGARDING THE TWO RATE DISCREPANCIES:

- 1) AN HOURLY RATE WAS REDUCED BY THE VENDOR AS COMPENSATION TO THE STATE FOR TERMINATION OF A CONTRACTED WORKER WITHOUT NOTICE.
- 2) THE RATE INCREASE FROM \$20 TO \$24 WAS DOCUMENTED IN AUGUST 1998.

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8. Contractual Service Payments (Concluded)

- E. CONTRACTS ARE TO BE DRAWN AND EXECUTED PRIOR TO OPERATIONS. EXIGENT CIRCUMSTANCES OCCASIONALLY INTERVENE. NO IMPROPER PAYMENT APPEARS TO HAVE BEEN MADE DUE TO DELAYED EXECUTION OF CONTRACTS.
- F. WE DISAGREE. THE CONTRACT AMENDMENT WAS SIGNED IN JUNE 1999. A COPY IS AVAILABLE FOR REVIEW.

9. Payments for Bedholding

Bedholding is the full per diem reimbursement made to a facility to hold a bed when a client is hospitalized. Title 471 NAC 12-011.06B states reimbursement for bedholding is allowed for up to fifteen days per hospitalization. Good internal control requires documentation be maintained to support payments made are proper. Good internal control also requires procedures to ensure billing data is accurate.

During our review, we selected 11 Medicaid clients in nursing facilities with more than 15 days of hospitalization. We noted the following:

- One client was hospitalized November 11, 1998 through December 18, 1998. The nursing home was properly paid 10 nursing home days and 15 bedhold days for November, but was paid 15 days for December instead of 13. This resulted in an overpayment of \$295 for the additional 2 days.
- One client was hospitalized for 16 consecutive days and the nursing home was overpaid 1 bedholding day. This resulted in an overpayment of \$77.
- One client for BSDC was paid for 14 nursing home days and 15 bedhold days, but should have been paid 13 nursing home days and 3 bedhold days. This resulted in an overpayment of \$2,880.
- Three payments made to nursing homes were not adequately supported. It is not always possible to determine whether the hospital stay covered a consecutive time period. Thus, improper payments for bedhold days may have been made. Three claims indicated hospital stays; however, the HHS computer system did not indicate any claims for hospital stays. Therefore, the auditor was unable to determine whether the hospital stays were accurate and whether the stay was for more than 15 consecutive days. If the hospital stays were for consecutive days, the nursing homes were overpaid.

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9. Payments for Bedholding (Concluded)

- For one client the nursing home reported ten hospital days and zero nursing home days. Claims Processing entered this as zero hospital days and ten nursing home days. We noted there are no controls to check for data entry errors in nursing home turnaround claims. Although edit checks are performed on discharge dates, discharge reasons, and transfers, transposition errors are not identified or corrected with the available edits.
- Four clients tested had separate hospital stays and did not have over 15 consecutive days bedholding, and were, therefore, paid correctly.

We further noted during our review that edit checks were not set up in the computer system to prevent improper bedhold payments from being made. During our review of Medicaid, we noted several occurrences of payments made to nursing homes with the entire month (31 days) consisting of hospital bedhold days.

Our testing of 11 clients included 3 clients with over 15 consecutive hospital days. Each payment to the nursing facility for these 3 clients was overpaid for bedhold days, a 100% error rate.

Without proper internal controls in place, there is an increased risk for error and abuse, resulting in the misuse of taxpayer dollars.

We recommend HHS implement procedures to ensure payments are proper, to maintain adequate supporting documentation, and to establish controls to identify and correct data entry errors. We recommend edit checks be put in place to prevent bedhold payments for hospital stays in excess of 15 days.

HHS RESPONSE: THE DEPARTMENT AGREES AND A WORK ORDER TO CORRECT THIS HAS BEEN ISSUED. THE DEPARTMENT WILL CONTINUE TO REVIEW CLAIMS FOR ACCURACY.

10. Nursing Facility Rates

HHS reported \$334,455,062 in Medicaid payments to nursing facilities for fiscal year ended June 30, 1999. Facilities are paid on a cost reimbursement basis. Interim rates are paid throughout the fiscal year, and then are adjusted after cost reports are received and the final rates are determined. There are approximately 230 nursing facilities.

We tested the calculation for the final 1999 rate for seven facilities. We noted the following:

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10. Nursing Facility Rates (Concluded)

- The cost components on HHS's system did not agree to the cost report filed for one facility tested. As a result, the facility was underpaid. HHS did not have adequate procedures to ensure costs were correctly input to the system.
- The calculation for the administration limitation did not include charges for respiratory therapy in the Direct Services component. Title 471 NAC 12-011.07A5b states the Direct Services component includes respiratory therapy. Title 471 NAC 12-011.06L states, "In computing the provider's allowable cost for determination of the rate, administration expense is limited to no more than 14 percent of the total otherwise allowable Direct Nursing, Direct Support Services, and Other Support Services Components for the facility."

Without adequate procedures for the determination of facility rates, there is an increased risk for errors to occur.

We recommend HHS improve procedures to ensure rates are correctly calculated. We further recommend HHS correct the errors noted above.

HHS RESPONSE: THE DEPARTMENT AGREES THAT THIS ONE PROVIDER WAS UNDERPAID APPROXIMATELY \$34,755. THE DEPARTMENT WILL TAKE THE NECESSARY STEPS TO ADJUST THE RATE.

THE DEPARTMENT AGREES THAT THE REVISED NURSING HOME PAYMENT PLAN IN 1992 DOES REQUIRE SOME CORRECTION. HOWEVER, A REVIEW OF ALL THE RATE COMPUTATIONS FOR THE PERIOD ENDING JUNE 30, 1999 TO DETERMINE THE FINANCIAL IMPACT RESULTED IN UNDERPAYMENTS BY MEDICAID OF \$154.07 FOR THE ENTIRE YEAR OUT OF \$334,455,062.00 IN TOTAL PAYMENTS.

11. Nursing Home Adjustments

Good internal control requires procedures to ensure payment adjustments are made in a timely manner and for the proper amount.

During our review of Medicaid, we noted nursing home adjustments submitted from Long Term Care to Nursing Home Claims Processing are not reviewed to ensure the adjustment was made. An employee in the Long Term Care Unit does not follow up on MC-10 forms submitted to Nursing Home Claims Processing. Without controls to ensure adjustments are made, an increased risk for misused funds exists.

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11. Nursing Home Adjustments (Concluded)

We selected one bedholding adjustment for a BSDC client and noted the adjustment to correct the charges from 30 nursing home days to 16 was correct; however, the year end rate adjustment was incorrectly computed on the 30 days. As a result, BSDC was overpaid \$310.

Adjustments made for nursing home claims, that may or may not require a refund, are not made in a timely manner. An MC-10 form adjustment dated September 3, 1999, had not been adjusted as of April 27, 2000. Without timely adjustments, there is an increased risk for misused funds.

We also noted an adjustment for a Nursing Home Turnaround claim was entered into the system 12 months after the Claims Processing/Claims Payment area had determined final daily rates were different from the daily rates used during the year to calculate total charges.

We recommend controls be established to ensure adjustments are made properly. We further recommend adjustments be made within one month following the date of the MC-10.

HHS RESPONSE: THE TIMING OF FOLLOW-UP OF MC-10 MESSAGES IS DEPENDENT UPON STAFFING LEVELS.

12. Performance Measures Not Developed

A key responsibility of state governments is to develop and manage services, programs, and resources as efficiently and effectively as possible, and to communicate the results of these efforts to the taxpaying public. Meaningful performance measurements assist government officials and citizens in identifying financial and program results, evaluating past resources decisions, facilitating qualitative improvements in future decisions regarding resources allocation, and communicating program results to the public.

State Statute Section 81-3005(7) R.R.S. 1999, states "The redesign of the agencies shall be accomplished based on the principles that a health and human services system should be . . . Outcome-based to assure that measurable results are achieved and reported by a well-informed management system." State Statute Sections 81-3007(2)(a) and (3)(a) R.R.S. 1999, require the Department of Regulation and Licensure to "develop evaluation measurements and analyze results throughout the [system]," and further requires the Department of Finance and Support to "provide meaningful data to determine whether desired outcomes are achieved."

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12. Performance Measures Not Developed (Concluded)

The Department of Administrative Services instructions for budget preparation require agencies to include “performance measures utilized by the agency to determine cost, efficiency, effectiveness, and results of services of this program for the fiscal years 1997-1998, 1998-1999, 1999-2000, 2000-2001.”

The Nebraska Health and Human Services System did not have performance measures developed for the Medicaid program (programs 348 and 349) for fiscal year 1999, and did not include performance measures in the budget document.

We recommend HHS develop and track performance measures for the Medicaid program as required by law. These measures should be included in the budget document.

HHS RESPONSE: PERFORMANCE MEASURES EXIST WITHIN THE MANAGED CARE CONTRACTS APPROVED BY THE HEALTH CARE FINANCING ADMINISTRATION (HCFA). PERFORMANCE STANDARDS HAVE BEEN FURTHER DEFINED ATTACHED TO PAYMENT INCENTIVES IN THE CURRENT STATEWIDE MENTAL HEALTH CONTRACT.

PERFORMANCE MEASURES FOR CHILDREN ARE INCLUDED IN THE MEDICAID—TITLE XXI STATE PLAN. THE PROGRESS IN MEETING EACH PERFORMANCE GOAL AND STRATEGIC OBJECTIVE IS REPORTED ANNUALLY TO HCFA.

QUALITY ASSURANCE FOR MEDICAID HAS BEEN ESTABLISHED WHICH, WITH THE ASSISTANCE OF THE PANEL OF HEALTH PROFESSIONALS, WILL IDENTIFY HEALTH OUTCOMES TO BE MEASURED.

PERFORMANCE MEASURES WILL BE IDENTIFIED AND MEASURED BY HHSS MANAGERS, INCLUDING MEDICAID, IN ACCORDANCE WITH THE GOVERNOR’S DIRECTION.

13. Claims Processing

Title 471 NAC 3-001.01 states claims will be approved for payment if the client was eligible for the Medicaid Program when the service was provided. Clients are not considered eligible after the date they are deceased. Good internal controls would not allow payment for claims for services provided with service dates after a client's date of death.

We noted paid claims for ten recipients had a date of service after the date of death of the client. This occurred because the ending eligibility date entered into the NFOCUS system was the last day of the month in which the individual died, not the date of death. Although it appears in these circumstances the claims were for legitimate services and would have been paid, there is an increased risk for unallowable claims to be paid when the date of death is incorrect on the system.

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13. Claims Processing (Concluded)

The ending date of eligibility entered on the NFOCUS system for a Medicaid client is normally the last day of the month. Clients lose eligibility for Medicaid on the last day of the month, except in the case of death, where eligibility ends on the date of death. The date of death should be entered as the ending eligibility date. Because the ending eligibility date was later than the date of death, claims with a date of service after the date of death were paid. The claims we noted were for prescriptions. Pharmacies bill on a unit dose basis, which means they bill Medicaid for multiple dates of service over a period of time. Per review with the State Pharmacist the claims were reasonable, but the dates of service should have been before or on the date of death.

Without adequate controls in place to ensure the ending eligibility date is correctly entered into NFOCUS, the possibility of invalid claims being paid is increased.

We recommend procedures be implemented to ensure the date of death is correctly entered as the ending date of eligibility.

HHS RESPONSE: WE AGREE. THE PUBLIC ASSISTANCE UNIT IS WITHIN 120 DAYS OF IMPLEMENTING A COMPUTER MATCH WITH THE VITAL STATISTICS UNIT, WHEREBY DEATHS OF MEDICAID CLIENTS ARE SENT TO THE ELIGIBILITY WORKER VIA AN ALERT AS THEY OCCUR. WE WILL BE MATCHING ON THE CLIENT'S SOCIAL SECURITY NUMBER, LAST NAME, FIRST NAME, DOB, AND SEX. WE EXPECT THE DATA TO BE HIGHLY RELIABLE. WE WILL REMIND THE ELIGIBILITY WORKERS THAT CASES ARE TO BE CLOSED EFFECTIVE WITH THE DATE OF DEATH AND ENSURE THERE ARE NO SYSTEM COMPLICATIONS WHEN WE NOTIFY THEM OF THIS NEW EXCHANGE.

HOWEVER, THERE IS NO EVIDENCE IN THIS AUDIT THAT ANY CLAIMS HAVE BEEN PAID POST-DEATH THAT WERE INAPPROPRIATE.

14. Surveillance and Utilization Review Subsystem

Title 42 CFR 456 requires the State to provide methods and procedures to safeguard against unnecessary utilization of care and services, including long-term care institutions. The Surveillance and Utilization Review Subsystem (SURS) was developed to aid in safeguarding against unnecessary utilization of care and services. SURS identifies potential fraud and misuse from the results of referrals and from a profiling system which identifies claims outside of parameters established by HHS.

SURS completed and closed only 25 of 203 cases opened in fiscal year 1999. All of the cases closed were from referrals. In 1998, SURS closed only 8% of its cases. HHS indicated that due to staffing issues they were unable to work on profile cases and only had time to investigate referrals.

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14. Surveillance and Utilization Review Subsystem (Concluded)

The reports and profiles generated by the system are not being utilized. As a result, there is an increased risk for fraud and unnecessary utilization of services to occur and not be detected.

We recommend HHS utilize the profiling process to safeguard against fraud and misuse of Medicaid services.

HHS RESPONSE: DURING THE AUDIT PERIOD SURS STAFF UTILIZED ONLY REFERRALS FROM INDIVIDUALS TO IDENTIFY FRAUD OR MISUSE. SIGNIFICANT STAFF TIME WAS UTILIZED FOR THE Y2K PREPAREDNESS OF THE MEDICAID PROGRAM, LIMITING OUR ABILITY TO PURSUE THE PROFILING PROCESS AS AN ATTEMPT TO DETECT FRAUD AND/OR ABUSE.

15. Temporary Employees

We noted documentation was not on file to support payments for temporary employees, such as contract period, pay rates, and billing rates. Furthermore, HHS did not have documentation to support contacting State Personnel to draw from the State's short-term labor pool. We tested one claim in the amount of \$14,451 from one temporary agency for one month of contract services for Medicaid.

During testing of that claim, we noted a bonus payment was made to a temporary employee in the amount of \$500. Documentation was not on file to support the bonus payment to the temporary employee. Per Title 273-Nebraska Classified System Personnel Rules Chapter 7, section 006, "Agencies may develop merit and/or bonus pay programs granting pay increases to employees in recognition of superior job performance . . . Prior to implementation, Agency merit and/or bonus pay programs must be on file with DAS State Personnel." HHS did not have a merit and/or bonus pay program on file with DAS State Personnel.

Good business practice requires HHS to have adequate documentation to support temporary employees, such as contract period, pay rates, billing rates, and bonus pay programs. Without adequate supporting documentation there is an increased risk of loss or misuse of State funds. State Statute Section 81-1307(6) R.R.S. 1999 states State Personnel "shall administer the Temporary Employee Pool containing applicants from which state agencies can draw when in need of a short term labor supply," and "State agencies must receive approval from the director before hiring any temporary employee."

We recommend HHS maintain adequate supporting documentation and comply with State Statute by using State Personnel to request temporary employees.

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15. Temporary Employees (Concluded)

HHS RESPONSE: THE HEALTH AND HUMAN SERVICES SYSTEM DOES PLACE ALL JOB ORDERS FOR TEMPORARIES THROUGH DAS/STATE PERSONNEL IN COMPLIANCE WITH THE 1999 STATUTE REVISION. PRIOR TO THAT TIME, AGENCIES WERE ALLOWED TO PLACE ORDERS DIRECTLY WITH OUTSIDE TEMPORARY SERVICES.

DAS/STATE PERSONNEL WILL BE NOTIFYING US OF THE AGREED UPON RATE ON EACH JOB ORDER FOR TEMPORARY HELP. THIS CAN THEN BE USED TO COMPARE WITH THE RATE STATED ON THE BILLING TO MAKE SURE THE AMOUNT IS CORRECT.

