ATTESTATION REPORT
OF THE
NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
PROGRAM 348 – MEDICAL SERVICES/AID

JULY 1, 2004 THROUGH JUNE 30, 2005

Issued on June 13, 2006

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
PROGRAM 348 - MEDICAL SERVICES/AID

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BACKGROUND

Budget Program 348 reflects payments made through the Medicaid program (Title XIX of the Social Security Act) for allowable medical services delivered to low-income persons meeting specific eligibility requirements. Eligibility requirements vary by age, income level, medical need, and medical status. The Health and Human Services System (HHSS) Department of Finance and Support (Department) pays the Medicaid provider directly for services provided. Certain medical services must be covered by State Medicaid programs to obtain Federal financial participation. Coverage of services beyond those required is a State option. Nebraska covers 24 optional services. Expenditures of State funds are matched with Federal funds on a percentage basis that is adjusted annually.

Program 348 also includes the Nebraska Tobacco Settlement Fund, which receives money from a 1998 settlement with the tobacco industry that was a result of states' efforts to recoup money spent to care for ill smokers, and the Nebraska Medicaid Intergovernmental Trust Fund, which accounts for money received under an arrangement with government-operated nursing homes to increase Medicaid dollars received from the Federal government. Annually, the State transfers a total of $50 million from the Tobacco Settlement Fund and the Medicaid Intergovernmental Fund to the Nebraska Health Care Cash Fund.

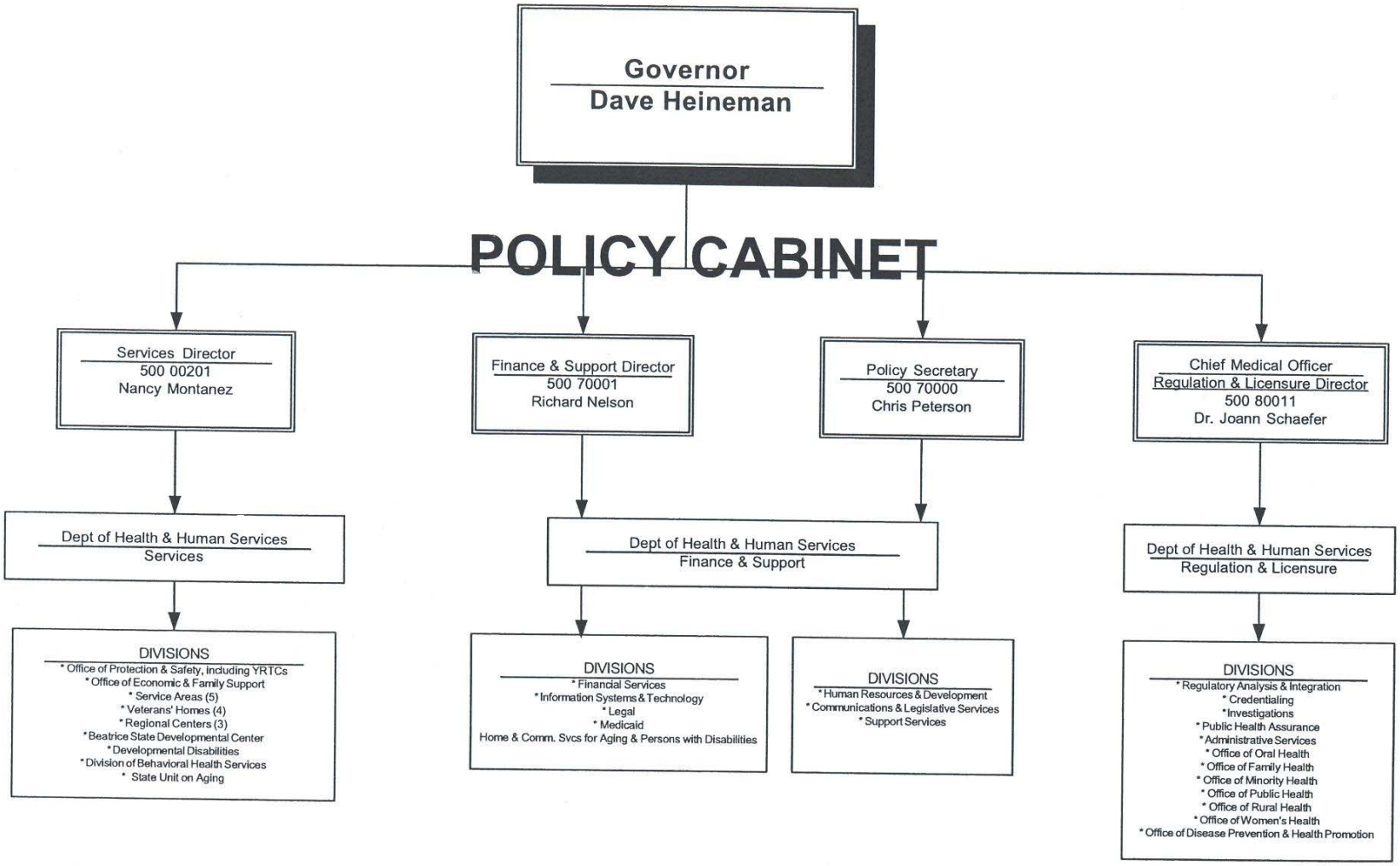
Program 348 reflects only aid payments for Medicaid services and does not include: the Childrens' Health Insurance Program 344; administrative expenditures accounted for in Program 341 Administration of Public Assistance; or the State matching for Medicaid of the Beatrice State Developmental Center accounted for in Program 421 Developmental Disability System.

MISSION STATEMENT

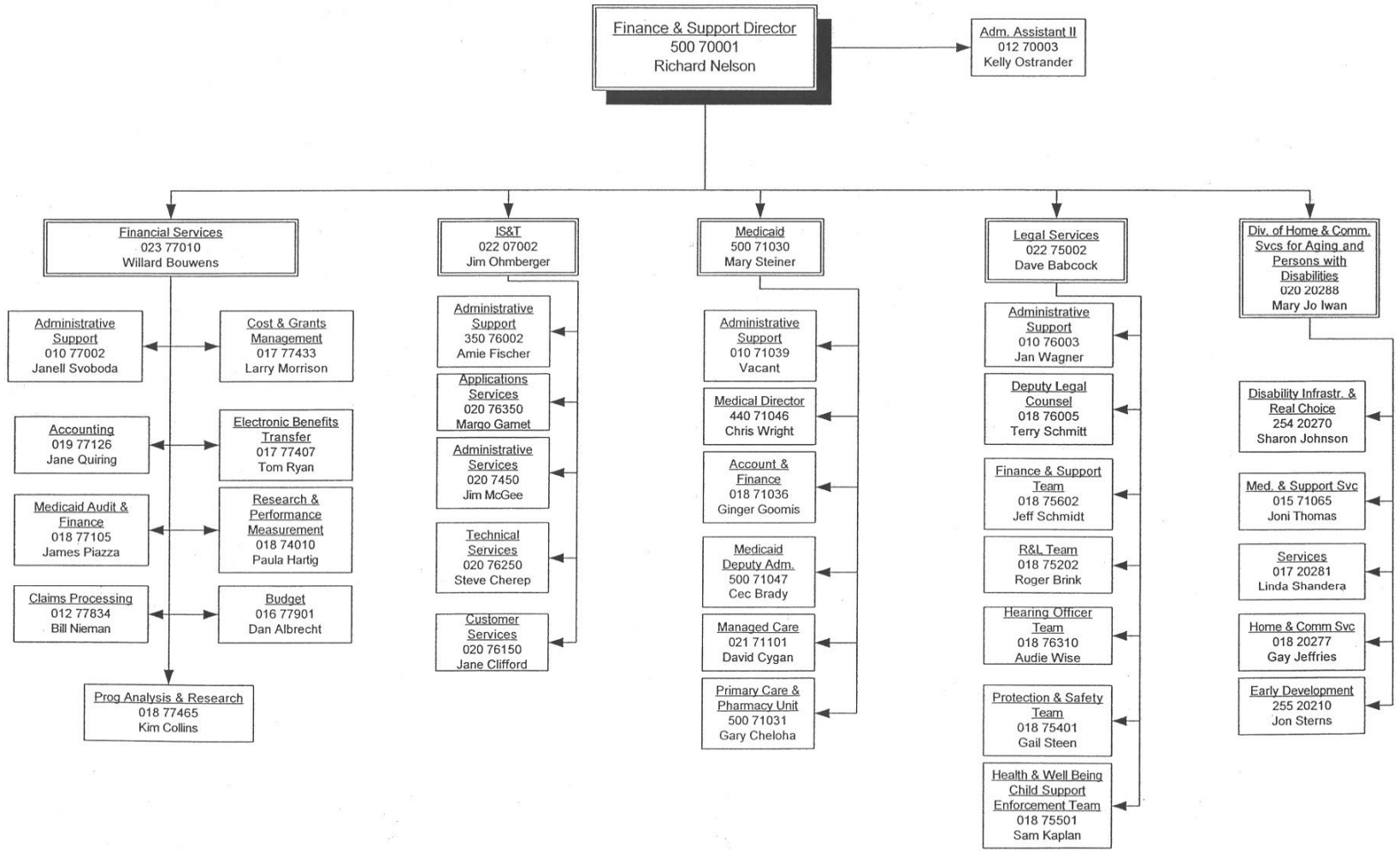
"We help people live better lives through effective health and human services."