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SCHEDULE OF DISBURSEMENTS AND SOURCES
 Fiscal Year Ended June 30, 1999

	Federal	State	Total
DISBURSEMENTS REPORTED:			
Administration	\$ 32,748,281	\$ 25,199,117	\$ 57,947,398
Aid:			
Nursing Facilities (IGT shown separately)	149,721,037	94,162,126	243,883,163
Hospital & Clinics (Net of \$9,524,931 overclaim)	80,776,184	49,923,603	130,699,787
Drugs (net of rebate)	57,551,908	35,937,149	93,489,057
Intergovernmental Transfer (IGT)	55,665,489	34,906,410	90,571,899
Home & Community Based Waivers	55,080,589	34,662,681	89,743,270
Managed Care	50,182,134	31,560,219	81,742,353
Physicians & Other Practitioners	39,004,137	24,261,537	63,265,674
Insurance Premiums	22,380,521	14,073,923	36,454,444
Intermediate Care Facilities-MR--Public	17,839,044	11,217,768	29,056,812
Home Health	10,041,632	6,317,962	16,359,594
Intermediate Care Facilities-MR--Private	8,880,807	5,586,048	14,466,855
Dental	8,851,186	5,563,912	14,415,098
Medical Supplies	8,760,176	5,530,487	14,290,663
Disproportionate Share Payments	6,916,662	4,489,546	11,406,208
Personal Care Services	4,005,989	2,519,439	6,525,428
Lab & Radiology	3,833,641	2,410,929	6,244,570
Speech/Occupational/Physical Therapy	3,665,669	2,314,215	5,979,884
Mental Health Facilities	3,435,890	2,159,074	5,594,964
Case Management	3,125,228	1,964,658	5,089,886
Medical Transportation	3,043,519	1,921,438	4,964,957
EPSDT (HealthCheck)	2,370,523	1,491,621	3,862,144
CHIPs (Title XXI Kids Connection)	1,792,491	678,412	2,470,903
Ambulance	952,193	601,139	1,553,332
Prosthetic Devices	1,035,012	41,680	1,076,692
Other Aid and Prior Year Adjustments	347,847	349,794	697,641
Third-Party Liability & Fraud Collections	(3,257,390)	(2,374,067)	(5,631,457)
Year End Settlement Adjustments	(1,627,608)	(1,054,092)	(2,681,700)
Other Collections & Reductions	(4,369,032)	(2,775,268)	(7,144,300)
Total Medicaid Reported*	622,753,759	393,641,460	1,016,395,219
Less IGT funds returned to General Fund		(34,906,410)	(34,906,410)
Net Disbursements	\$ 622,753,759	\$ 358,735,050	\$ 981,488,809
SOURCES:			
State General Funds			
Program 341/348/349 Appropriations		\$ 315,830,766	\$ 315,830,766
Program 421/424 Appropriations		46,054,673	46,054,673
Total State Funds		361,885,439	361,885,439
Federal Funds	\$ 616,742,397		616,742,397
MIPS Local School Funds		1,612,722	1,612,722
Nebraska Health Care Trust Fund 2266		622,745	622,745
Other Local Match		625,506	625,506
Total Sources	\$ 616,742,397	\$ 364,746,412	\$ 981,488,809
VARIANCE (Over/(Under) Paid):	\$ (6,011,362)	\$ 6,011,362	\$ -

*Adjusted for reporting error (Note 5)
 See Notes to Schedules

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
MEDICAID PROGRAM

Schedule of Medicaid Expenditures per Federal Reports
Fiscal Years Ended June 30, 1995 through 1999

	1999	1998	1997	1996	1995	% Change from Prior Fiscal Year				% Ch 95
						98/99	97/98	96/97	95/96	
Administration (note 3)*	\$ 57,947,398	\$ 41,620,982	\$ 35,970,485	\$ 37,606,184	\$ 32,287,212	39%	16%	-4%	16%	
Aid:										
Nursing Facilities (note 4)	243,883,163	234,631,901	219,632,335	208,441,962	193,960,744	4%	7%	5%	7%	
Inpatient Hospital	97,605,339	96,414,481	99,403,689	108,136,695	124,014,731	1%	-3%	-8%	-13%	
Outpatient Hospital	27,263,239	22,786,273	21,608,733	23,500,340	26,592,922	20%	5%	-8%	-12%	
Clinic Services (note 5)*	5,831,209	4,613,418	7,060,450	12,615,038	17,210,905	26%	-35%	-44%	-27%	
Drugs	113,255,312	92,141,713	81,003,337	71,077,249	62,878,857	23%	14%	14%	13%	
Drug Rebate	(19,766,255)	(16,071,551)	(14,732,937)	(10,793,893)	(11,746,042)	23%	9%	36%	-8%	
Home & Community Based (note 6)	89,743,270	72,032,650	71,953,023	52,282,766	41,281,554	25%	0%	38%	27%	
Managed Care (note 7)	81,742,353	70,155,410	71,480,975	49,113,503		17%	-2%	46%		
Physicians	55,047,873	42,500,026	43,508,679	43,675,776	46,036,435	30%	-2%	0%	-5%	
Other Practitioners (note 8)	8,217,801	6,790,630	4,070,479	2,946,377	3,284,176	21%	67%	38%	-10%	
Insurance Premiums (note 9)	36,454,444	34,408,768	34,785,281	29,686,878	28,669,828	6%	-1%	17%	4%	
ICF MR Public (note 11)	29,056,812	28,579,952	24,083,151	22,590,832	22,066,842	2%	19%	7%	2%	
ICF MR Private (note 11)	14,466,855	14,326,920	11,926,146	13,548,347	12,848,080	1%	20%	-12%	5%	
Dental	14,415,098	8,896,137	7,800,861	7,391,500	7,253,651	62%	14%	6%	2%	
Personal Care Services (note 10)	6,525,428	5,089,590	4,927,514	3,907,046	4,015,636	28%	3%	26%	-3%	
Lab & Radiology	6,244,570	5,434,437	5,699,057	5,923,719	6,158,213	15%	-5%	-4%	-4%	
Mental Health Facilities	5,594,964	6,633,465	3,148,750	1,989,326	3,688,598	-16%	111%	58%	-46%	
Case Management	5,089,886	3,884,560	3,366,133	4,228,832	5,799,753	31%	15%	-20%	-27%	
EPSDT HealthCheck (note 12)	3,862,144	3,261,862	3,324,842	3,843,353	3,985,031	18%	-2%	-13%	-4%	
CHIPS (Kids Connection) (note 13)	2,470,903	92,094								
Home Health Services	16,359,594	14,502,096	13,126,082	13,438,972	13,149,749	13%	10%	-2%	2%	
Sterilizations	695,707	823,099	835,432	850,405	772,242	-15%	-1%	-2%	10%	
Hospice Benefits	945,976	1,498,145	519,507	337,790	319,928	-37%	188%	54%	6%	
Disproportionate Share (note 14)	11,406,208	1,963,916	7,182,365	4,243,298	13,597,378	481%	-73%	69%	-69%	
Other (note 15)	27,444,816	20,359,902	20,390,654	21,365,915	17,750,096	35%	0%	-5%	20%	
Prior Federal Year Adjustments (note 16)	(523,330)	(3,386,237)	27,976,514	982,557	1,383,971					
Third Party Liability Collections (note 17)	(5,506,856)	(6,131,229)	(5,683,852)	(5,105,975)	(4,801,231)	-10%	8%	11%	6%	
Fraud Collections (note 18)	(124,601)	(297,236)	(296,656)	(148,673)	(272,319)	-58%	0%	100%	-45%	
Other Collections & Reductions (note 19)	(9,826,000)	(7,490,973)	(6,564,009)	(9,083,429)	(8,484,462)	31%	14%	-28%	7%	
Net Aid excluding IGT	867,875,922	758,444,219	761,536,535	680,986,506	631,415,266	14%	0%	12%	8%	
Intergovernmental Transfer (note 4)	90,571,899	45,285,950								
Total Medicaid	\$ 1,016,395,219	\$ 845,351,151	\$ 797,507,020	\$ 718,592,690	\$ 663,702,478	20%	6%	11%	8%	

*Adjusted for reporting errors noted

See Notes to Schedules

See Department Explanations for Selected Increases

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
 MEDICAID PROGRAM
SCHEDULE OF ADMINISTRATIVE COSTS
 Fiscal Year Ended June 30, 1999

Administration by Cost Allocation Plan Activity:

Services Management	\$ 18,975,154
Computer System Administration	10,945,239
Managed Care	9,974,342
NFOCUS Information Engineering	4,771,625
Claims Processing	1,863,157
Medical Operations	2,542,036
Individual & Community Services	2,479,167
Aging Care Management & Screening	2,151,142
Accounting & Finance	773,530
Long Term Care	636,902
Legal Services	589,612
SURS	322,405
Kids Connection	212,759
Other	1,710,328
Total Administrative Costs	\$ 57,947,398

Administration by NAS Major Account Code:

Personal Services	\$ 19,160,698
Operating (Consists primarily of Data Processing Payments to DAS)	10,008,979
Contractual Services	
Lincoln/Lancaster Health Dept	3,389,149
Business Security Software	1,736,357
Med Stat Group	1,281,737
Promark Alliance, Inc	1,016,416
Sunderbruch Corporation	947,496
Kraftware	843,103
Netron, Inc	794,962
First Health Services	566,568
Options, Inc	438,859
DAS-SOS Temporary Services Pool	319,383
Other	6,123,051
	17,457,081
Travel	322,137
Capital Outlay	457,856
Indirect Allocated*	10,540,647
Total Administrative Costs	\$ 57,947,398

*The Department utilizes a cost allocation plan (CAP) to charge administrative costs to the various programs. The CAP assigns costs to activity pools. These pools may be directly charged to a program such as Medicaid or may be allocated to various benefitting programs. The pools may also be charged to another pool in a "stepdown" allocation. The amounts presented by major account code were compiled from direct charges to Medicaid. Costs which were indirectly allocated through stepdown charges are shown as Indirect Allocated, as it is not feasible to determine the related account code.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
MEDICAID PROGRAM
NOTES TO SCHEDULES

Fiscal Year Ended June 30, 1999

1. **Accounting Policies**

A. **Reporting Entity** Medicaid (under Title XIX of the Social Security Act) is awarded by the U.S. Department of Health and Human Services and regulated by the Health Care Financing Administration (HCFA). The schedules reflect amounts reported to HCFA for Medicaid and Kids Connection (Title XXI) under Catalog of Federal Domestic Assistance (CFDA) 93.777. Aid disbursements for Medicaid are recorded in Program 348 Medical Services and Program 349 Long-Term Care. Program 348 and 349 also include \$968,037 in medical assistance payments for recipients who are not eligible for Medicaid; this amount is not included in the schedules presented. The State match for Medicaid Developmental Disability recipients is recorded in Programs 421 and 424. Aid disbursements for Kids Connection are recorded in Program 344 Children's Health Insurance. Disbursements for administrative costs are recorded in Program 341 Administration of Public Assistance and are allocated to Medicaid through the Cost Allocation Plan. Administrative costs for Survey and Certification CFDA 93.778 are not included in the schedules. For additional program description information, see the Background Section of this report.

B. **Basis of Accounting** The schedules were prepared on the cash basis of accounting, as reported by the Nebraska Health and Human Services System to the Health Care Financing Administration.

C. **Information Management Systems** The Medicaid Program uses a number of information management systems to determine eligibility, pay claims, and generate management reports. Significant systems include the following:

Medicaid Management Information System (MMIS) – This system is used to process and pay providers for claims for services provided to Medicaid Program recipients. It includes subsystems for data on recipients, providers, medical claims, surveillance and utilization review, management reporting, screening of eligible children, third party liability, and managed care. Included as part of the MMIS are various mainframe computer applications on CICS1, which can be used to query information related to claims paid.

Warrant Writer System – This system is generally used to process and pay Medicaid Program costs for one time payments where there is a negotiated rate instead of ongoing payments for a set fee.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
MEDICAID PROGRAM
NOTES TO SCHEDULES

1. **Accounting Policies (Concluded)**

Nebraska Family On-Line Client User System (NFOCUS) – This system is used to determine the eligibility of clients to participate in Medicaid. NFOCUS is also used to process claims for Home and Community Based Services Waivers, and Non-Emergency Medical Transportation.

2. **Partnership Project** The Nebraska Partnership for Health and Human Services Act transferred the programs and functions of the Department on Aging, the Department of Health, the Department of Public Institutions, the Department of Social Services, and the Office of Juvenile Services to the Health and Human Services System effective January 1, 1997. Prior to the redesign, the Department of Social Services was responsible for administering the Medicaid program.

3. **Administration and Cost Allocation Plan** HHS utilizes a cost allocation plan to allocate administrative costs to the various State and Federal programs. All Medicaid administrative costs including payroll, contractual services, furniture and equipment, data processing, rent, etc. are assigned to the various programs through this plan. HHS became aware that various costs were erroneously reported. As a result HHS is submitting a correction for over claiming Medicaid administration of \$5,706,035 for State fiscal year 1998 and under claiming \$3,774,648 for 1999. The amount for 1999 has not been adjusted on the schedules as the correction is not yet finalized.

4. **Nursing Facilities and Intergovernmental Transfer** In April 1998, HHS began an intergovernmental transfer arrangement with government-operated nursing facilities. The arrangement involves creating a proportionate share pool to increase Medicaid dollars received from the Federal government. HHS estimates the difference between the maximum Medicare rate and the Medicaid rate paid to the nursing facilities. This amount is then distributed to governmental nursing homes. The nursing homes, after keeping a \$10,000 participation fee, transfer the funds back to HHS. The funds are deposited into the State General Fund to reimburse the matching dollars used for the initial payment, and the remainder (the Federal portion) is deposited into the Nebraska Health Care Trust Fund. This is the source of funds for Cash Fund 2266, which was used for the State-matching share for Title XXI Kids Connection. The intergovernmental transfer (IGT) is shown as a separate line item on the schedules.

5. **Clinic Services Overclaim** Due to an error in completing the report to the Federal regulatory agency, payments for certain rehabilitation services were included in both clinic services and physician services. The amounts over reported were \$1,274,768 and \$9,524,931 in State fiscal years 1998 and 1999, respectively. The amounts for clinic services have been adjusted on the schedules for these reporting errors. See also the Comments Section of this report.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
MEDICAID PROGRAM
NOTES TO SCHEDULES

6. **Home and Community Based Services** Medicaid offers, under a waiver, an array of community-based services to individuals who would otherwise require institutionalized care. Home and Community Based Waivers include Adults with Mental Retardation and Related Conditions for individuals ages 21 or older, who are eligible for ICF-MR services; a waiver for children with developmental disabilities; and the Aged and Disabled Waiver for persons who would otherwise require nursing facility care.
7. **Managed Care** The Medicaid Managed Care Program requires certain recipients in Douglas, Sarpy, and Lancaster counties to enroll in a health maintenance organization or primary care case management plan for primary care services. Managed Care does not include drugs, personal care aides, or nursing facilities, which are paid on a fee-for-service basis.
8. **Other Practitioners** Includes practitioners for vision care, psychotherapy, chiropractic, podiatry, nursing, and midwife services.
9. **Insurance Premiums** Medicaid covers payment for health insurance premiums for individuals who are otherwise eligible for Medicaid when determined to be cost effective. Medicaid would pay for premiums, coinsurance, and deductibles. Medicaid also pays Medicare Part B premiums for clients 65 years of age or older or those who qualify under the eligibility of the Aged, Blind and Disabled Program.
10. **Personal Care Services** Medicaid covers personal care services when ordered by the client's physician based on medical necessity. Personal care services are medically-oriented tasks related to a client's physical requirements such as grooming, assisting with oral medication, assistance with nutrition, and accompanying the client to physician office visits.
11. **ICF-MR** Intermediate Care Facilities-Mentally Retarded (ICF-MR) are reported to HCFA separately for public (BSDC) and private facilities.
12. **EPSDT (Health Check)** Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) was established for individuals ages 20 and younger who are eligible for medical assistance. The goal is to provide preventive health care through regular and periodic screening examinations and by promoting healthy lifestyles.
13. **CHIPs (Kids Connection)** The Children's Insurance Program (CHIPs) is also referred to as Kids Connection. In 1998, Nebraska expanded the Medicaid Program to 185% of poverty for pregnant women and children ages 18 and under as per Title XXI of the Social Security Act.
14. **Disproportionate Share** Disproportionate Share payments are made to hospitals which have higher utilization by Medicaid or low-income patients.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
MEDICAID PROGRAM
NOTES TO SCHEDULES

15. **Other** Other aid payments include medical supplies, speech therapy, physical therapy, occupational therapy, medical transportation, ambulance, prosthetic devices, and optical supplier services.
16. **Prior Federal Year Adjustments** The federal fiscal year runs October 1, through September 30. The State fiscal year is July 1, through June 30. Adjustments reported for the prior quarter but within the State fiscal year are reflected in the individual category. Adjustments for prior fiscal years are shown as Prior Federal Year Adjustments.
17. **Third Party Liability Collections** These are collections from other sources, primarily insurance companies.
18. **Fraud Collections** Collections from providers and/or recipients as a result of investigations by the HHS Medicaid Fraud Unit.
19. **Other Collections and Reductions** Includes collections, reductions, and warrant cancellations for such items as duplicate payments, clerical errors, year-end settlement adjustments, and uncashed warrants.
20. **Year-End Settlement Adjustments** Nursing facilities are paid an interim rate as a per diem for each patient day. Interim rates are paid during the period and then retroactively adjusted when final costs and census data are available.
21. **Medicaid in Public Schools** Federal Medicaid funds are provided to school districts for special education and related services provided to students with disabilities, as allowed under the Medicare Catastrophic Coverage Act of 1988. The match required is provided by the school district; HHS reimburses the school for the federal portion only. The General Fund appropriation for special education aid is reduced each year by the amount of federal Medicaid funds provided to the schools, and is used to carry out the provisions of the Early Intervention Act. (See State Statutes Section 43-2501 et seq.)

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
MEDICAID PROGRAM

DEPARTMENT EXPLANATION FOR SELECTED INCREASES

The following information was provided by HHS staff to explain selected increases in Medicaid expenditures:

Physicians (30% increase in SFY 1999 over prior year)

\$9.5 million in new claims for the Medicaid Rehabilitation Option were incorrectly double counted in FY 1999 reports as both physician and clinic services. This amount will be adjusted in a subsequent HCFA-64 filing and will be backed out of the physician category.