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
PROGRAM 348 - MEDICAL SERVICES/AID

ORGANIZATIONAL CHARTS



ORGANIZATIONAL CHARTS



EXIT CONFERENCE

An exit conference was held May 11, 2006, with the Program to discuss the results of our examination. Those in attendance for the Nebraska Health and Human Services System - Program 348 - Medical Services/Aid were:

NAME	TITLE
Mary Steiner	Medicaid Director, HHS F & S
Willard Bouwens	Administrator – Financial Services
Mary Jo Iwan	Administrator Home & Community Services
Linda J. Shandera	LTCSC Program Manager Home & Community Services
Gaylene R. Jeffries	Administrative 1 – HCS Division
Kay Wessel	MMIS Business Manager
Sandi Kahlandt	Medicaid Unit Manager
Kris Azimi	Services Unit Manager
George Kahlandt	Administrative, Economic Assistant
Kim Collins	Program Analysis & Research Administrator
Mike Harris	Deputy Administrator, OEFS
Duane Singsaas	Performance Measurement Consultant
Larry Morrison	Cost Accounting Manager
Lois Hanson	MMIS Technical Unit Manager
Patricia Darnell	Medicaid Claims Processing Administrator
Cecile Brady	Deputy Administrator
Don Swartz	Accounting and Finance Manager
Dale Shallenberger	Audit Supervisor
Tom Jurgens	Accounting & Finance Manager
Margo Gamet	IS & T Application Services Manager
Daryl Wusk	OEFS Administrator
Jenifer Roberts-Johnson	Legal
David Cygan	Managed Care Administrator
Ginger Goomis	Medicaid Administrator

SUMMARY OF COMMENTS

During our examination of the Nebraska Health and Human Services System - Program 348 - Medical Services/Aid, we noted certain matters involving the internal control over financial reporting and other operational matters which are presented here.

1. ***Questionable Financing Arrangements:*** Some states have used creative financing schemes that take advantage of statutory and regulatory loopholes to claim excessive Federal matching payments. We noted two financing arrangements, UNMC DSH and ICF-MR Tax, which appear to be questionable.

2. ***Questionable Accounting Practices:*** In June 2004, the Department transferred $7 million from Federal funds to the State General Fund, which was "paid back" in 2005; as a result, aid expenditures for fiscal year 2005 are overstated by $7,000,000 in the General Fund and are understated in the Federal Fund. In addition, the financial schedule includes $1,161,611 of aid expenditures in the Federal Clearing Fund, which should have been recorded as an adjustment to the fund balance. Therefore, Total Aid Expenditures are overstated on the financial schedule. We further noted $9,826,469 was reported to the Federal regulatory agency as Medicaid expenditures; however, a corresponding entry was not made on NIS to record these costs.

3. ***Reconciliation Procedures Should be Improved:*** The Department prepares the Federal report using total expenditures and multiplies by the applicable Federal percentage to report the allocation between Federal and State funds. There is no reconciliation to ensure the Federal reports agree to NIS.

4. ***Incorrect Payments to Providers:*** Overpayments were noted for 13 of 151 claims tested with a dollar error of $19,918 and an extrapolated error of $11,929,153.

5. ***Claims Paid After Recipient's Death:*** During our testing of practitioner claims, we noted 1 of 45 claims were paid to a provider for services to a recipient who was deceased.

6. ***Payments for Bedholding:*** For six of nine individuals tested with hospital stays over 15 consecutive days, each payment to the nursing facility was overpaid for bedhold days, a 67% error rate.

7. ***Transportation Services:*** Claims for transportation services were not adequately reviewed. We were unable to verify the payment amount or rate was correct for three transportation claims tested and one transportation provider was paid twice for the same services. We also noted services for this same provider appeared unreasonable.

8. ***Retroactive Settlement Payments Incorrectly Calculated:*** Retroactive settlement payments to Hastings Regional Center and Lincoln Regional Center were incorrect.

SUMMARY OF COMMENTS
(Continued)

9. ***Recipient Share of Cost:*** We noted 2 of 14 claims tested that required share of cost did not have the recipient's share of cost applied to the claims, resulting in overpayments of $2,486.

10. ***Personal Assistance and Chore Services:*** Of the 15 claims tested, 10 had one or more exceptions noted; a 66% error rate.

11. ***Early Intervention Program:*** We noted service coordination expenses for the Early Intervention Program were reported twice on the Federal CMS 64 report. The payroll for these six employees were reported as administration expenditures and reported again as service coordination aid expenditures resulting in duplicate reporting on the Federal report.

12. ***Mental Health Practitioners:*** The Department did not have adequate procedures to ensure claims paid to Provisional Licensed and Licensed Mental Health Practitioners were reasonable and proper.

13. ***Lack of Segregation of Duties Over Receipts:*** One employee, who handles the Other Over-Payments from Providers, receives checks, makes the adjustments in MMIS, and reviews the entries made in MMIS. This employee is involved in all the key processes of MMIS Provider receivables.

14. ***Provider Agreements Not on File:*** We noted 5 of 127 provider claims tested did not have an approved agreement on file.

15. ***NIS Security:*** Our review of NIS security authorizations at June 30, 2005, noted 14 employees could prepare and approve their own transactions on NIS; 8 of these were corrected in July 2005. We also noted 11 employees had NIS user security to prepare transactions, but no one was set up on NIS for batch approval of these transactions.

16. ***Outstanding Warrants:*** The Department did not follow up on outstanding warrants.

17. ***CAFR and Statewide Single Audit Findings:*** Findings were noted in the Fiscal Year Ended June 30, 2005, State of Nebraska CAFR and Statewide Single Audit regarding general computer controls, Medicaid eligibility, and Medicaid reporting.

18. ***Reconciliation of Bank Records to the Nebraska Information System:*** The Department of Administrative Services' reconciliation process is still not done in a timely manner and continues to reflect unknown variances.

SUMMARY OF COMMENTS
(Continued)

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

Draft copies of this report were furnished to the Program 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, the Program 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 examination.

We appreciate the cooperation and courtesy extended to our staff during the course of the examination.

COMMENTS AND RECOMMENDATIONS

1. Questionable Financing Arrangements

The following are excerpts from the Government Accountability Office (GAO) report number GAO-04-574T entitled "Medicaid: Intergovernmental Transfers Have Facilitated State Financing Schemes" which was released on March 18, 2004.

> For many years states have used varied financing schemes, sometimes involving IGTs, to inappropriately increase federal Medicaid matching payments. Some states, for example, receive federal matching funds on the basis of large Medicaid payments to certain providers, such as nursing homes operated by local governments, which greatly exceed established Medicaid rates. In reality, the large payments are often temporary, since states can require the local-government providers to return all or most of the money to the states. States can use these funds--which essentially make a round-trip from the states to providers and back to the states--at their own discretion.
>
> States' financing schemes undermine the federal-state Medicaid partnership, as well as the program's fiscal integrity.
>
> The schemes effectively increase the federal matching rate established under federal law by increasing federal expenditures while state contributions remain unchanged or even decrease.
>
> There is no assurance that these increased federal matching payments are used for Medicaid services, since states use funds returned to them via these schemes at their own discretion.

During our review, we noted two financing arrangements which appear to be questionable.

The State made a $12,567,008 disproportionate share (DSH) payment to the University of Nebraska Medical Center (UNMC). DSH payments are provided per Section 1902(a) and Section 1923 of the Social Security Act to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs. Nebraska distributes the DSH payments using a pool calculation per Rules and Regulations 471 NAC 10-010.03H. Neb. Rev. Stat. Section 85-134 R.S.Supp., 2004, established the UNMC Medical Education Revolving Fund to be administered by the Department of Health and Human Services Finance and Support. The fund shall be used to fund medical education. The DSH payment of $12,567,008 was made UNMC on June 17, 2005. The University then deposited $12,567,008 to the UNMC Medical Education Revolving Fund. On June 22, 2005, the Department prepared a journal entry which transferred the money from the UNMC Fund to the State General Fund. The entry was coded as an expenditure from the UNMC Fund and was coded as a negative expense in the General Fund. The initial expenditures for medical education were made from General and Federal funds.

COMMENTS AND RECOMMENDATIONS
(Continued)

1. Questionable Financing Arrangements (Continued)

While there does not appear to be a violation of Federal regulations, there was no written agreement with UNMC regarding the deposit of funds, which appears to be a return of the DSH payment to the State. Furthermore, the initial expenditures, were made from both General and Federal funds, and were reported to CMS as State and Federal expenditures.

2004 Neb. Laws LB 841 required each intermediate care facility for the mentally retarded (ICF-MR) to pay a tax equal to six percent of its revenue. Total tax collected for the fiscal year ended June 30, 2005, was $3,357,698. Per LB 841, the tax proceeds were distributed $55,000 to the the Department for administration of the fund; $1,351,167 to the General Fund for the State share of rate increase paid to ICF-MRs for the cost of the tax; $300,000 for a one-time increase in payment to non-state-operated ICF-MR; $312,000 for payment to providers of community-based services for the purpose of reducing the waiting list of persons with developmental disabilities; and $1,346,571 money remaining in the fund after the required allocations transferred to the General Fund. Again, although State and Federal regulations were not violated, this appears to be a financing scheme as described by the GAO. The State matching funds are immediately repaid, but the increase for the tax is repaid by Federal and State dollars; the net effect is an increase in Federal expenditures without a corresponding increase in State dollars; thereby decreasing the effective match rate. An estimate of the effect for fiscal year 2005 is an additional $3,093,937 received by the State and an additional $750,000 received by the private provider of ICF-MR services, funded by an increase of $3,843,937 from the Federal government. We do not believe the Federal regulatory agency fully understood the ramifications of this tax.

When questionable financing arrangements are used, there is an increased cost to the Federal government and taxpayers, with limited accountability by the State for the funds.

> We recommend the Department review these arrangements in depth with the appropriate Federal regulatory agencies to ensure transactions are proper.

Department's Response: The Medicaid State Plan amendment to provide for a separate pool that includes the Nebraska Medical Center was thoroughly reviewed by the federal Centers for Medicare and Medicaid (CMS) prior to their approval. The change was triggered by legislative intent from the Nebraska Legislature that HHSS continue to include direct and indirect medical education as a component of the DRG inpatient hospital payment for Medicaid.

The ICF/MR provider tax arrangement was directed by state statute and also approved by CMS prior to implementation. The Department consulted with CMS while state legislation was under debate to determine what provisions would be acceptable to the federal agency. The Legislature specifically tied implementation of the tax to federal approval as articulated in Section 6 of

COMMENTS AND RECOMMENDATIONS
(Continued)

1. Questionable Financing Arrangements (Concluded)

Department's Response, Concluded:
Legislative Bill 841. Department staff worked closely with CMS personnel over a period of six months after the passage of the bill to ensure that Nebraska's provider tax arrangement met federal guidelines.