The balance of the growth in physician service expenditures is attributable to a 3% fee schedule increase implemented 7/1/98 and to increases in the numbers of children eligible through KIDS Connection and state wardship.

Drugs (23% increase in SFY 1999 over prior year)

Drug payments are impacted by the availability of new and costly drugs; the Medicaid payment amount is based on the cost to the pharmacist to purchase the drug plus a dispensing fee. Increases in Medicaid drug expenditures run parallel to general changes in the pharmaceutical industry.

On the utilization side, the increase has been fueled by the growth in Kids Connection recipients.

Dental (62% increase in SFY 1999 over previous year)

A fee schedule increase averaging 38% was implemented 7/1/98 that adjusted Medicaid fees to roughly 80% of rates being charged by dentists. Prior to adjustment, Medicaid was reimbursing 55-60% of customary rates and access to dental care for Medicaid clients was limited in some geographic areas. Possibly as a result of improved access, usage had increased for disabled and family recipients.

In addition, the new Kids Connection population has utilized dental services extensively.

Home & Community-Based Services (25% increase in SFY 1999 over previous year)

This category includes "waiver" services that provide a less expensive alternative to institutional care. The population served by the Aged & Disabled Waiver was expanded in conjunction with the Long Term Care Plan to reduce nursing home occupancy. The Developmentally Disabled Waivers (adults and children) have experienced an increase in persons served and rates of payment. LB 1108 (1998) extended certain services to clients reaching age 21 and to individuals with elderly caregivers. LB 389 (1997) raised reimbursement rates for community-based providers. State wards with developmental disabilities are being shifted from child welfare coverage to Medicaid coverage in order to maximize federal funding. All of these factors impacted the level of spending in 1999.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
MEDICAID PROGRAM

DEPARTMENT EXPLANATION FOR SELECTED INCREASES

Personal Care Services (28% increase in SFY 1999 over previous year)

Rates paid to personal care aids were increased July 1, 1998 by approximately 25%. LB 1130 had been introduced during the 1998 session to direct HHS F&S to raise rates, but the Department administratively elected to adjust rates because of provider shortages, which limited client access to services, so the legislation was not needed.

Utilization of personal care aides has also increased due to emphasis on expanding alternatives to nursing home care.

Case Management (31% increase in SFY 1999 over previous year)

This category captures the support provided by contractors and HHS staff who coordinate client access to appropriate services. Effective July 1, 1998, contracts were implemented with the Area Agencies on Aging and the Independent Living Centers to manage services for Aged & Disabled Waiver clients. Expansion of the A & D waiver is a component of the Long Term Care Plan. In addition, the SFY 1999 totals include a retroactive claim for HHS workers who coordinate social services for Medicaid eligible individuals.

Other (35% increase in SFY 1999 over previous year)

The "other" category includes expenditures for items such as eyeglasses, prosthetic devices, medical supplies, and medical transportation. Transportation costs are initially posted through the N-FOCUS system; those costs which meet Medicaid criteria are subsequently identified and charged against Title XIX. A retroactive adjustment for medical transportation costs for April 1997 through March 1999 was posted to Medicaid in the quarter ending June 1999. This transaction contributed to the large growth in this category in FY 1999. The remainder of the increase is attributable to changes in price and numbers of eligible individuals.

Net Administration (39% increase in SFY 1999 over previous year)

The growth in the administrative category parallels changes in the cost allocation plan, which reflect organization changes within HHS. Overall system dollars shifted to the cost allocation plan grew from \$37.7 million for the September 1997 quarter to \$57.2 million for the June 1999 quarter, and the amount assigned to Medicaid grew in tandem. In addition, FY 1999 costs for Medicaid were higher due to the new cost of Kids Connection administration and additional staff/contractual resources devoted to Y2K systems modifications.

Other Practitioners (150% increase since FY 1996)

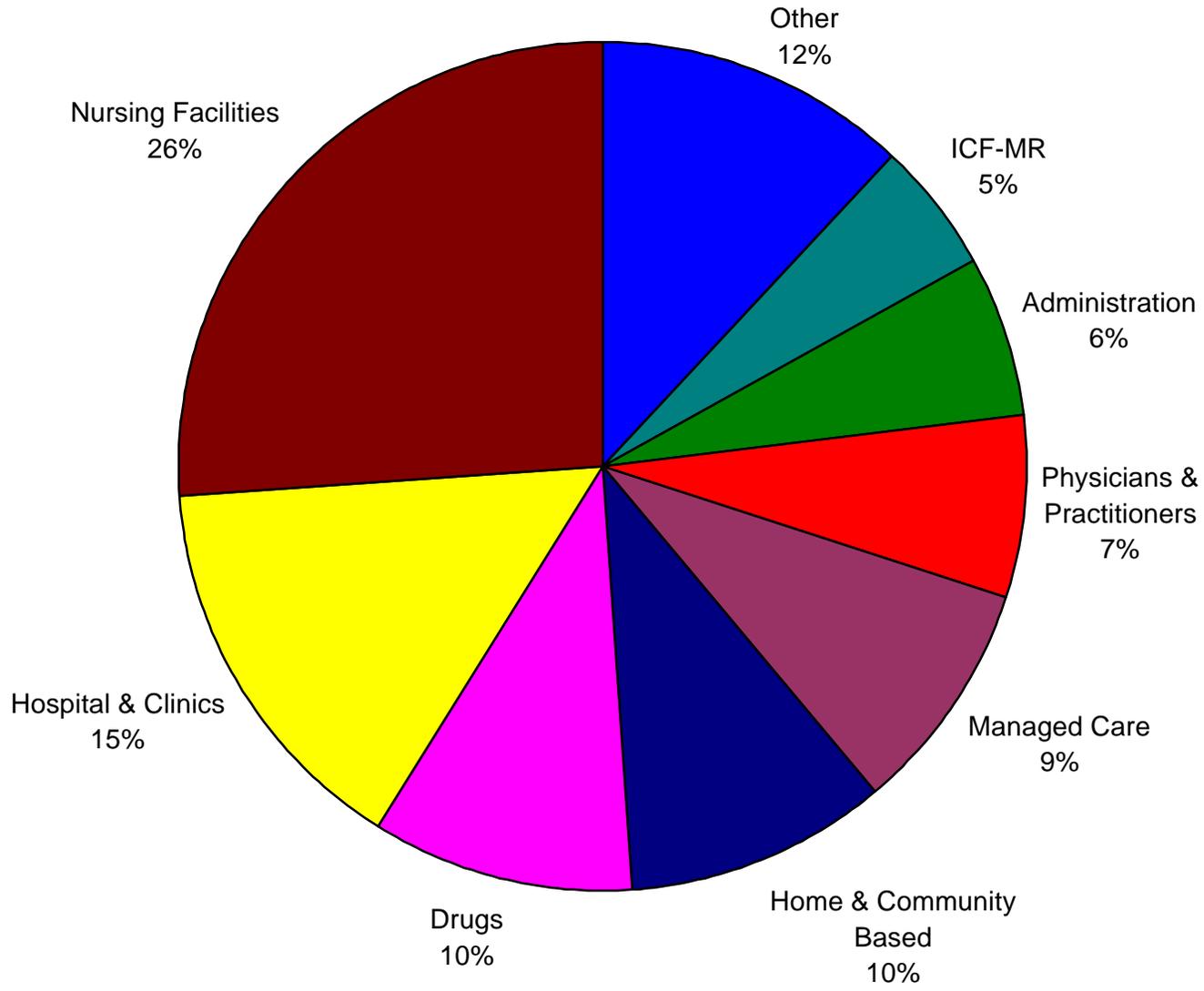
In addition to an increase in Medicaid recipients during this period, there have been changes in the categorization of expenditures over time. Vision services and ophthalmologist-related appliance services were shifted to this category in March 1997. Utilization of optical care and professional nursing services has increased with the growth in eligibles over the four-year period.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
 MEDICAID PROGRAM
MEDICAL CARE PRICE INDEX, UNITED STATES
 1995 through 1999

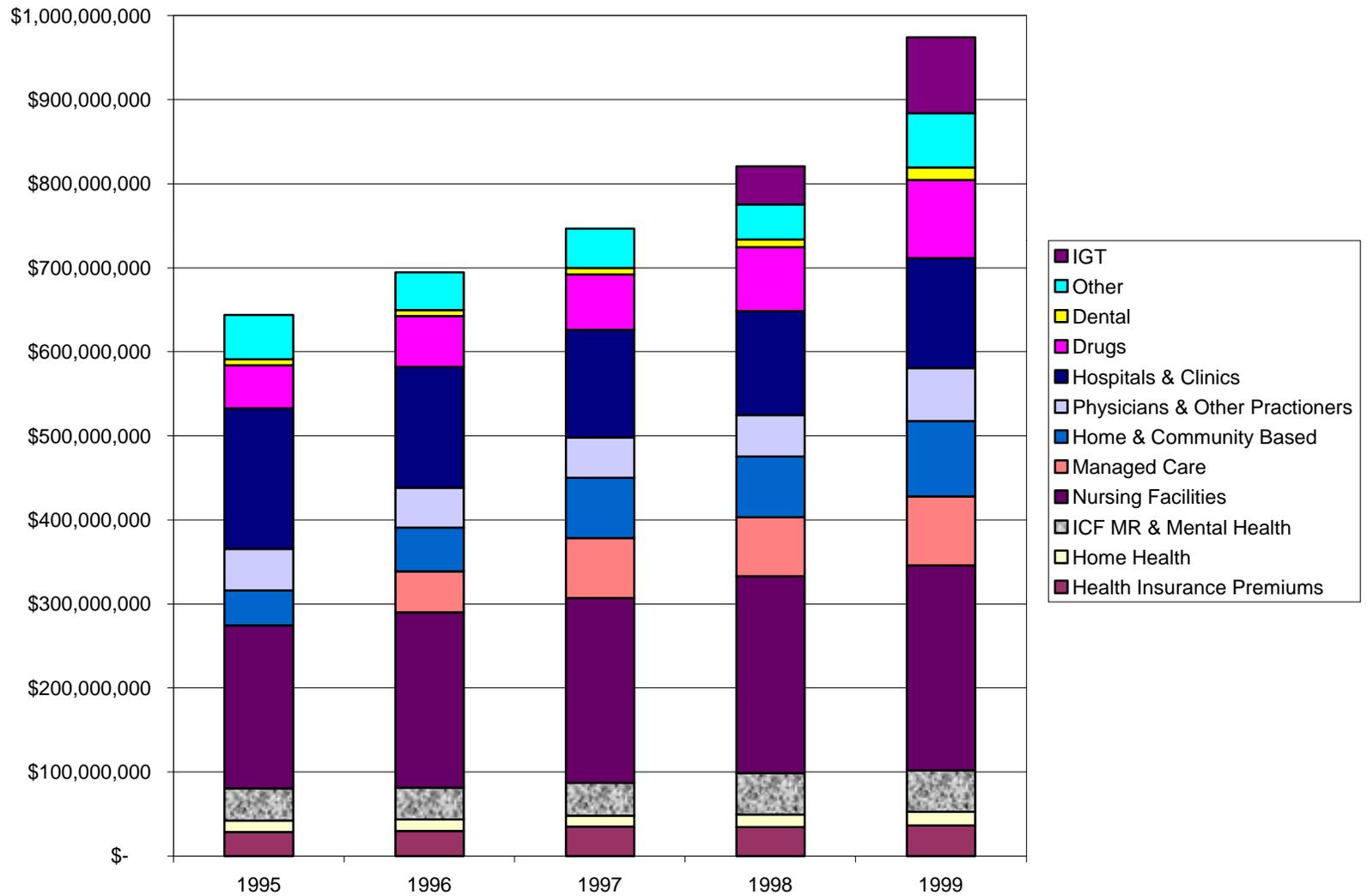
Year	Medical CPI	Percent Increase in Medical CPI Over Previous Year
1995	220.5	4.4%
1996	228.2	3.5%
1997	234.6	2.8%
1998	242.1	3.2%
1999	250.6	3.5%
1995/1999		Percent Increase in Medical CPI 1995 to 1999 13.7%

MCPI--Similar to the Consumer Price Index (CPI), the Medical Care Price Index (MCPI) is a measure of the growth of all goods and services associated with the provision of health care. Both the MCPI and the CPI adjust for changes in the population and per capita income to allow for calculation of increases in the quantity of medical and other services purchased per person, and the measure of the growth of all goods and services.
 Source: Bureau of Labor Statistics

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
MEDICAID PROGRAM
DISBURSEMENTS BY SERVICE CATEGORY
Fiscal Year Ended June 30, 1999

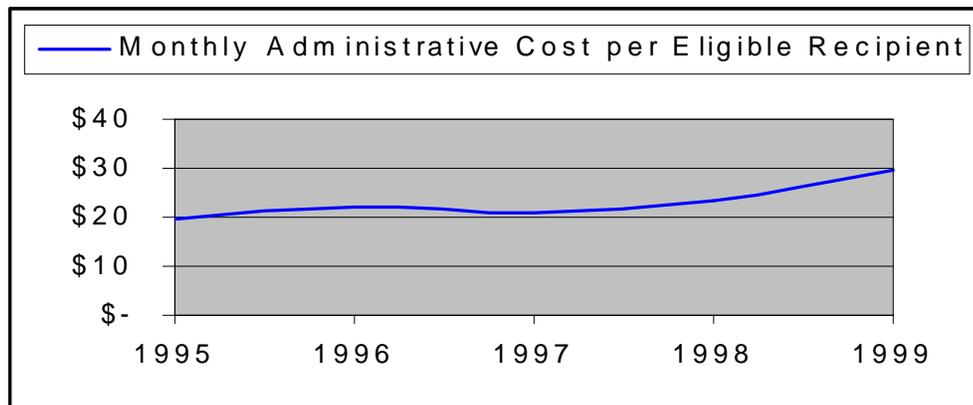
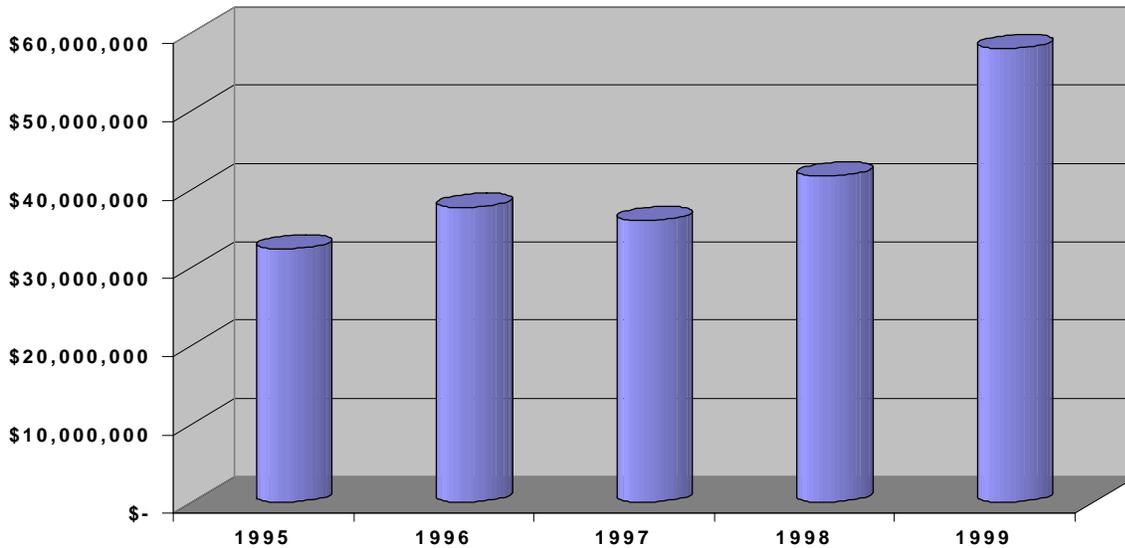


**NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
 MEDICAID AID DISBURSEMENTS BY SERVICE CATEGORY**
 Fiscal Years 1995 through 1999



* Aid Disbursements have not been reduced for collections, reductions, and prior year adjustments