These funding mechanisms have been used to reimburse providers for health care services. They do not constitute "questionable" financing arrangements. IGT and CPE arrangements are reviewed in depth by CMS personnel, who have determined Nebraska's mechanisms to be appropriate.

CMS is the federal agency with jurisdiction over administration of state Medicaid programs. The Government Accountability Office (GAO) advises Congress but has no direct relationship with or authority over Medicaid; it would be inappropriate for HHSS to review Medicaid financing arrangements with GAO.

2. Questionable Accounting Practices

Good internal control and sound accounting practices require governments to provide accurate financial reporting and fiscal accountability to demonstrate compliance with public decisions and regulatory authorities for the raising and spending of public monies. State participation rates apply to medical assistance payments. The Federal financial participation rate at June 30, 2005, was 59.64%. CMS-64, *Quarterly Statement of Expenditures for the Medical Assistance Program* is required to be prepared quarterly and submitted electronically to CMS within 30 days after the end of the quarter. Title 45 CFR 92.20 requires fiscal control and accounting procedures to permit preparation of reports required. Accurate, current, and complete disclosure of the financial results of financially assisted activities must be made in accordance with the financial reporting requirements of the grant.

During our review of journal entries, we noted:

- In June 2004, the Department transferred $7,000,000 from the Federal Fund to the General fund by reducing aid expenditures paid from the General Fund and charging the expenditures to the Federal Fund. It appeared the Department did not have sufficient General Funds remaining in the 2004 allotment to cover the expenses. In July 2004, the Department reversed the journal entry and "paid back" the Federal Fund; however, journal entries were subsequently prepared so that $3,500,000 was repaid in August, $1,750,000 was repaid in October, and the remaining $1,750,000 was repaid in April 2005. As noted, these transactions were recorded in the government aid account; therefore, government aid expenditures for fiscal year 2005 are overstated by $7,000,000 in the General Fund and are understated in the Federal Fund.

COMMENTS AND RECOMMENDATIONS
(Continued)

2. Questionable Accounting Practices (Continued)

- The Department records refunds and adjustments in the Federal Clearing Fund until the proper disposition can be determined. Monies are then transferred to the original fund from which the expenditure was made. Although Neb. Rev. Stat. Section 81-1121(7) R.S.Supp., 2004 provides for the refunds to be credited, the fund and account from which the disbursement was made as an adjustment to expenditures and not as a receipt, the statute does not provide for accounting in the Federal Clearing Fund. From the period March 2003 through October 2004, the Department accounted for these funds as an adjustment to expenditures in the Federal Clearing Fund, and not as a liability (Due to Fund), nor were the monies correctly transferred. In April 2005, the Department initiated a journal entry to correct the balance of the Federal Clearing Fund and transfer the monies to the proper fund; however, the Department adjusted the Federal Clearing Fund expenditure account rather than adjusting the fund balance. As a result, the financial schedule includes $1,161,611 of aid expenditures in the Federal Clearing Fund, which should have been recorded as an adjustment to the fund balance. Therefore, total aid expenditures are overstated on the financial schedule.

- The Department identified $9,826,469 of State disability claims paid from January 2003 through March 2005 that were Medicaid allowable. These claims were reported on the CMS-64 to the Federal regulatory agency with $3,747,399 reported as State expenditures and $6,079,070 Federal expenditures; however, a journal entry was only prepared to transfer the fiscal year 2005 General Fund expenditures of $914,128 from the State disability program to the Medicaid program. Therefore, the Federal reports do not agree with State accounting records and Federal expenditures have been charged, but Federal funds have not been drawn for these claims.

Inadequate accounting increases the risk for noncompliance with appropriation limits, Federal sanctions, and incorrect financial statements.

We recommend the Department implement procedures to ensure accurate financial reporting and fiscal accountability.

Department's Response: We disagree with the finding on the Federal Clearing Fund. The Department was correcting a prior period adjustment when the error was initially made during the deposit. We made this correction in accordance with the State Accounting Manual Policy AM-005 #7. This was to ensure that expenditures were not recorded twice. Additionally, the State did report and has drawn the Federal funds supporting the State Disability Program.

APA's Response: The correction was not made in accordance with State Accounting Manual Policy AM-005 #7. AM-005 #7 requires material adjustments to be made to fund

2. Questionable Accounting Practices (Concluded)

APA's Response, Concluded:
equity and nonmaterial adjustments corrected using the Miscellaneous Adjustments account. The Miscellaneous Adjustments account is a revenue account, but the Department made an adjustment to the expenditures account.

3. Reconciliation Procedures Should be Improved

Title 45 CFR 92.20 requires fiscal control and accounting procedures of the State sufficient to permit preparation of required reports and permit the tracing of funds to expenditures adequate to establish the use of these funds were not in violation of applicable regulations. The Nebraska Information System (NIS) is the official accounting system of the State and all expenditures are generated from NIS. Good internal control requires timely, periodic reconciliations between required reports and the accounting system.