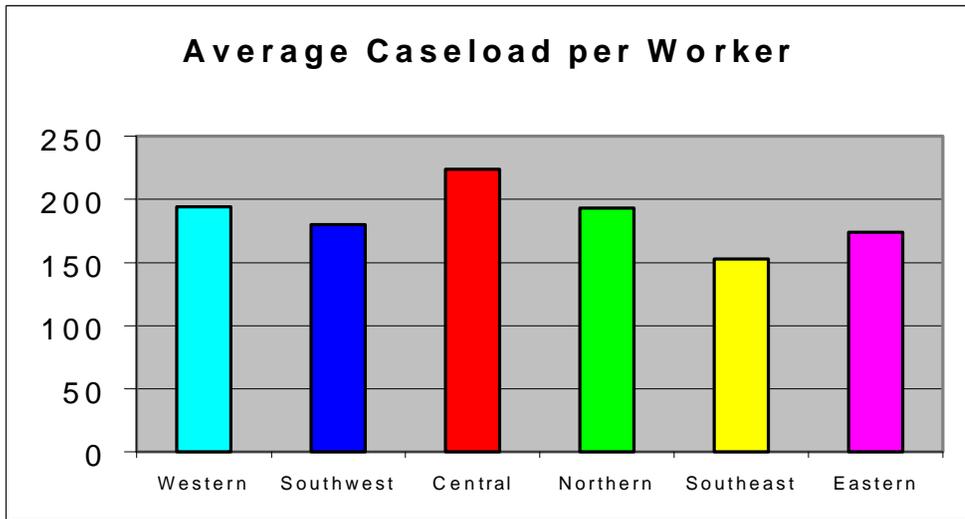
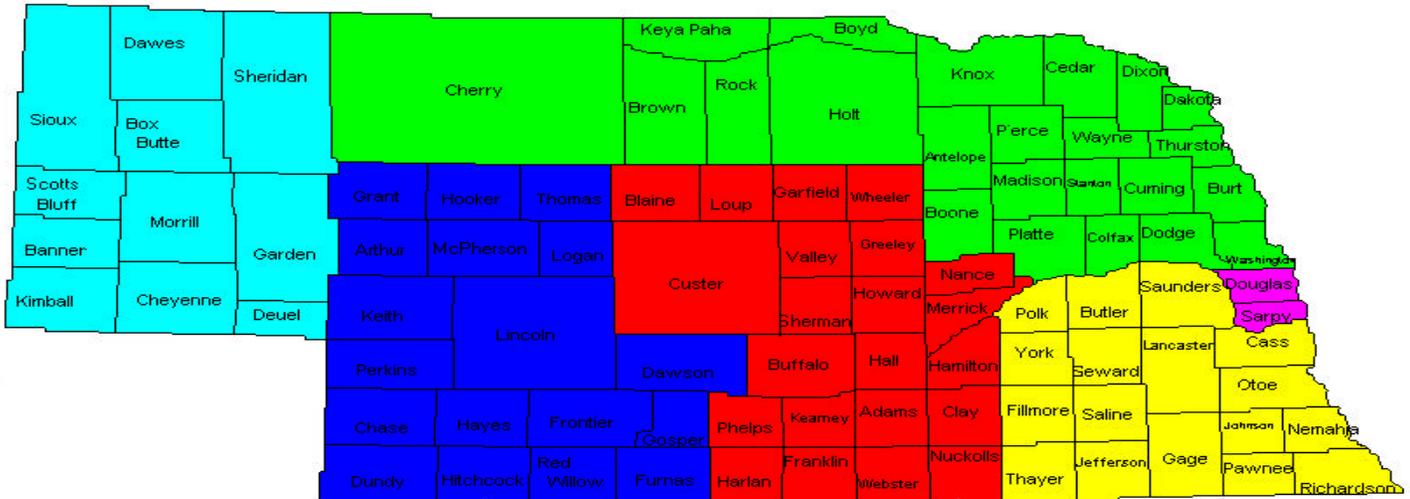
NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
 MEDICAID PROGRAM
MEDICAID ADMINISTRATIVE COSTS
 Fiscal Years 1995 through 1999



	1995	1996	1997	1998	1999
Administration	<u>\$ 32,287,212</u>	<u>\$ 37,606,184</u>	<u>\$ 35,970,485</u>	<u>\$ 41,620,982</u>	<u>\$ 57,947,398</u>
Average Monthly Eligible Medicaid Recipients					
Aged	17,730	17,846	17,713	17,520	17,650
Blind & Disabled	20,930	22,150	22,963	23,172	23,865
ADC Adult	19,069	22,276	22,562	23,632	25,187
Children	79,247	79,283	81,001	84,474	96,262
Total	<u>136,976</u>	<u>141,555</u>	<u>144,239</u>	<u>148,798</u>	<u>162,964</u>

Note Per HHS: Medicaid administrative costs during the fiscal year ending June 30, 1999 increased due to Y2K with language conversion work done for MMIS. Nebraska's management information system must meet the same standards as all other states regardless of claims volume. Economies of scale affect the cost per recipient calculation.

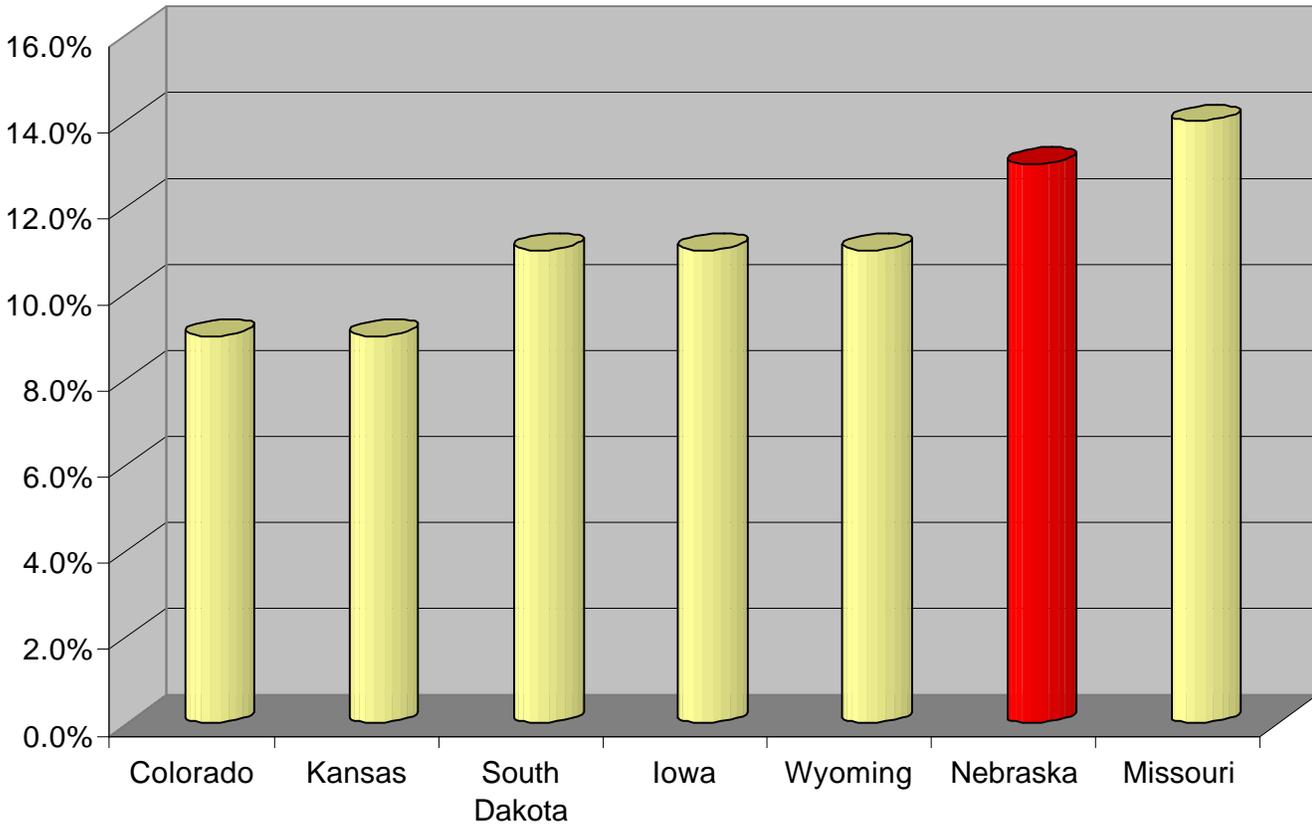
NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
 MEDICAID PROGRAM
CASELOAD BY DISTRICT
 Fiscal Year Ended June 30, 1999



District	Caseworker FTEs	Medicaid Eligibles	Average Caseload
Western	69	13,407	194
Southwest	71	12,713	180
Central	106	23,787	224
Northern	141	27,117	193
Southeast	247	37,661	153
Eastern	333	57,999	174
Total	967	172,684	179

NEBRASKA HEALTH AND HUMAN SERVICE SYSTEM
 MEDICAID PROGRAM
MEDICAID RECIPIENTS AS A % OF STATE POPULATION
COMPARISON OF SURROUNDING STATES
 Federal Fiscal Year 1998*

Medicaid Recipients as a Percent of Population



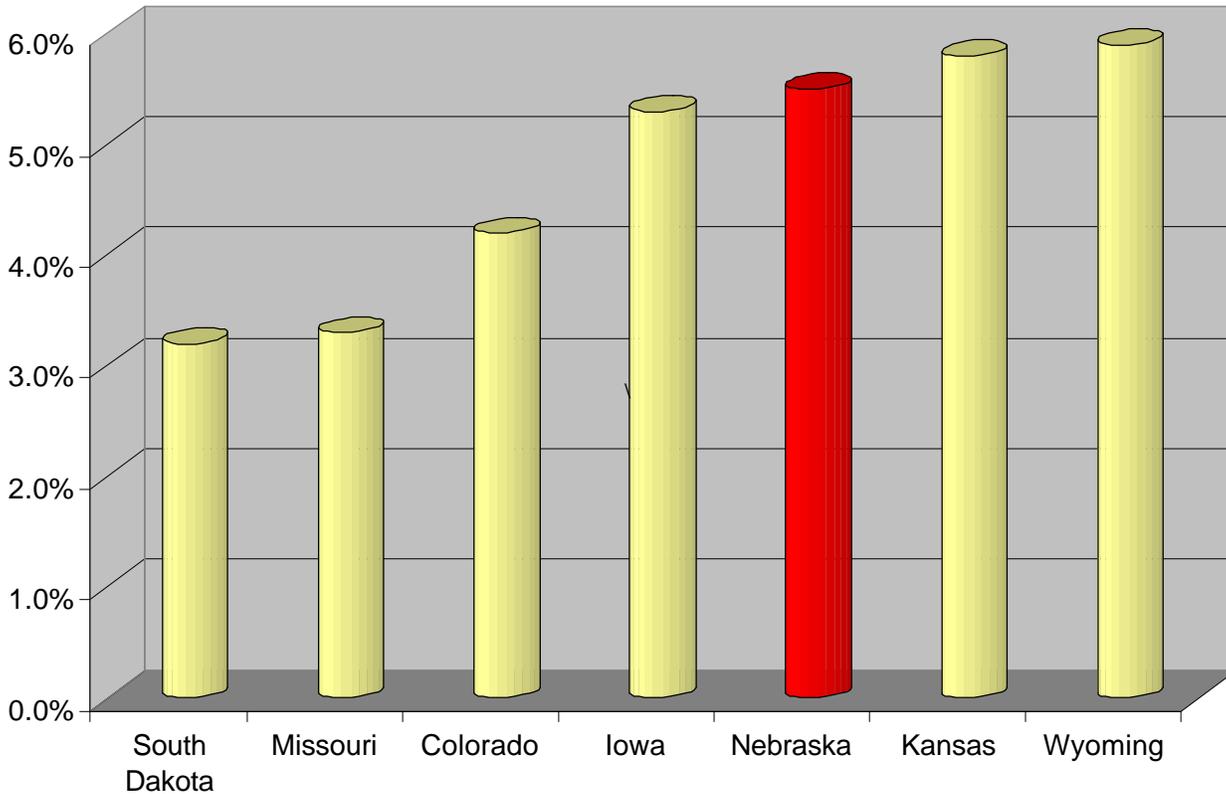
State	# of Medicaid Recipients	Population of State	Medicaid Recipients as a Percent of Population
Colorado	346,928	3,970,971	9%
Kansas	246,598	2,629,067	9%
Wyoming	51,367	480,907	11%
Iowa	321,119	2,862,447	11%
South Dakota	83,111	738,171	11%
Nebraska	210,261	1,662,719	13%
Missouri	772,622	5,438,559	14%

Source: Bureau of the Census, U.S. Department of Commerce, Medicaid Statistical Information System, HCFA Reports

*Note: Federal Year 1998 was the most current information available as of the date of report.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
 MEDICAID PROGRAM
ADMINISTRATIVE COSTS COMPARED TO SURROUNDING STATES
 Federal Fiscal Year 1999

Administrative Costs as a % of Total Medicaid

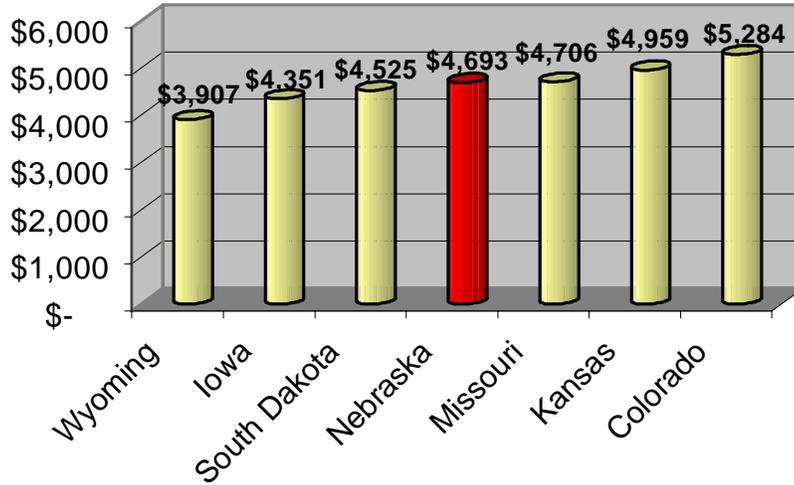


State	\$ Administration	\$ Assistance	Total Medicaid	% Administration
South Dakota	12,471,058	376,117,181	388,588,239	3.2%
Missouri	123,675,073	3,636,191,199	3,759,866,272	3.3%
Colorado	80,983,104	1,833,259,417	1,914,242,521	4.2%
Iowa	78,062,415	1,397,271,929	1,475,334,344	5.3%
Nebraska	57,061,069	986,802,078	1,043,863,147	5.5%
Kansas	75,178,318	1,222,928,982	1,298,107,300	5.8%
Wyoming	12,646,019	200,684,719	213,330,738	5.9%

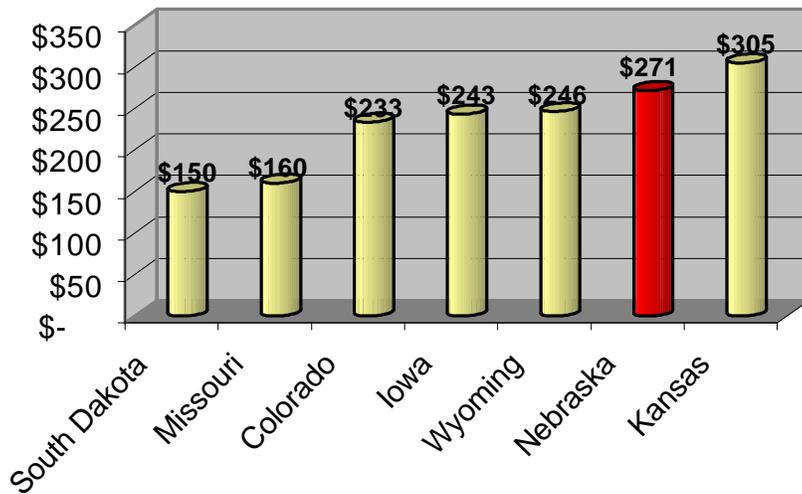
Nebraska administration costs have not been adjusted for error (see note 3). All amounts are per HCFA reports for the federal fiscal year October 1, 1998 through September 30, 1999.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
 MEDICAID PROGRAM
 Average Recipient Costs Compared to Surrounding States
 Federal Fiscal Year 1999

Average Annual Aid per Recipient



Average Administrative Cost per Recipient



NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
 MEDICAID PROGRAM
PAYMENTS FOR SIX RECIPIENTS
 Fiscal Year Ended June 30, 1999

The following is the total annual payments made for six clients sampled in our claims testing. The information is shown to give the reader an understanding of the type and total payment amounts made under the Medicaid program.

Type of Service	Client 1	Client 2	Client 3	Client 4	Client 5	Client 6
Drugs	\$ 11,123	\$ 1,011	\$ 1,870	\$ 1,748	\$ 814	\$ 349,213
Practitioners	1,085	3,669		186	2,531	3,595
Dental				35	320	
EPSDT					127	
Crossover Practitioner	2,893		24	714		
Outpatient					2,516	990
Managed Care		4,722				
Inpatient				7,750		4,542
Crossover Inpatient	1,528					
Crossover Outpatient	2,051			1,397		
Insurance Premiums			4,469		579	
Total for Fiscal Year	\$ 18,680	\$ 9,402	\$ 6,363	\$ 11,830	\$ 6,887	\$ 358,340

Crossover payments are those made after Medicare has paid their share of a claim.

The average annual payments for a Medicaid recipient in Nebraska is \$4,693.

Client 1 was a 49 year-old female.

Client 2 was a 46 year-old male.

Client 3 was a 61 year-old female.

Client 4 was a 74 year-old female.

Client 5 was an 8 year-old female.

Client 6 was a 17 year-old male.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
 MEDICAID PROGRAM
PRESCRIPTION DRUG CLAIMS TESTED
 Fiscal Year Ended June 30, 1999

The following are Prescription Drugs sampled in our claim testing. The information is shown to give the reader an understanding of the types of drugs paid by Medicaid and how the payment amount is determined.