The Department utilizes the Medicaid Management Information System (MMIS), the NFOCUS system, and NIS to prepare the quarterly Federal reports to the Center for Medicare and Medicaid Services (CMS). The Department reconciles NIS and NFOCUS batches daily, and reconciles MMIS to NIS monthly; however, no reconciliation is performed between the Federal reports to NIS.

Our review of Medicaid aid expenditures reported compared to NIS noted:

Aid Expenditures	Federal	State	Total
Reported to CMS {adjusted}	$ 866,967,357	$ 554,737,692	$ 1,421,705,049
Per NIS	$ 872,472,963	$ 547,443,000	$ 1,419,915,963
Variance Over/(Under) Paid	$ 5,505,606	$ (7,294,692)	$ (1,789,086)

The Department prepares the Federal report using total expenditures and multiplies by the applicable Federal percentage to report the allocation between Federal and State funds. There is no reconciliation to ensure the Federal reports agree to NIS. A similar finding was noted in our prior report and a cursory review of fiscal year 2004 also noted a significant variance. In addition, a review by quarter also noted large variances.

Without adequate controls, there is an increased risk for misuse of funds and inaccurate reporting. In addition, the State could be subject to Federal sanctions.

We recommend the Department perform a quarterly reconciliation of Medicaid aid expenditures reported to NIS.

COMMENTS AND RECOMMENDATIONS
(Continued)

3. Reconciliation Procedures Should be Improved (Concluded)

Department's Response: Financial Services agrees with the recommendation. Beginning Q2 2006, a CMS64 NIS Reconciliation Summary Report will be developed to identify source documents (NFocus, MMIS, spreadsheets, etc.) and NIS account numbers used to report the expenditures contained in the CMS-64 Report. Once developed, this report will be reviewed with administrative staff and subsequently filed with applicable CMS64 Report binders for future reference and audit purposes.

Target Implementation Date: End of Q3 2006.

4. Incorrect Payments to Providers

Title 471 Nebraska Administrative Code (NAC) 33-002.07 states, "The Nebraska Medical Assistance Program (NMAP) pays for covered HEALTH CHECK services … at the lower of-

1. The provider's submitted charges; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule for that date of service."

Per Title 471 NAC 34-004.02 payments to Independent Rural Health Clinics are paid "at the reasonable cost rate per visit as established by Medicare."

Per Title 471 NAC 34-004-01 payments to Provider-Based Rural Health Clinics are paid to "clinics that are associated with hospitals under 50 beds at the lower of cost or charges as established by Medicare."

Per Title 471 NAC 3-004.03 "Medicaid clients who have third party resources must exhaust these resources before Medicaid considers payment for any services. Medicaid shall not pay for medical services as a primary payor if a third party resource is contractually or legally obligated to pay for the service." The Center for Medicare and Medicaid Services (CMS) Third Party Liability (TPL) Overview also states, "The Medicaid program by law is intended to be the payer of last resort; that is, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid." Good internal controls require funds from liable parties be properly recovered.

Per Title 471 NAC 6-005, "A maximum fee is covered per tooth for any combination of amalgam or resin restoration procedure codes. The maximum fee is equal to the Medicaid fee for a four or more surface restoration." Per Title 471 NAC Fee Schedule for Dental Services amalgam-two surfaces, primary procedure had a maximum allowable rate of $53 and amalgam-four or more surfaces primary procedure had a maximum allowable rate of $70.

The contract rate for psychotherapy office visit was $57. Good internal control requires Medicaid to pay according to the contracted amount.

4. Incorrect Payments to Providers (Continued)

Good internal control also requires amounts paid be in accordance with NAC Fee Schedules or supporting documentation be available to support rates paid.

During our review of 151 Medicaid claims, we noted the following:

- One of three Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) claims tested was overpaid $53. Procedure was paid at $11.99/mg for 150 units, or $1,799. Per the NAC Fee Schedule for Physician Services, the rate per unit was $11.64/mg, which would have calculated a maximum allowable cost of $1,746.

- Two of six Outpatient claims tested were overpaid by a total of $136.

- One of two claims were paid to an Independent Rural Health Clinic in the amount of $69. All Rural Health Clinics send an annual Cost Report to Medicare, which is used to determine the encounter rate to be paid for each visit. Medicare sends a letter to the clinic notifying them of their encounter rate and the clinic sends a copy of the letter to Medicaid as documentation for the rates they are to be paid. The rates are entered into MMIS and used to determine payment for Independent Rural Health Care services. There was no documentation available of the rate assigned by Medicare to ensure the proper rate was paid.

- The other claim tested was a payment to a Provider-Based Rural Health Clinic in the amount of $67, which was the actual cost submitted on the claim. There was no support for the Medicare rate to determine the actual costs were less than the Medicare rate to verify the lesser of the two rates was properly paid.

- One of four Hospital Inpatient claims tested were overpaid by $4,200. Recipient had insurance and Medicaid was not aware of the coverage at the time services were provided. Coverage was later added to the MMIS system; however, the claim was not submitted for recovery of costs.