Prescription Drug Descriptions	EAC	SMAC	Pharmacy's Dispensing Fee	Usual & Customary	\$1.00 Co-Pay by Client	Amount Paid on Claim	Brand/ Generic Name Drug	If a Brand, is a Generic Available
Note 1								
1. Sulfamethoxazole w/ Trimethoprim Susp	\$ 2.09	\$ 1.85	\$ 4.66	\$ 8.46	\$ -	\$ 6.51	G	N/A
2. Triamterene/Hctz Tablet	\$ 26.51	\$ 2.75	\$ 3.09	\$ 43.99	\$ 1.00	\$ 4.84	G	N/A
3. Acetaminophen w/COD	\$ 11.73	\$ -	\$ 4.66	\$ 10.98	\$ 1.00	\$ 9.98	G	N/A
4. Remeron	\$ 63.24	\$ -	\$ 4.66	\$ 81.11	\$ -	\$ 67.90	B	NO
5. Furosemide Tablet	\$ 2.33	\$ 0.59	\$ 4.66	\$ 4.99	\$ -	\$ 4.99	G	N/A
6. Phrenilin Forte Capsule	\$ 9.05	\$ -	\$ 4.07	\$ 17.81	\$ 1.00	\$ 12.12	B	YES
7. Cyproheptadine Tablet	\$ 2.18	\$ 0.48	\$ 4.84	\$ 8.19	\$ -	\$ 5.32	G	N/A
8. Prozac Capsule	\$ 205.52	\$ -	\$ 4.87	\$ 213.90	\$ 1.00	\$ 209.39	B	NO
9. Cytotec Tablet	\$ 93.84	\$ -	\$ 4.84	\$ 94.09	\$ 1.00	\$ 93.09	B	NO
10. Albuterol Inhalation Aerosol	\$ 19.56	\$ 7.47	\$ 4.69	\$ 13.99	\$ 1.00	\$ 11.16	G	N/A
11. Amitriptyline Tablet	\$ 12.00	\$ 38.40	\$ 4.84	\$ 9.89	\$ 1.00	\$ 8.89	G	N/A
12. Furosemide Tablet	\$ 8.54	\$ 2.29	\$ 4.86	\$ 10.55	\$ 1.00	\$ 6.15	G	N/A
13. Nystatin Oral Susp	\$ 9.31	\$ 3.12	\$ 4.84	\$ 23.24	\$ -	\$ 7.96	G	N/A
14. Lotrisone Cream	\$ 20.67	\$ -	\$ 4.40	\$ 27.99	\$ -	\$ 25.07	B	NO
15. Verapamil SR Tablet	\$ 33.10	\$ 9.34	\$ 4.84	\$ 12.90	\$ 1.00	\$ 11.90	G	N/A
16. Guaifenesin-Pseudoephedrine	\$ 24.80	\$ -	\$ 4.58	\$ 19.49	\$ -	\$ 19.49	G	N/A
17. Zolofit Tablet	\$ 57.38	\$ -	\$ 4.66	\$ 67.89	\$ 1.00	\$ 61.04	B	NO
18. Nasonex Spray	\$ 91.14	\$ -	\$ 4.22	\$ 109.89	\$ 1.00	\$ 94.36	B	NO
19. Zolofit Tablet	\$ 27.96	\$ -	\$ 4.84	\$ 38.20	\$ -	\$ 32.80	B	NO
20. Haloperidol Tablet	\$ 59.05	\$ 4.59	\$ 3.09	\$ 73.37	\$ -	\$ 7.68	G	N/A
21. Pepcid Tablet	\$ 76.36	\$ -	\$ 4.66	\$ 101.15	\$ -	\$ 81.02	B	NO
22. Cefzil Oral Susp	\$ 100.27	\$ -	\$ 4.84	\$ 120.09	\$ -	\$ 105.11	B	NO
23. Digoxin Tablet	\$ 2.75	\$ -	\$ 4.40	\$ 5.99	\$ 1.00	\$ 4.99	G	N/A
24. Lanoxin Tablet	\$ 5.19	\$ -	\$ 4.91	\$ 9.40	\$ -	\$ 9.40	B	YES
25. Lorazepam Tablet	\$ 18.79	\$ 16.28	\$ 4.84	\$ 19.20	\$ -	\$ 19.20	G	N/A
26. Methylphenidate SR Tablet	\$ 63.39	\$ -	\$ 4.54	\$ 58.99	\$ -	\$ 58.99	G	N/A
27. Propoxyphene Napsylate/	\$ 18.60	\$ 8.80	\$ 4.85	\$ 18.85	\$ 1.00	\$ 12.65	G	N/A

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
 MEDICAID PROGRAM
PRESCRIPTION DRUG CLAIMS TESTED
 Fiscal Year Ended June 30, 1999

Prescription Drug Descriptions	EAC	SMAC	Pharmacy's Dispensing Fee	Usual & Customary	\$1.00 Co-Pay by Client	Amount Paid on Claim	Brand/ Generic Name Drug	If a Brand, is a Generic Available	
28. Ketorolac Tablet	\$ 20.67	\$ -	\$ 4.84	\$ 27.61	\$ 1.00	\$ 24.51	G	N/A	
29. Risperdal Tablet	\$ 64.49	\$ -	\$ 4.91	\$ 79.19	\$ -	\$ 69.40	B	NO	
30. Methylphenidate Tablet	\$ 82.05	\$ 77.68	\$ 4.84	\$ 6.57	\$ -	\$ 76.57	G	NO	
31. Cosopt Drops	\$ 32.92	\$ -	\$ 4.87	\$ 43.95	\$ -	\$ 37.79	B	NO	
32. Rythmol Tablet	\$ 101.76	\$ -	\$ 4.84	\$ 120.13	\$ 1.00	\$ 105.60	B	NO	
<table border="1" style="width: 100%;"> <tr> <td style="padding: 5px;">Doctor Prescribed Over the Counter Drug Description</td> </tr> </table>									Doctor Prescribed Over the Counter Drug Description
Doctor Prescribed Over the Counter Drug Description									
33. Hydrocortisone Cream	\$ 2.36	\$ -	\$ 3.97	\$ 3.29	\$ -	\$ 3.29	G	N/A	
MARKUP AMOUNT	\$ 1.18								

EAC = Estimated Acquisition Cost. All drug products will be assigned an EAC which will be the actual cost at which most Nebraska pharmacy providers may obtain the product.

SMAC = State Maximum Allowable Cost. Certain multiple source drug products will have a SMAC assigned by the Medical Services Division of HHS.

Pharmacy Dispensing Fee = HHS assigns a dispensing fee to each individual pharmacy.

Usual & Customary = The amount the pharmacy charges to the general public.

Note 1: The amount paid on the claim for a prescription drug is the lower of the (EAC or SMAC) plus the dispensing fee, or the Usual and Customary Charge. Then a \$1.00 Co-Pay by the client is deducted, if the Co-Pay was applicable to the Medicaid client.

The amount paid on the claim for an Over-The-Counter drug is the lower of the (EAC or SMAC) plus a 50% markup of the maximum of the EAC or SMAC amount, unless the markup is more than the dispensing fee. Then the dispensing fee is used. If the Usual and Customary Charge is less than the previous calculation, the Usual and Customary amount is paid.

Note 2: A different EAC or SMAC amount for the same drug description listed above is due to either different quantities of the drug being filled or a change in the EAC or SMAC due to the prescription being filled in a different time period.

Note 3: The use of a Brand Name Drug (B) or a Generic Name Drug (G) does not affect the amount that Medicaid pays for a prescription. When a prescription is filled, the pharmacist is paid the lower of the allowable costs as defined above. The pharmacist may fill the prescription with either a Brand Name or Generic, but will receive the same amount in payment, for which ever type of drug is used.

If a Doctor prescribes a Brand Name specifically, and files a form for this prescription with HHS in this case only, will Medicaid pay the Brand Name cost, even if the cost is more than the EAC or the SMAC.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
MEDICAID PROGRAM

MEDICAID INFORMATION - COMMON QUESTIONS

Medical Assistance is a statewide program through which medical care and services may be provided for low-income Nebraskans. Medical Assistance is sometimes called Medicaid.

Who may be eligible for Medicaid?

You may be eligible if you are:

- 65 years of age or older.
- An individual under 65 years of age who has a disability, or is visually impaired according to Social Security guidelines.
- An individual 20 years of age or younger.
- A dependent child who meets the eligibility requirements of the Aid to Dependent Children Program.

Where do I apply?

You may apply for Medical Assistance at the Department of Health and Human Services Office closest to where you live. You may also be asked to apply for Supplemental Security Income (SSI) at the Social Security Office.

What type of care is available under Medical Assistance?

The following medical services are available:

- Hospital care and doctor visits.
- Dental care; eye care; speech, hearing and physical therapy.

- Laboratory and x-ray therapy.
- Nursing home care.
- Home health care services.
- Prescribed drugs, medical equipment and health aids.
- Care in institutions for mental diseases if persons are 20 years of age or younger or 65 years of age or older.
- Regular health checks for children.
- Family planning.

What resources may I have and be eligible to receive Medical Assistance?

- The home in which you reside.
- One motor vehicle.
- Property you use to operate a trade or business. For example, land, machinery and equipment.
- Irrevocable burial fund up to \$3,000.
- Resources, in addition to the above, which do not exceed:
 - \$4,000 for one member family
 - \$6,000 for two member family
 - \$25 for each additional family member

Children age 18 and younger and pregnant women are not subject to a resource test.

May I dispose of a resource by giving it away or selling it for less than fair market value?

If you give away your home or other resources, you may be giving away a resource which may be used for support. Therefore, you may be found ineligible for Medical Assistance.

May I have income and still be eligible?

Yes, provided you meet all other eligibility requirements and your income does not meet your basic living and medical needs according to eligibility guidelines. You may be required to spend a portion of your income on medical expenses, and show proof of the medical need.

How long must I live in Nebraska in order to be eligible for Medical Assistance?

Your legal residence must be in Nebraska at the time you apply for Medical Assistance.

**NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
MEDICAID ELIGIBILITY CATEGORIES**

AID TO DEPENDENT CHILDREN (ADC/TANF)

These families receive an ADC cash assistance grant and are Medicaid eligible as a result. Parents and other caretaker adults qualify for Medicaid cases closed due to collection of child support and are automatically eligible for Medicaid (both children and adults) without an income or resource test for four months.

AID TO DEPENDENT CHILDREN MEDICALLY NEEDY (ADC/MA)

These families have income over the ADC standard but less than the Medically Needy Standard. The parents and other caretaker adults can qualify for Medicaid. Excess Income: These cases have income over the income limit but can spenddown or share the cost by paying for medical bills over the medically needy income level (MNIL) and establish eligibility. Once the excess income expenditure is met they establish Medicaid eligibility.

TRANSITIONAL MEDICAL ASSISTANCE (ADC/TMA)

ADC cases that are ineligible for a cash grant due to earnings and a member of the unit received a grant in 3 of the last 6 months. The first six months eligibility is without regard to income. In the next 18 months earned income must be below 185% of the Federal Poverty Level. All members of the family are eligible if their earned income is below 100% FPL; if above 100% FPL the family can pay a premium and be Medicaid eligible.

RIBICOFF

Children age 20 or younger who are not eligible as an ADC child. The eligible children can spenddown or share the cost to establish eligibility.

SUPER-ENHANCED MEDICAL ASSISTANCE FOR CHILDREN (SE-MAC)

Unborn children whose family income is equal to or less than 185% FPL. The mother is eligible for prenatal, delivery and sixty-day postpartum period. Under federal law children born to Medicaid eligible women are eligible for 12 months following the birth.

ENHANCED MEDICAL ASSISTANCE FOR CHILDREN (E-MAC)

Infants up to age one whose family income is less than 150% of the Federal Poverty Level. No ability to obligate income above the standard to establish eligibility. Only the children in the family are eligible, no adults can be Medicaid eligible under this category.

MEDICAL ASSISTANCE FOR CHILDREN (MAC)

Medical assistance for children ages 1 through 5 (through the month of the 6th birthday) and family income equal to or less than 133% FPL

SCHOOL AGE MEDICAL (SAM)

Children 6 through 18 years of age (through the month of the 19th birthday) and family income is equal to or less than 100% FPL

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Children through age 18 (through the month of the 19th birthday) with family income below 185% FPL who do not have creditable health insurance coverage and who do not qualify for one of the Medicaid Eligibility groups listed above.

TWELVE MONTHS CONTINUOUS COVERAGE

Children 18 and younger who are found Medicaid eligible for one month are eligible for twelve months with no income or resource test after month one.

**NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
MEDICAID ELIGIBILITY CATEGORIES**

PRESUMPTIVE ELIGIBILITY

Process whereby a qualified provider can presumptively (based on a declaration of income) determine a child or pregnant women eligible for Medicaid. This eligibility continues until the local Health and Human Services offices determine continuing eligibility for Medicaid.

AID TO THE AGED, BLIND, AND DISABLED (AABD)

Aged Blind and Disabled who receive a Supplemental Security Income payment or a State Supplement Program. Aged are over 65, the Blind and Disabled are determined as such utilizing the Social Security Administration's definitions.

AID TO THE AGED, BLIND, AND DISABLED MEDICALLY NEEDY (AABD/MA)

AABD clients who have income over cash assistance standards but have a medical need and are not eligible under the 100% FPL standard. This Medicaid category allows the individual to obligate their income above the standard on their own medical bills and establish Medicaid eligibility.

AID TO THE AGED, BLIND, AND DISABLED 100% FPL

AABD clients whose income is below 100% of FPL. The Federal Law requires us to pay only Medicare premiums, copayments and deductibles for clients less than 100% FPL. Because of computer system limitations and the additional Medicaid services involved quality of life issues, the decision was made to offer full Medicaid coverage to this group instead of limiting payment to just Medicare premiums, copayments, and deductibles. No obligation of income above this standard allowed.

AID TO THE AGED, BLIND, AND DISABLED QUALIFIED MEDICARE BENEFICIARIES & QUALIFIED INDIVIDUALS

AABD clients for whom the State is required to pay Medicare Part B Premiums, and AABD clients for whom the State pays the cost of shifting from Medicare Part A to Part B, the portion of the premium meant to pay for Home Health Services.

QUALIFIED WORKING DISABLED INDIVIDUALS

AABD clients who were eligible for Medicare as a disabled individual and who return to work. The agency is required to pay the Medicare Part A premium for individuals with income less than 250% FPL.

BUY-IN FOR DISABLED

Disabled clients who are eligible for Medicaid except for their earnings and disabled trying to work but need to retain their Medicaid coverage to enable the return to work. They are eligible without paying a premium to 200% FPL, between 200% FPL and 250% FPL they must pay a premium.

SPOUSAL IMPOVERISHMENT

Process whereby resources are split and more income is allocated to the community spouse when one member of a married couple is institutionalized. The value of the resources is determined the first month of institutionalization to determine the spousal shares.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
 MEDICAID PROGRAM
 1999 Federal Poverty Levels

Family Size	Annual Income	133%	150%	185%	200%
1	\$ 8,240	\$ 10,959	\$ 12,360	\$ 15,244	\$ 16,480
2	\$ 11,060	\$ 14,710	\$ 16,590	\$ 20,461	\$ 22,120
3	\$ 13,880	\$ 18,460	\$ 20,820	\$ 25,678	\$ 27,760
4	\$ 16,700	\$ 22,211	\$ 25,050	\$ 30,895	\$ 33,400
5	\$ 19,520	\$ 25,962	\$ 29,280	\$ 36,112	\$ 39,040
6	\$ 22,340	\$ 29,712	\$ 33,510	\$ 41,329	\$ 44,680
7	\$ 25,160	\$ 33,463	\$ 37,740	\$ 46,546	\$ 50,320
8	\$ 27,980	\$ 37,213	\$ 41,970	\$ 51,763	\$ 55,960
For each additional person, add	\$ 2,820	\$ 3,751	\$ 4,230	\$ 5,217	\$ 5,640

Source: Federal Register

APPENDICES

APPENDIX A

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
MEDICAID PROGRAM

STATE OF NEBRASKA
STATEWIDE SINGLE AUDIT
Schedule of Findings and Questioned Costs
Year Ended June 30, 1999

Finding #99-26-19

Program: CFDA #'s 93.777 & 93.778 – Medical Assistance Program Cluster – Activities Allowed or Unallowed and Allowable Costs/Cost Principles

Federal Grantor Agency: U.S. Department of Health and Human Services

Criteria: In accordance with 42 CFR Section 431.625, the State may enroll certain Medicare eligible recipients under Medicare Part B, pay the premium, deductible, cost sharing, and other charges.

Condition: We were unable to test for compliance with this allowability requirement because the Agency has not retained the list of recipients obtained from the Health Care Finance Administration (HCFA) for the period under examination. As a result, the population detail was not available to test the Medicare Part B eligibility requirement.

Questioned Costs: Questioned costs may exist; however, we were unable to test and therefore determine their existence.

Context: The Agency has not addressed this requirement.

Cause: The Agency is not retaining the list of recipients under Medicare Part B obtained from HCFA.

Effect: We were unable to test for compliance to ensure the allowability of the premiums paid for the Medicare Part B recipients.

Recommendation: We recommend the Agency keep the listing obtained by HCFA in order to ascertain who is receiving benefits each quarter.

Finding #99-26-20

Program: CFDA #'s 93.777 & 93.778 – Medical Assistance Program Cluster – Special Tests and Provisions

Federal Grantor Agency: U.S. Department of Health and Human Services

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
MEDICAID PROGRAM

STATE OF NEBRASKA
STATEWIDE SINGLE AUDIT
Schedule of Findings and Questioned Costs
Year Ended June 30, 1999

Criteria: 45 CFR 95.621 states the State ADP Security requirements shall include the following: (a) determination and implementation of appropriate security requirements, (b) establishment of a security plan and policies and procedures to address physical security of ADP resources and equipment security, (c) periodic risk analyses to ensure that appropriate cost effective safeguards are incorporated into new and existing systems, (d) ADP security system reviews of installations involved in the administration of Health and Human Services programs on a biennial basis.

Condition: We found the Agency has procedures in place to address parts (a) and (b) of this requirement, but they are not performing periodic risk analyses or biennial systems reviews, parts (c) and (d) of the requirement.

Questioned Costs: None.

Context: The physical and data security functions are being performed on a statewide basis by Information Management Services; however, no specific procedures are performed relating to risk analysis and biennial system reviews relative to the Medicaid Management Information System (MMIS) and the NFOCUS system.

Cause: The Agency has not implemented procedures to perform periodic risk analyses or biennial security reviews.

Effect: There is an increased risk with respect to the security status of the system.

Recommendation: In order to ensure that appropriate safeguards are incorporated into the existing systems and to ensure compliance with the Federal requirements, we recommend the Agency implement procedures to perform periodic risk analyses and biennial security reviews.

Management Response: The Agency disagrees with the finding that there are no specific procedures performed relating to MMIS periodic security reviews/risk analysis. A review relating to update capability access to the MMIS DB2 operator tables and the RACF profiles was performed in 1999 and described in documentation provided. We agree, however, that the documentation does not fully and clearly demonstrate these activities. Documentation supporting periodic risk analysis will be developed, along with procedures and documentation for biennial MMIS security system reviews.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
MEDICAID PROGRAM

STATE OF NEBRASKA
STATEWIDE SINGLE AUDIT
Schedule of Findings and Questioned Costs
Year Ended June 30, 1999

Finding #99-26-21

Program: CFDA #'s 93.777 & 93.778 – Medical Assistance Program Cluster – Special Tests and Provisions

Federal Grantor Agency: U.S. Department of Health and Human Services

Criteria: 42 CFR sections 435.10, 440.210, 440.220, and 440.180 state funds can only be used for Medicaid benefit payments (as specified in the State plan, Federal regulations, or an approved waiver), administration and training, the State Survey and Certification Program, and State Medicaid Fraud Control Units. 42 CFR parts 455, 456, and 1002 indicates the State plan must provide methods and procedures to safeguard against unnecessary utilization of care and services, including long-term care institutions. The Agency must have procedures to safeguard against unnecessary utilization of care and services, including long-term care institutions. The Agency must have procedures for the ongoing post-payment review, on a sample basis, of the need for and the quality and timeliness of Medicaid services. The State Medicaid Agency may conduct this review directly or may contract with a Peer Review Organization (PRO).

Condition: The Agency contracted with Sunderbruch Corporation to perform the necessary case reviews of inpatient hospital claims. Sunderbruch Corporation is monitored through annual evaluations by the Health Care Financing Administration (HCFA) and Sunderbruch is subject to an annual A-133 compliance audit. The Agency, however, does not obtain the results of these evaluations and audits. Consequently, we are unable to determine whether the Agency is in compliance.

Questioned Costs: None.

Context: The federal financial participation for inpatient hospital claims amounted to 10% of total federal financial participation and \$63,895,817 during the Agency's fiscal year 1999.

Cause: The Agency believed that by contracting with a PRO, responsibility for federal compliance was transferred away from the Agency and to the PRO.

Effect: Without proper monitoring of the Sunderbruch Corporation, the Agency cannot ensure that federal and state funding is not utilized ineffectively or inappropriately.

Recommendation: We recommend that the Agency request copies of the reports of the annual HCFA evaluations and A-133 compliance audits performed on the Sunderbruch Corporation, review the reports for noncompliance and follow up on noncompliance, if necessary.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
MEDICAID PROGRAM

STATE OF NEBRASKA
STATEWIDE SINGLE AUDIT
Schedule of Findings and Questioned Costs
Year Ended June 30, 1999

MANAGEMENT RESPONSE: (NOTE: NOT INCLUDED IN STATEWIDE REPORT, SUBMITTED BY HHS WITH MEDICAID REPORT.

HHSS AGREES WITH THE AUDITOR RECOMMENDATION THAT HHSS REQUEST COPIES OF AND REVIEW THE ANNUAL HCFA EVALUATIONS AND A-133 COMPLIANCE AUDITS PERFORMED ON THE SUNDERBRUCH CORPORATION (TSCN). HHSS REQUESTED THIS MATERIAL FROM THE FEDERAL DIVISION OF CLINICAL STANDARDS AND QUALITY IN KANSAS CITY AND WILL REVIEW THE MATERIAL WHEN IT IS RECEIVED AND TAKE APPROPRIATE ACTION.

HHSS DISAGREES, HOWEVER, WITH THE CONCLUSION THE AGENCY IS UNABLE TO DETERMINE WHETHER TSCN IS PERFORMING ITS CONTRACTUAL RESPONSIBILITIES TO CONDUCT MEDICAL AND UTILIZATION REVIEW OF CERTAIN FEE-FOR-SERVICE CARE. HHSS PROGRAM AND POLICY STAFF CONFER MONTHLY WITH TSCN REPRESENTATIVES TO MONITOR THE UTILIZATION REVIEW PROCESS AND CORRECT ANY PROBLEMS AS NECESSARY.

Finding #99-26-25

Program: CFDA #10.551 – Food Stamps – Activities Allowed or Unallowed & Allowable Costs/Cost Principles
CFDA #93.558 – Temporary Assistance for Needy Families – Activities Allowed or Unallowed & Allowable Costs/Cost Principles
CFDA #93.568 – Low-Income Home Energy Assistance – Activities Allowed or Unallowed & Allowable Costs/Cost Principles
CFDA #93.575 & #93.596 Child Care Cluster – Activities Allowed or Unallowed & Allowable Costs/Cost Principles
CFDA #93.658 – Foster Care – Title IV-E – Activities Allowed or Unallowed & Allowable Costs/Cost Principles
CFDA #'s 93.777 & 93.778 – Medical Assistance Program Cluster – Activities Allowed or Unallowed & Allowable Costs/Cost Principles

Federal Grantor Agency: U.S. Department of Health and Human Services
U.S. Department of Agriculture

Criteria: According to 45 CFR Section 95.517, a State must claim federal financial participation for costs associated with a program only in accordance with its approved cost allocation plan.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
MEDICAID PROGRAM

STATE OF NEBRASKA
STATEWIDE SINGLE AUDIT
Schedule of Findings and Questioned Costs
Year Ended June 30, 1999

Condition: Data processing costs associated with the NFOCUS computer system are allowed to be allocated based on quarterly case counts of benefiting federal programs according to the approved cost allocation plan for the Health and Human Services System. Contrary to the plan, these costs are being allocated based on historical case counts instead of current quarter case counts.

Questioned Costs: None.

Context: Total costs charged to the NFOCUS cost pool during the State's fiscal year 1999 amounted to \$20,606,541. These costs are being allocated between the proper programs but not in the correct proportion. Since case counts are not expected to fluctuate drastically from quarter to quarter, the estimated allocation determined from historical case counts may not differ drastically from the allocation determined by actual case counts.

Cause: Current quarter case counts were expected to be determined from the NFOCUS computer system; however, this system is not currently capable of performing this function. Therefore, historical case counts have been used as a substitute to best estimate the allocation.

Effect: Amount charged to these federal programs from the NFOCUS cost pool may not be the correct amounts.

Recommendation: We recommend the Agency develop a different method for determining case counts and amend the cost allocation plan to reflect the new method.

MANAGEMENT RESPONSE: (NOTE: NOT INCLUDED IN STATEWIDE REPORT, SUBMITTED BY HHS WITH MEDICAID REPORT)

BECAUSE THE N-FOCUS SYSTEM DID NOT PROVIDE CASE COUNT DATA WHEN IT BECAME OPERATIONAL, HHSS CONTINUED TO USE THE APD APPROVED ALLOCATION FOR THE DEVELOPMENT PHASE AS THE BEST ESTIMATE UNTIL PROGRAMMING COULD BE COMPLETED TO ACQUIRE THE DESIRED CASE COUNTS. HHSS DEVELOPED AN AD HOC PROGRAM TO ACCUMULATE THE CASE DATA FROM THE N-FOCUS DATABASE. IN THE NEAR FUTURE THIS SAME DATA WILL BE GENERATED BY N-FOCUS WITHOUT THE NEED FOR RUNNING THE AD HOC PROGRAM. CALCULATIONS FOR THE QUARTERS COMPLETED BASED ON OLD DATA WILL BE REVISED AND FEDERAL FINANCIAL REPORTS WILL BE ADJUSTED ACCORDINGLY. BECAUSE HHSS DEvised A METHOD TO GATHER THE STATISTICS FROM N-FOCUS DATA, HHSS BELIEVES A PLAN AMENDMENT IS NOT REQUIRED.

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Finding #99-26-26

Program: CFDA #93.558 – Temporary Assistance from Needy Families – Cash Management
CFDA #93.563 – Child Support Enforcement – Cash Management
CFDA #93.568 – Low-Income Home Energy Assistance – Cash Management
CFDA #93.575 & #93.596 – Child Care Cluster – Cash Management
CFDA #93.658 – Foster Care – Title IV-E – Cash Management
CFDA #93.667 – Social Services Block Grant – Cash Management
CFDA #'s 93.777 & 93.778 – Medical Assistance Program Cluster – Cash Management

Federal Grantor Agency: U.S. Department of Health and Human Services

Criteria: Treasury regulations at 31 CFR 205, which implement the Cash Management Improvement Act of 1990, require recipients to enter into agreements which prescribe specific methods of drawing down federal funds for selected large programs.

Condition: Currently, the Agency draws down federal funds for all indirect costs on an estimated basis, as expenditures are incurred and paid, which may result in the over or under drawing federal funds. As a result, the reporting process becomes complex.

Questioned Costs: None.

Context: Actual Federal expenditures reported on the federal financial report do not always equal the amount drawn.

Cause: The causes are as follows: a) Indirect costs are allocated quarterly through the cost allocation plan, and as a result, monthly draws have to be estimated; b.) Haphazard monitoring procedures are in place over the entire process.

Effect: The Agency may draw more federal funds than what was actually expended and reported on the federal financial report for certain programs at various times throughout the year.

Recommendation: The Agency is working on establishing a formalized, systematic process to address this issue. We encourage the Agency to continue working toward such a process.

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MANAGEMENT RESPONSE: (NOTE: NOT INCLUDED IN STATEWIDE REPORT, SUBMITTED BY HHS WITH MEDICAID REPORT)

HHS IS DEVELOPING A FORMALIZED, SYSTEMATIC PROCESS TO DRAW INDIRECT COSTS FROM THE PROPER PARTICIPATING FEDERAL GRANT. WE ANTICIPATE THIS PROCESS WILL BE IN PLACE JULY 1, 2000.

Finding #99-26-27

Program: CFDA #'s 10.551 & 10.561 – Food Stamp Cluster-Eligibility, Activities Allowed or Unallowed, Allowable Costs/Cost Principles, Reporting.
CFDA #93.558 – Temporary Assistance for Needy Families – Eligibility, Activities Allowed or Unallowed, Allowable Costs/Cost Principles, Reporting
CFDA #93.568 – Low-Income Home Energy Assistance – Activities Allowed or Unallowed, Allowable Costs/Cost Principles, Reporting
CFDA #93.575 & 93.596 – Child Care Cluster – Eligibility, Activities Allowed or Unallowed, Allowable Costs/Cost Principles, Reporting
CFDA #93.658 – Foster Care - Title IV-E – Eligibility, Activities Allowed or Unallowed, Allowable Costs/Cost Principles, Reporting
CFDA #93.659 – Adoption Assistance – Eligibility, Activities Allowed or Unallowed, Allowable Costs/Cost Principles, Reporting
CFDA # 93.667 – Social Service Block Grant – Eligibility, Activities Allowed or Unallowed, Allowable Costs/Cost Principles, Reporting
CFDA #93.777 & 93.778 – Medical Assistance Program Cluster – Eligibility, Activities Allowed or Unallowed, Allowable Costs/Cost Principles, Reporting

Federal Grantor Agency: U.S. Department of Health and Human Services
U.S. Department of Agriculture

Criteria: The Agency is required to maintain internal control to ensure compliance with requirements applicable to federal award programs.

Condition: We noted high residual risk over manual over-rides in the NFOCUS system. “Manual over-rides” is a necessary function. In a few cases, due to the rigid application of the rules, the system rejects certain programs for an eligible client and the manual over-ride function is needed to adjust the eligibility value.

Questioned Costs: None.

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Context: As these adjustments take place later in the process, it makes the controls in place earlier in the process, ineffective.

Cause: Manual over-rides are necessary, as NFOCUS sometimes inappropriately rejects programs for eligible clients. However, the manual overrides are not documented or approved by a manager.

Effect: The risk from the lack of appropriate control over this function is not limited to fraud but also has the potential for negligence. Large implementations can be time consuming and sometimes a frustrating experience for end users, who could potentially be by-passing the embedded-system controls by using the “manual over-ride” function.

Recommendation: We recommend management consider implementing controls over this area. These controls can be preventive and/or detective, such as where a supervisor approves the over-rides through the review of periodic summary reports that indicate the case number, the case worker, the system-generated value, the over-ride value and an explanation for the over-ride.

Management Response: The Agency disagrees with the finding. NFOCUS uses a client server environment to determine financial eligibility for program cases (TANF, Aid to Aged, Blind, and Disabled, Medicaid, Food Stamps, etc.) The program criterion in the Expert portion of the system (that part which configures household composition, resources, and income to calculate budgets and send notices) is about 90% accurate in its calculation. The system is not able to address all potential variations of household configurations and ownership of resources income. The workers are allowed to override the system results if they are incorrect. The program administration areas do not consider this any different or greater risk than the legacy system, which allowed workers to directly enter grant or eligibility amounts after completion of a paper budget. The recommendation that the system implement some type of control or tracking component would be extremely expensive and impractical. In many cases, offices are managed by a traveling supervisor who covers 2 to 3 offices in a wide geographic area. The supervisors are not available on a daily basis to review the override and if the worker had to wait for approval, considerable delay would occur in getting timely benefits to the client. Additionally, the cost of building this type of enhancement in the system is not supported by the Program areas at the time, due to other enhancements/changes that have been prioritized.

Cases reviewed by the supervisors during program eligibility redetermination time frames (6 months usually for most programs). At that point, all previous budgets and benefits are screened for accuracy, corrective action measures are taken if results are incorrect.

APPENDIX B

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
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NURSING FACILITIES INTERGOVERNMENTAL TRANSFERS

April 1, 1998 through June 30, 1999

BACKGROUND

The Nebraska Health Care Trust Fund was established by Legislative Bill 1070 and approved by the Governor in April 1998. This fund was created for the purpose of receiving funds from an intergovernmental transfer arrangement between government-operated nursing facilities and the State of Nebraska.

The arrangement involves creating a proportionate share pool to increase Medicaid dollars received from the Federal government. Per Federal regulation, State payments to nursing facilities for Medicaid may not exceed the amount that can reasonably be estimated to be paid under Medicare. HHS methodology for Medicaid payments to nursing facilities results in an amount under the Medicare upper limit. HHS estimates the difference between the maximum Medicare rate per day and the Medicaid per diem allowable. This amount is then distributed to governmental nursing facilities based on their proportionate share of the pool (based on share of Medicaid inpatient days). The nursing homes, after keeping a participation fee, are required to transfer the remainder back to HHS. The funds are deposited into the State General Fund to reimburse the matching dollars used for the initial payment, and the remainder is deposited into the Nebraska Health Care Trust Fund. The first intergovernmental transfer in April 1998 totaled \$45,285,950 and the second in October 1998 totaled \$90,571,899.

LB 1070 also created the following three funds:

- Nursing Facility Conversion Cash Fund for the purpose of providing grants to create new or convert existing nursing home beds to assisted living facilities, and for expenses incurred to administer the grants;
- Children's Health Insurance Cash Fund for the purpose of providing the state's matching share for children's health insurance under Title XXI of the federal Social Security Act, and for expenses incurred to administer the program; and
- Excellence in Health Care Trust Fund for awarding grants of a variety of purposes related to public health issues, such as education, preventive health measures, providing medical testing, and staffing needs. Up to one half of the Fund may be used for additional nursing facility conversion grants. This Fund may also be used for the state's matching share for children's health insurance under Title XXI of the federal Social Security Act in excess of the funds paid out of the Children's Health Insurance Cash Fund.

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PROCEDURES

1. The HHS methodology for the April and October 1998 transfers used for each nursing facility the actual calendar year 1996 payments multiplied by an increase of 7.5% and the actual 1996 inpatient days multiplied by a decrease of 2% to obtain an estimated average rate for 1998. This rate was then compared to the upper Medicare limit and the difference multiplied by the estimated inpatient days for each facility. This amount was then totaled for all 225 facilities to obtain the pool amount which was distributed to the governmental facilities based on the percentage of Medicaid inpatient days.