- One of fifteen Dental claims tested was overpaid by $4. The paper claim submitted by the provider billed the same surface for the same tooth for both procedures; MMIS disallowed the second procedure but did not correctly pay the maximum allowed.

- Eight of sixty-seven Practitioner claims tested were overpaid by a total of $15,525.

    - The first claim was overpaid $68. The claim paid $125 for a psychotherapy office visit; however, per contract this procedure should have been paid at $57. Upon review of the original paper claim, it was noted this was a data entry error.

4. Incorrect Payments to Providers (Continued)

- One claim was overpaid $9,989. Per Title 471 NAC Fee Schedule for Injectibles, this procedure code should be paid "By Report," which requires the provider to submit an invoice for the price of this injection and reimbursement will be made for the invoice amount. The provider did not submit an invoice; therefore, no supporting documentation was available to support the amount paid.

- One claim was overpaid $4,950. A payment of $4,950 was made for mental health services. Per Medicaid personnel, there should be a contract for this procedure code; however, Medicaid was unable to locate a contract for this procedure. Provider was paid for 18 units of service at a rate of $275 per unit, totaling $4,950.

- One claim was overpaid by $80. The claim paid $40 for a procedure code, which, according to Medicaid personnel, is a code which is no longer used. This code was for casting materials and was noted twice on the claim, but for different dates, with the total amount $80. There was no supporting documentation for the calculation of the amount paid.

- One claim was overpaid by $189. The claim paid $189 for durable medical equipment. The rate for this procedure was not documented in the Title 471 NAC Fee Schedule for Medical Supplies for July 1, 2004, to June 30, 2005.

- One claim was overpaid $141. The claim paid $2,686 for a cardiovascular procedure. Per Title 471 NAC Physician Fee Schedule the payment should have been $2,544.

- The final two claims were overpaid $108. One claim was overpaid $53 and another $55. Both payments were for injections and there was no documentation available for the rates paid.

We noted 13 of 151 claims with a total dollar error of $19,918. The claim error rate was 8.6% with an extrapolated dollar error of $11,929,153. Without adequate internal controls over claims processing, there is an increased risk of loss or misuse of State and Federal funds. There is also a risk of noncompliance with contractual agreements along with NAC Regulations and an increased risk of incorrect payments to providers. A similar finding was noted in our prior report.

> We recommend the Department review claims entered manually in MMIS to ensure payments are proper and rates paid agree to contracted amounts. We also recommend the Department review procedures to ensure all payments are correctly calculated in accordance with the requirements set

COMMENTS AND RECOMMENDATIONS
(Continued)

4. Incorrect Payments to Providers (Continued)

forth in the Title 471 NAC Fee Schedules or other supporting documentation. We further recommend the Department review procedures to ensure all third party resources meet their liable obligations to pay the claim before Medicaid pays.

Department's Response: The audit report notes overpayment of 13 of 151 claims tested. The Department disagrees with this finding. Nine of the thirteen claims identified as being 'overpaid' were found to be paid correctly; four claims were paid incorrectly.

Eight claims were identified as not being paid correctly according to the NMAP fee schedules or other 'supporting documentation.' These claims were actually paid at the correct rate in effect on the date of service. The fee schedules are published annually and the information contained in them is subject to revision as state and federal regulations dictate. The pricing loaded in the MMIS controls pricing of Medicaid service. Using the MMIS pricing as the determinative documentation leads to the conclusion of correct payments.

One overpayment was related to third party liability and the claim was found to have been correctly submitted to the third party carrier.

Four claims were found to have been paid incorrectly. All incorrect payments were related to manual entry or review. Manual entry and review is necessary to process certain claims. After manual entry, paper claims are processed through MMIS batch cycles that apply a series of edits to determine if the claim is payable. When an edit sets, the claim is suspended for manual review. Many of these edits are designed to identify claims that may have been entered incorrectly. Procedures for paper claim review include comparison of the entered claim data with the data present on the actual scanned copy of the claim. If entry errors are identified, the claim data is corrected. Other edits require manual review to ensure correct pricing, documentation and medical necessity. The Department is confident that adequate claims examination exists through payment review functions and staff supervision. HHSS is in the process of procuring a new management information system that should provide enhanced claims review capabilities when it is implemented.

In the case of disagreement with audit findings, case specific information that documents the validity of payments is available. This information can be provided or HHSS staff are willing to meet upon request.

HHSS disagrees with extrapolating the results of the limited claim review performed. According to Pat Reding, the "claims were haphazardly selected." Therefore, it was not a systematic random sample resulting in findings valid for extrapolation to a larger universe. Nothing more can be projected than what relates to the specific claims reviewed.

4. Incorrect Payments to Providers (Concluded)

APA's Response: When verifying whether the correct amount was paid on the claim we reviewed both the rates on MMIS as well as the NAC Fee Schedule. For 8 of the 13 claims tested the claims were not paid in accordance with the NAC Fee Schedule for the service date noted on the claim. For 2 of the 13 claims tested, the claims were not paid in accordance with the Managed Care contractual agreement with Magellan. One claim tested was for an Independent Rural Health Clinic and the Department was not able to provide adequate documentation to support the amount paid. One claim tested, was for Provider-Based Rural Health Clinic which is to be paid at the lower of actual costs or rate established by Medicare. This claim was paid based on actual costs submitted by the provider and the Department was unable to support the Medicare rate; therefore, unable to determine if the actual costs were less than the Medicare rate. One claim was overpaid as the recipient had private medical insurance coverage at the time of service of which Medicaid was not aware; therefore, the claim was overpaid and the costs were not recovered.