A. We noted HHS did not have written documentation supporting the estimated 2% decrease in inpatient days. Without adequate supporting documentation, auditors were unable to determine whether the estimates used were reasonable. We further noted the documentation provided by HHS for the estimated increase in costs supported a 7% rather than 7.5% increase.

We recommend HHS maintain written documentation to support estimates used.

B. We reviewed the data used to compute the Intergovernmental Transfer (IGT) proportionate share pool. We tested 25 of 230 nursing facilities to determine whether the dollar amount of claims paid and the number of inpatient days used in the calculation agreed to the HHS database. No exceptions were noted.

C. We recalculated the IGT pool using the HHS summary of claims paid and inpatient days for 1996. We noted for 2 of 225 nursing facilities the amount of claims paid per the HHS summary and the amount used in the calculation did not agree. The result was the April 1998 pool was \$99,689 too high and the October 1998 pool was \$199,377 too high. Therefore, excess federal funds may have been drawn.

We recommend HHS review procedures to ensure amounts used are accurate. We further recommend HHS determine whether an adjustment is needed to the next IGT for errors noted.

D. We tested the IGT payment to the nursing facilities to determine the correct amount was transferred from the State. We also tested the transfer from the nursing facilities to the State to determine the correct amount, adjusted for the

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participation fee, was returned to the State and the proper amounts were deposited to the General Fund and the Nebraska Health Care Trust Fund based on the Federal participation rate.

Title 471 NAC 12-011.07.F Provisions for Governmental Facilities – City and County Owned Nursing Facility Proportionate Share Pool states, “City and County owned facilities may retain as a participation fee, the greater of:

1. \$10,000; or
2. For facilities with a 40% or more Medicaid mix of inpatient days, the current NMAP Federal Financial Participation percentage multiplied by the facility’s allowable costs above the respective maximum for the Direct Nursing and the Direct Support Services Components.”

City and County owned nursing facilities other than Douglas County Hospital received \$10,000 each transfer. Douglas County Hospital received \$997,499 for fiscal year 1999. This amount was not reduced from the proportionate share pool but was paid from federal funds. As a result this amount was paid twice from federal Medicaid funds. The participation fee should have reduced the amount available to be transferred to the Nebraska Health Care Trust Fund.

Also, Douglas County Hospital received \$905,210 in fiscal year 1998 paid from federal Medicaid funds. As the proportionate share pool transfer in April 1998 was calculated at one half of the October 1998 transfer, \$452,605 should have been reduced from the April 1998 transfer to the Nebraska Health Care Trust Fund.

In total, \$1,450,104 was paid twice from federal funds. The \$1,450,104 received by the Nebraska Health Care Trust Fund, plus accumulated interest, should be reimbursed to the Federal government.

We recommend HHS immediately notify the appropriate federal agency and resolve this issue.

- E. We noted during testing a nursing facility participated in the April 1998 transfer, but did not participate in the October 1998 transfer. State Statute Section 71-7607 R.S. Supp., 1998 states the department “shall adopt and promulgate rules and regulations to establish the procedures for participation by governmental nursing facilities.” Title 471 NAC 12-011.07J states that City or

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County owned facilities may retain a participation fee. The nursing facility in question operates in a building owned by the County, but the County is not involved in operations of the nursing facility. The department has revised the regulations to clarify that ownership refers to the physical structure. However these regulations were not approved as of January 21, 2000. We also noted the NAC regulation excludes governmental nursing facilities operated by Hospital districts.

We recommend HHS review this issue and determine whether funds are owed to the nursing facility because it was incorrectly omitted from the October 1998 transfer or whether the State is owed because the facility incorrectly participated in the April 1998 transfer.

- F. Title 471 NAC 12-011.07J states, "The estimated pool and the facilities' estimated proportionate share are reconciled after final cost reports are received and final calculations made. Estimated amounts will be compared to final calculations and necessary adjustments will be made to the facilities' estimated distribution in the subsequent distribution."

We noted the estimated pool for the April 1998 transfer and the estimated pool for the October 1998 transfer were not reconciled and were not adjusted in the subsequent distribution. The Department performed a transfer in November 1999 before reconciling and adjusting for previous transfers.

We recommend HHS reconcile and adjust estimated amounts on a timely basis. We further recommend no additional transfers be performed unless previous estimates have been reconciled and adjusted.

2. State Statute Section 71-7612, R.S. Supp., 1998 required HHS to transfer funds from the Nebraska Health Care Trust Fund as follows:
- the first \$40 million plus accumulated interest to the Nursing Facility Conversion Cash Fund;
 - the next \$25 million plus accumulated interest to the Children's Health Insurance Cash Fund; and

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- beginning January 15, 1999, only the interest accruing on the Nebraska Health Care Trust Fund balance in excess of the above \$65 million to the Excellence in Health Care Trust Fund.

We reviewed the transfers from the Nebraska Health Care Trust Fund as required by State Statute. \$40 million plus the accumulated interest was transferred to the Nursing Facility Conversion Cash Fund, and \$25 million plus the accumulated interest was transferred to the Children's Health Insurance Cash Fund. However, we noted \$31,946 of October 1998 interest that was to be transferred to the Excellence in Health Care Trust Fund, was not transferred but remains in the Nebraska Health Care Trust Fund. The remaining months of accumulated interest were properly transferred to the Excellence in Health Care Trust Fund.

We recommend HHS advise the State Treasurer to transfer \$31,946 from the Nebraska Health Care Trust Fund to the Excellence in Health Care Trust Fund.

3. We reviewed disbursements from the funds that received the statutory transfers from the Nebraska Health Care Trust Fund.
 - A. Nursing Facility Conversion Cash Fund 2262:

We tested 3 of 27 payments to nursing facilities to determine:

- ◆ an approved grant agreement was on file, and
- ◆ the Architectural & Finance Review did not exceed the \$15,000 maximum allowance.

No exceptions were noted.

We tested 4 of 24 grants awarded to determine:

- ◆ the award did not exceed \$1.1 million per facility,
- ◆ the award per each assisted living unit created did not exceed \$52,000,
- ◆ the facility was a current Medicaid provider, and
- ◆ the facility had participated as a provider under the Nebraska Medical Assistance Program for at least 3 years.

No exceptions were noted.

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B. Children's Health Insurance Cash Fund 2266:

We tested one payment for 4 recipients to determine:

- ◆ Per HHS computer system the individual was eligible for Kid's Connection, and
- ◆ Per HHS computer system the individual did not have health insurance at the time of the claim.

No exceptions were noted.

C. There were no disbursements from the Excellence in Health Care Trust Fund 2264 as of June 30, 1999.

4. We noted a need for improvement of personal computer procedures. A personal computer was upgraded which resulted in the loss of access to spreadsheets containing information for the IGT. HHS requested the audit be delayed so the information could be recreated.

We recommend HHS improve personal computer procedures to ensure supporting documentation is maintained.

APPENDIX C

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
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PROGRAM 424 – DEVELOPMENTAL DISABILITY AID

For the Fiscal Year Ended June 30, 1998

SUMMARY OF COMMENTS

During our audit of the Nebraska Health and Human Services System (HHS) - Program 424 - Developmental Disability Aid, we noted certain matters involving the internal control over financial reporting and other operational matters that are presented here. Comments and recommendations are intended to improve the internal control over financial reporting, ensure compliance, or result in operational efficiencies.

1. Program Evaluation
2. Payment of Provider Services
3. Provider Payment Procedures
4. HCFA Billing Disagreement
5. Provider Rate Calculation Procedures
6. Bidding of Provider Services
7. Accounting for Federal Draw Downs
8. Quality Review Teams
9. HHS Internal Audits of Providers
10. Ability to Pay Procedures
11. Ability to Pay Receipt Procedures
12. Provider Billing System Procedures
13. Outside Audits of Providers
14. Client Leave Days
15. Internal Quality Reviews of the Local Field Offices

More detailed information on the above items is provided hereafter. It should be noted that this report is critical in nature since it contains only our comments and recommendations on the areas noted for improvement and does not include our observations on any strong features of the Program.

Draft copies of this report were furnished to HHS to provide them an opportunity to review the report and to respond to the comments and recommendations included in this report. All formal responses received have been incorporated into this report. Where no response has been included, HHS declined to respond. Responses have been objectively evaluated and recognized, as appropriate, in the report. Responses that indicate corrective action has been taken were not verified at this time but will be verified in the next audit.

We appreciate the cooperation and courtesy extended to our auditors during the course of the audit.

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PROGRAM 424 – DEVELOPMENTAL DISABILITY AID

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COMMENTS AND RECOMMENDATIONS

1. Program Evaluation

The Department of Health and Human Services' (HHS) 1997 to 1999 budget request included 11 "principles of the Health and Human Services system." Two of these principles were:

- Outcome-based to assure that measurable results are achieved and reported by a well-informed management system.
- Fiscally sound by ensuring that financial and human resources are sufficiently invested and responsively managed to assure progress on the outcomes in a unified and efficient health and human services system of care.

In HHS's "Steps Toward the Future - System Strategies - The Implementation Plan for the Developmental Disabilities Services Act - July 1, 1995 through June 30, 2001," the following six quality improvement measures of success were listed:

- An increase in the quality of life of persons receiving services is indicated by Quality Review Team Survey results;
- An indication of service system quality by random samples of customer satisfaction surveys;
- The services provided meet the objectively assessed needs of individuals;
- The fact that consumers and their families have a better understanding of their support/service options and how to access them;
- The supports and services provided are more integrated; and
- Quality Review Team Survey results are available to the public.

These program plans indicate HHS's desire to measure the results of the Developmental Disabilities program. However, during our review we noted HHS had few program measurements in place to evaluate the effectiveness of the Program's spending, whether resources were responsively managed, and whether improvements were made in the quality of services being provided. While each person receiving services did have regular quality of life and services reviews, HHS had no measurements in place to evaluate the quality of services provided for the program as a whole.

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COMMENTS AND RECOMMENDATIONS

1. Program Evaluation (Concluded)

Sound business practices require a system be established for measuring the extent to which program goals have been achieved and for determining whether the program expenditures are achieving the desired goals.

We recommend HHS implement an annual evaluation process to determine the program's effectiveness.

HHS'S RESPONSE: HHS DISAGREES THAT FEW PROGRAM MEASUREMENTS ARE IN PLACE. THE DDS HAS IMPLEMENTED THE SIX QUALITY IMPROVEMENT MEASURES IDENTIFIED. THESE PERFORMANCE MEASURES AS WELL AS OTHERS CONTINUE TO PROVIDE THE DD SYSTEM WITH PROGRAM EVALUATION DATA AND INDICATORS OF SYSTEMIC PERFORMANCE.

2. Payment of Provider Services

HHS entered into contracts with various entities (providers) in the State to provide Developmental Disability services to clients. HHS's Client Service Contract for the Provision of Services stated the contract was a "purchase of services," and the 1992 funding methodology documentation stated, "direct service staff intervention hours will be the measure of intensity of services delivery in responding to consumer needs." Therefore, the basis of service was an hour and the provider billings and payments were based on the hours of service provided.

In order to pay the service providers, HHS sent each provider an "Intervention Hour Monthly Verification Report" at the beginning of each month. This Verification Report included all authorized clients and the number of hours of services authorized to be provided. At the end of the month, the providers recorded the actual number of hours of services provided, signed the report and sent the report to HHS's local office. The local office's Service Coordination Manager reviewed the Verification Report for accuracy, approved the report, and sent the report to HHS's central office for payment. However, while the Service Coordination Manager was responsible for determining whether the services were provided, this individual did not have direct knowledge that the billed service hours had all been performed.

Sound business procedures require billing invoices be reviewed prior to payment to insure the items billed had been received. While HHS staff and numerous outside parties on a regular basis reviewed each client's individual developmental progress, these individuals did not and probably could not determine whether all contract services were provided. Therefore, there was no one insuring all service hours paid for were actually provided.

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COMMENTS AND RECOMMENDATIONS

2. Payment of Provider Services (Concluded)

We recommend HHS review their procedures to ensure hours of service paid are being provided. If it is not possible to verify all service hours, HHS should consider using a different method to pay the service providers.

HHS'S RESPONSE: HHS AGREES THAT EXCEPTIONS EXISTED. HHS HAS TAKEN STEPS TO REVIEW AND RETRAIN STAFF IN ESTABLISHED PROCEDURES RELATING TO SERVICE AUTHORIZATIONS. HHS IS CURRENTLY INVESTIGATING POSSIBLE EXCEPTION REPORT DESIGNS.

3. Provider Payment Procedures

Good internal controls include a plan of organization, procedures and records designed to safeguard assets and provide reliable financial records. A system of internal control should include proper segregation of duties so no individual is capable of handling all phases of a transaction from the beginning to the end. Also, HHS procedures require each client's approved service hours be documented in the client's IPP, the Service Coordinators notify the central office by e-mail when any changes in hours are approved, and the Service Coordinators initial the billing document for any changes in approved hours that could not be made before the billing document was sent to the provider.

During our audit of HHS's payments to providers, we noted the following during our testing of payments made to providers for 24 clients:

- One individual in HHS's central office was responsible for entering information into the provider billing system, generated the provider billing document (verification report), entered changes made to the billing document by the providers, and generated the provider payments. No one reviewed or approved the changes this individual made on the billing system and the billing system generated no error, exception, or change reports.
- One client was authorized for 259 hours in January, 1998. The provider increased the monthly intervention hours verification report to 263 hours. The Service Coordinator Manager did not initial the increase or send an e-mail to the central office to authorize the change. The provider was paid the additional four hours.

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3. Provider Payment Procedures (Concluded)

- One client was authorized and paid for 56 hours in May, 1998. However, the person's Individual Program Plan (IPP) only authorized 43 hours. We were told the person changed providers in 1992 and the IPP was not updated.
- One client was authorized on the billing system for 60 hours in January, 1998 but was paid 173 hours after the Service Coordinator had initialed the billing report change. Our review of the next 12 monthly intervention hours verification reports indicated this 113 hour increase was still not on the billing system, but had been initialed each month by the Service Coordinator. Our review of the client's service coordination file showed a temporary increase of 113 hours was made that was to end January 1, 1998. However, it appears the increase was made permanent as the client's IPP for April, 1998, showed the increase of 113 hours. However, there was no further documentation that the increase had been made permanent and there was no message ever sent to the central office to update the monthly billing report.
- Two clients were both authorized and paid for more hours than their IPPs approved. We were informed this occurred because a blanket increase of 3 to 4.3 hours was made for several clients in 1996 when the providers took over the medical duties of the clients. It appears the IPPs were never updated for these increases.

As a result of the lack of segregation of duties and the lack of documentation on service hours paid there was an increased risk of incorrect or improper payments to the providers.

We recommend HHS take steps to insure all changes in each client's service hours are correctly reflected in the client's IPP and supported by e-mail messages to the central office. If increases are needed and changes cannot be made to the billing report due to timing problems, these changes need to be initialed by the Service Coordinator and should be limited to one month.

In addition, we recommend HHS have the billing system generate a monthly edit or exception report for all changes made to approved service hours and this report be reviewed and approved by a second central office employee.

HHS'S RESPONSE: HHS AGREES THAT ONE INDIVIDUAL IS RESPONSIBLE FOR ENTERING INFORMATION INTO THE BILLING SYSTEM. HHS IS IMPLEMENTING A PERIODIC REVIEW BY A SECOND PERSON OF THE AUTHORIZATION AND BILLING FILES.

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COMMENTS AND RECOMMENDATIONS

4. HCFA Billing Disagreement

Federal regulations require all costs claimed against a federal program be actual costs paid or incurred and not be estimations of costs. If estimations are used for billing purposes, a reconciliation of actual costs to estimated costs must be made on a regular basis and the actual costs must then be reported.

During our audit, we noted HHS had an ongoing disagreement with the U.S. Department of Health and Human Services Health Care Financing Administration (HCFA). In 1993, HHS performed a reconciliation between the providers actual costs to provide the services and the amount HHS received from HCFA. (The amount paid by HCFA is the same as the amount HHS paid to the providers based on the providers' contracted rates.) This reconciliation showed the providers' actual costs were higher than the payments they received from HHS. As a result, HHS filed an amended claim with HCFA for an additional \$2,700,000 in Medicaid funding. HCFA reviewed this amended claim and raised the following questions:

1. Should the additional \$2,700,000 draw down request be paid to the service providers or can HHS keep the additional draw down because HHS had a contract with the providers and that contract has been fulfilled?
2. Did HHS correctly eliminate room and board expenses in their reconciliation of the providers' actual costs to contract payments?

According to HHS, these HCFA questions are still in dispute and no final disposition has been made.

As a result of this ongoing disagreement, HHS has not performed any reconciliations of provider costs to the costs claimed from HCFA since 1993. Also, HHS has not received any of the \$2,700,000 in additional draw downs resulting from the 1993 reconciliation and HHS has not received any possible additional federal payments that may exist if actual provider costs were greater than the amounts claimed from HCFA after 1993.

We recommend HHS settle the disagreements with HCFA as quickly as possible, perform the reconciliations for all years after 1993, and make any amended Medicaid claims with HCFA as necessary.

HHS'S RESPONSE: HHS AGREES THAT THERE IS A DISAGREEMENT WITH HCFA. HHS HAS BEEN AND CONTINUES TO WORK AT RECONCILING DIFFERENCES WITH HCFA.

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COMMENTS AND RECOMMENDATIONS

5. Provider Rate Calculation Procedures

HHS calculated an annual “methodology” rate used to pay service providers. This methodology rate was established in 1992 based on the State’s costs to provide similar services at the State’s Beatrice State Developmental Center (BSDC). This “methodology” calculation used the salary rate of an average BSDC employee, added the employee’s benefit costs, and added the employee’s leave time to determine the total direct service costs. Then costs for direct administration/supervision, non-personnel, transportation, facility, and other administration were added. This calculation resulted in the methodology rate per service hour.

During our review of HHS’s methodology calculation we noted the following estimates and assumptions were made that were not supported by substantiating documentation:

- Estimation of the average leave hours of a service provider employee. Service provider leave hours added \$2.26 or 11% to the total rate.
- Estimation that a service provider employee needs 1 hour of direct supervision for each 8 hours of employee time. The rate methodology calculated the hourly supervisor costs to be \$17.71. Since the supervision factor was set at 1 to 8, this added \$2.21 or 11% to the total rate.
- Estimation of the average leave hours of a supervisor. Supervision leave hours added \$.35 of the \$2.21 in total supervision costs. This was 2% of the total rate.
- Estimation that a service provider needs ½ hour of pre and post intervention time for each hour of direct service for supported day and residential care services. This added \$3.34 or 16% to the total rate.
- Estimation that other payroll costs, such as taxes and insurance, are 20% of direct salary costs. Total other payroll costs added \$2.31 or 11% to the total rate.
- Estimations of the amount of non-personnel costs, transportation costs, facility costs, and other administration costs. These costs added \$4.57 or 22% to the total rate.

While it appears reasonable to include costs for these areas in the rate calculation, approximately 70% of the total rate calculation is not supported by substantiating documentation. We also noted similar questions were raised by the HCFA in 1993.

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5. Provider Rate Calculation Procedures (Concluded)

The methodology calculation also included the following factors that appear to be unneeded or duplicated costs:

- The rate calculation included 80 hours of direct service provider payroll costs when the client is sick or on leave from the facility. This allowed for the facility to be fully staffed even when the client is temporarily gone from the facility. However, the billing process also allowed the provider to bill and be paid for up to 52 days of leave each year for each client. This appears to have been a duplication of payments for client leave time. The 80 hours of consumer leave added \$.46 or 2% to the total rate.
- The rate calculation included an increase in direct supervision hours by 80 hours for client leave time. Client leave time does not affect the amount of direct supervision needed and shouldn't increase the rate paid. This 80 hours of consumer leave added \$.07 to the total rate.
- The rate calculation included an increase in the direct supervision hours by a factor of 1.5 to allow for the pre and post intervention hours of the service provider. This factor is not needed as it overstates the supervision needed for the pre and post intervention time of the service provider. This factor added \$.52 or 2% to the total rate.

In total, 4% of the rate calculation appears to be unneeded or duplicated costs.

We recommend HHS do an intensive review of the rate methodology calculation for reasonableness. In addition, we recommend HHS obtain documentation to support all numbers and amounts used in the calculation.

HHS'S RESPONSE: HHS DOES NOT AGREE AN EXTENSIVE REVIEW OF THE METHODOLOGY RATE CALCULATION IS NEEDED. CURRENT PROVIDER REIMBURSEMENT RATES ARE NOT ONLY LESS THAN THE METHODOLOGY RATES BUT THEY ARE INTERIM RATES IN BILLING HCFA FINANCIAL PARTICIPATION (FFP) OF THE CLAIMS.

6. Bidding of Provider Services

Executive Order 95-4 directs all State agencies use an open competitive process for bidding services in excess of \$25,000.

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6. Bidding of Provider Services (Concluded)

During our audit, we noted HHS did not bid out Developmental Disability services during the fiscal year. Instead, HHS established the rate to be paid to each provider and then placed clients in those providers' facilities as needed. In 1992, HHS determined rates for similar services should be the same throughout the State. HHS contracted with Deloitte and Touche, LLP, for consultation on rate setting methodologies for paying for the services. Services were then contracted with providers at the methodology rates established during the consultation.

While the rate methodology process did provide some rate equity throughout the State, HHS cannot provide any documentation to support this process provided cost savings to the State. In fact, competitive bidding of services could have provided savings to the State.

We recommend HHS implement procedures to ensure quality services are provided at the lowest cost to the State. This could include bidding the services, but capping the rates at the rates established in the consultation methodology.

HHS'S RESPONSE: HHS DISAGREES THAT DD SERVICES SHOULD BE BID OUT AND THAT THERE IS NO DOCUMENTATION TO SUPPORT SAVINGS. THE HHS CONTROLS AND CAPS UNIT RATES CONTRACTED WITH PROVIDERS. HHS ALSO DETERMINES THE NUMBER OF UNITS AUTHORIZED FOR AN INDIVIDUAL BASED UPON AN OBJECTIVELY ASSESSED NEED.

7. Accounting for Federal Draw Downs

During our audit, we noted HHS billed HCFA for Medicaid waiver Developmental Disability costs through Fund 4000 and transferred the money into Fund 4812. Payments to the service providers were then made from Fund 4812. The amount of Medicaid drawdowns and provider payments were calculated slightly differently and resulted in different amounts. HHS did not reconcile the activity in these two funds. For services provided between June 1, 1997 and May 31, 1998, HHS paid providers a total of \$40,509,698 in federal funds from Fund 4812, but Medicaid draw downs totaled \$40,424,731 for a difference of \$84,967.

The difference appears to be that HHS billed HCFA for adult Medicaid waiver Developmental Disability costs based on the number of days of services provided, while HHS pays the providers based on the number of hours of service provided. The conversion of billable hours to billable days resulted in a difference between the amount billed to HCFA and the amount paid to the providers. However, HHS did not reconcile this difference.

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7. Accounting for Federal Draw Downs (Concluded)

Sound business practices require provider payments be reconciled to federal reimbursements. In addition, sound accounting practices would suggest the provider payments be made directly from the Fund used to draw down Federal payments.

We recommend HHS make payments to providers directly from Fund 4000, as part of the Medicaid draw down process.

We recommend HHS reconcile on a regular basis the total HCFA draw downs to the total vendor payments or take the steps necessary to use the same basis for both the HCFA billing and the provider billing.

We also recommend HHS reconcile the balance in the program's Fund 4812 and properly distribute those balances.

HHS'S RESPONSE: HHS DISAGREES THAT HHS SHOULD MAKE PAYMENTS TO PROVIDERS DIRECTLY FROM FUND 4000. A RECONCILIATION IS MADE IN FUND 4812 OF PAYMENTS TO PROVIDERS AND CLAIMS TO HCFA.

8. Quality Review Teams

HHS's regulations for organizing and implementing services for persons with developmental disabilities section 205 NAC 2-006 and State Statute Section 83-1213, R.R.S. 1994, establish Quality Review Teams to promote the quality of services being provided to clients. NAC regulations state an annual quality-of-life survey is to be conducted of all clients receiving services in the region.

Our review noted, during the fiscal year ending June 30, 1998, HHS had established nine Quality Review Teams that reviewed the quality-of-life in 15 different provider residential facilities. However, during the fiscal year there were 27 providers and approximately 600 total provider residential facilities. Therefore, Quality Review Teams monitored the services being provided in only 3% of the total provider residential facilities.

We recommend HHS take steps to ensure all persons receiving services have a quality-of-life review done on a regular basis by a Quality Review Team.

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8. Quality Review Teams (Concluded)

HHS'S RESPONSE: HHS DISAGREES. QUALITY REVIEW TEAMS (QRT) ARE EXPANDING AS RESOURCES WILL ALLOW. IN ADDITION TO QRT, HHS CONTRACTS WITH THE ARC OF NEBRASKA TO PRODUCE THE PROVIDER PROFILE. THE PROVIDER PROFILE INCLUDES THE QUALITY OF LIFE SURVEY RESULTS THAT IS CONDUCTED FOR ALL PERSONS RECEIVING SERVICES FUNDED THROUGH THE DD SYSTEM.

9. HHS Internal Audits of Providers

HHS performed an internal audit of a service provider in June, 1998, after questions were raised whether the provider had enough staff working in its facility to provide the contracted number of service hours. Our review of this service provider audit and HHS's internal audit process noted the following:

- The internal audit was performed on a provider location, which is all facilities for a specific provider in one city.
- Internal audits have been done on a very limited basis, and have not been done on all providers. In fact, only one of approximately 67 provider locations was audited during the fiscal year ending June 30, 1998.
- The providers were never formally informed that internal audits could be done and were not informed as to the type of personnel and time records they should be maintaining.
- The provider audited had major concerns with HHS's assumption that 1.5 hours of staff time is needed for each 1 hour of non-intervention services being provided. This assumption greatly affects the number of staff needed by a provider to provide the contracted hours.

HHS's contracts with the providers allow HHS to audit or inspect the records of the providers. In addition, sound business practices require an entity insure contracted services are provided. This can be accomplished by performing on site visits and audits of the providers.

We recommend HHS perform on a regular basis an internal audit of all providers. Also, HHS should be more specific when informing the providers as to what records the providers should be maintaining.

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9. HHS Internal Audits of Providers (Concluded)

We also recommend HHS review the assumption that 1.5 hours of staff time is needed for each 1 hour of non-intervention services being provided. If this assumption is revised, HHS will also need to amend the rate calculation, as this assumption is also included in calculating the contracted rates.

HHS'S RESPONSE: HHS AGREES TO REVIEW THE INTERNAL AUDIT PROCESS. HOWEVER, HHS DISAGREES THAT THE PROVIDER IS USING THE ASSUMPTION THAT 1.5 HOURS OF STAFF TIME IS NEEDED FOR ONE HOUR OF INTERVENTION.

10. Ability to Pay Procedures

State Statute Section 83-1211 R.R.S. 1994, requires that the person receiving services and their relatives are responsible for the cost of and determination of their ability to pay for the services being provided. In order to comply with this statute, HHS established policies for determining an individual's ability to pay assessment, which are found in Rules and Regulations, 202 NAC 1.

Our review of HHS's procedures for determining an individual's ability to pay and HHS's procedures for collecting these assessments noted the following:

- HHS's Financial Responsibility staff determined the ability to pay for Developmental Disabilities services as established in the NAC and sent monthly billings/statements for these services. However, HHS staff was taking no additional measures to collect unpaid accounts. As of March 3, 1999, there were 511 accounts with total outstanding balances of \$3,442,915. Of this amount, \$3,082,290, or 90% was more than 90 days outstanding and one account had a past due balance of \$243,439.
- HHS informally made changes to three sections of 202 NAC 1 without amending the NAC as required by State Statute Section 84-907, R.R.S. 1994. These changes increased the amount of assets excluded from a person's total assets, waived parents' assessments for the first 12 months of services provided, and reduced the parents' assessment after 12 months of service.

We recommend HHS take direct steps to collect the outstanding ability to pay balances. This may include sending specific collection letters and taking legal action.

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10. Ability to Pay Procedures (Concluded)

We also recommend HHS take steps to formally amend the NAC for any changes that have been made and make no further changes to the NAC until the changes have been formally approved as required by statute.

HHS'S RESPONSE: HHS AGREES TO TAKE DIRECT STEPS TO COLLECT OUTSTANDING BALANCES. RULE CHANGES HAVE ALREADY BEEN DRAFTED, PRESENTED FOR COMMENTS, APPROVED BY FINANCE AND SUPPORT AND ARE CURRENTLY AT REGULATION ANALYSIS AND INTEGRATION FOR REVIEW.

11. Ability to Pay Receipt Procedures

Our review of HHS's procedures for processing ability to pay assessments received noted the following:

- No one in the Financial Responsibility division that collected and processed these payments was ensuring all deposits were correctly recorded in the Nebraska Accounting System (NAS).
- A clerk in the Financial Responsibility division opened the mail, separated the mail by area, and ran an adding machine tape of checks for each area. The checks, correspondence, and adding machine tapes were then sent to a second clerk who processed/recorded the collections after verifying the total of the checks to the adding machine tape. The adding machine tape generated by the clerk opening the mail was then discarded.

Good internal controls include a plan of organization, procedures and records designed to safeguard assets and provide reliable financial records. This includes verifying that all documents processed are properly recorded in the accounting records and maintaining all documentation that indicates controls were in place. Without these controls, there is an increased risk of loss or misuse of State funds.

We recommend HHS verify all deposits are properly posted to NAS and retain all adding machine tapes, as they are the initial record of the amount of money received each day.

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11. Ability to Pay Receipt Procedures (Concluded)

HHS'S RESPONSE: HHS AGREES AND A TAPE IS BEING USED AND MAINTAINED ON FILE. ACCOUNTING IS INVESTIGATING IF VERIFICATION PER DEPOSIT IS BEING CONDUCTED.

12. Provider Billing System Procedures

Our review of the provider billing computer system noted access to the billing system was controlled through the use of user ID numbers. During the audit period nine employees had authorized access to the system. Of these nine, two were information systems support staff, one worked with provider payments and billings, one worked with client registration, one was the Developmental Disability Manager, and four worked with ability to pay billings and collections. However, we also noted that once an employee was authorized access to the system that employee had access to all areas of the system including client information, provider billings and payments, and third party billings and collections. This could result in someone accessing and changing information from an area they normally do not work with.

Good internal controls require access to computer systems be controlled and limited to only those employees authorized to make changes to the system.

We recommend HHS review all employees' access to the system and ensure employees have the ability to make changes only in those areas they directly work with.

HHS'S RESPONSE: HHS AGREES THAT, ONCE AN EMPLOYEE IS AUTHORIZED TO ACCESS ECHO, THE EMPLOYEE HAS ACCESS BEYOND THEIR IMMEDIATE NEED OR RESPONSIBILITY. HHS IS CURRENTLY REVIEWING METHODS TO ESTABLISH SECURITY PROFILES TO LIMIT RISK OF ACCIDENTAL ERRORS. IN THE MEAN TIME, RISK IS MANAGED THROUGH TRAINING OF THE LIMITED NUMBER OF STAFF AUTHORIZED TO ACCESS ECHO.

13. Outside Audits of Providers

HHS's contract with service providers requires all contractors file an OMB Circular A-133 audit with HHS. During our review of these provider audits, we noted one of the four providers we tested had a financial audit on file which did not meet all the requirements of OMB A-133, such as including a report on compliance with rules and regulations. The other three audits tested did meet OMB A-133 requirements.

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13. Outside Audits of Providers (Concluded)

We recommend HHS ensure all providers comply with the contract terms and have an annual OMB A-133 audit performed and filed with HHS.

HHS'S RESPONSE: THE PROVIDER WILL BE NOTIFIED FOR A COPY OF THE A-133 AUDIT.

14. Client Leave Days

HHS's service provider billing document procedures say the State will pay the service providers for up to 52 days when the client is on leave from the provider's facility. This is intended to allow the provider to continue to fully staff a facility even if certain clients are on leave.

Our review of HHS's procedures for recording leave days paid noted the provider billing system did accumulate the number of leave days paid for each client and stopped leave day payments once the 52 day maximum had been reached. However, the billing system did not generate any reports to document the total number and costs of leave days paid. HHS estimated 200 clients reached the maximum 52 days during the fiscal year ending June 30, 1998.

Without complete documentation of the number and costs of leave days paid, HHS management can not know the total effect of the decision to pay up to 52 days of service when the client is on leave.

We recommend HHS annually document the number and costs of leave days paid to providers each year.

Additionally, we recommend HHS use this information to evaluate the reasonableness of the practice of paying for up to 52 days of client leave.

HHS'S RESPONSE: HHS AGREES 52 LEAVE DAYS PER YEAR MAY BE AUTHORIZED FOR PERSONS WHO ARE RECEIVING SERVICES IN ASSISTED SERVICE SETTINGS. HOWEVER, WE DISAGREE THAT HHS SHOULD EVALUATE THE REASONABLENESS OF THE PROCESS FOR PAYING THE LEAVE DAYS. FIFTY-TWO LEAVE DAYS PER PERSON PER YEAR FOR THOSE PERSONS IN ASSISTED SERVICE SETTINGS IS REASONABLE.

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15. Internal Quality Reviews of the Local Field Offices

HHS's policy and procedures, 205 NAC 2 – 009, says the developmental disabilities division will develop and implement an internal quality improvement plan to monitor the performance of each local field office to identify and implement the steps necessary to enhance system wide performance.

Our review of the program's procedures noted no such quality improvement plan had been formally developed or implemented.

We recommend HHS develop and implement a quality improvement plan to monitor the local field offices.

HHS'S RESPONSE: HHS DISAGREES. THE DD SYSTEM HAS IMPLEMENTED QUALITY ASSURANCE ACTIVITIES THAT ARE SUPPORTED BY PROCEDURES. THESE DOCUMENTED ACTIVITIES INCLUDE BUT ARE NOT LIMITED TO MONTHLY MONITORING TO ENSURE THAT SERVICES ARE PROVIDED AND DOCUMENTED. THERE IS A SUPERVISORY REVIEW OF SAMPLES OF INDIVIDUAL PROGRAM PLANS. THERE IS MONITORING OF MEDICAID WAIVER ELIGIBILITY, AUTHORIZATION, AND UTILIZATION.