Haphazard selection is a recognized sampling method within auditing standards. The extrapolated error is not a statistical projection; however, it is a valid estimation based on the errors noted.

All findings were discussed with HHSS staff during fieldwork. Also, the May 11, 2006, exit conference agenda specifically stated, "It is your responsibility to ensure we have been provided the correct information during our examination. If you feel that any of our comments are incorrect, please indicate so now. Do not wait until the draft report is issued to say our information is incorrect." The draft report was issued May 23, 2006, and the Department responded June 8, 2006. We have not received any documentation from the Department to indicate our comments are incorrect.

5. Claims Paid After Recipient's Death

Title 471 NAC 3-002.01 states claims will be approved for payment if the client was eligible for the Medicaid Program when the service was provided. Clients are not eligible after the date they are deceased. Good internal control requires adequate procedures are in place to ensure no claims are processed and paid for a client after the client's death. Good internal control also requires adequate procedures exist to ensure errors are detected and corrected.

During our testing of practitioner claims, we noted 1 of 45 claims was paid to a provider for services to a deceased recipient. It appears, during the data entry of the claim, the recipient number of a stillborn child was entered instead of the client's number on the claim. The child's date of death was not entered into NFOCUS. This resulted in a claim for a doctor visit to be paid under the recipient number, for a stillborn child. The total of this claim amounted to $24. Upon

5. Claims Paid After Recipient's Death (Concluded)

further review, we noted a total of 18 claims were paid under the deceased child's recipient number in fiscal year 2005, with total payments of $1,624. The Department did not have adequate controls to detect and void the claims being paid for a deceased individual. This was also a finding in our fiscal year 1999 report.

Without proper controls or procedures in place to ensure payments are only made for eligible recipients, there is an increased risk of loss or misuse of State and Federal funds.

> We recommend the Department implement policies and procedures to ensure payments are made only for eligible recipients.

Department's Response: The Department disagrees with the audit finding. Payment was appropriate under Medicaid requirements to pay for the post-partum expenses of the mother of the stillborn child. Nebraska is required to cover qualified pregnant women per 42 CFR 435.116. Pregnant women who are not eligible in their own right as a specified relative (42 CFR 435.310) or are 18 or younger (42 CFR 435.229) are eligible for prenatal care, delivery and postpartum care because they are carrying an unborn child. As such the Medicaid Card lists the unborn child as the eligible individual. In cases of a stillborn child, the actual date of the stillborn birth of the child is not entered into N-FOCUS. This is done because the mother of the stillborn is required to receive 60 days postpartum care, which would not be paid for if the case was closed effective the date that the stillborn birth occurs. (42 CFR 435.170) The HHSS practice is to not enter the stillborn's date of birth until the mother has received the required postpartum coverage to allow appropriate services to be reimbursed.

APA's Response: We reviewed the original paper claim. The provider submitted this claim under the stillborn's recipient Medicaid number, but services were for a 3 year-old child. This claim should have been submitted under this child's recipient Medicaid number. Since this claim was manually entered, the Department should have caught this and returned the claim to the provider for correction.

6. 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 15 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 15 Medicaid clients in nursing facilities with more than 15 days of hospitalization. We noted the following:

COMMENTS AND RECOMMENDATIONS
(Continued)

6. Payments for Bedholding (Continued)

- One client was hospitalized for a total of 31 days. The nursing home was paid for 18 instead of 15 bedhold days. This resulted in an overpayment of $330 for the additional 3 days.

- One client was hospitalized August 17, 2004, through September 7, 2004, and September 28, 2004, through September 30, 2004. The nursing home was properly paid for 16 nursing home days and 15 bedhold days for August, but was paid for 9 bedhold days for September instead of 3. This resulted in an overpayment of $690 for the additional 6 days.

- One client was hospitalized October 20, 2004, through November 18, 2004, for a total of 29 consecutive days. The nursing home was properly paid 19 nursing home days and 12 bedhold days for October, but was paid for 17 bedhold days in November instead of 3. This resulted in an overpayment of $1,880 for the additional 14 days.

- One client was hospitalized November 23, 2004, through December 9, 2004, for a total of 16 consecutive days. The nursing home was properly paid 10 nursing home days and 8 bedhold days for November, but was overpaid for 1 bedhold day in December. This resulted in an overpayment of $103 for the additional day.

- One client was hospitalized November 15, 2004, through December 8, 2004. The nursing home was properly paid for 14 nursing home days; however, the nursing home was paid for 16 bedhold days instead of 15. Also, the nursing home was paid for 7 bedhold days in December instead of 0. This resulted in an overpayment of $777 for the additional 8 days.

- One client was hospitalized for 16 consecutive days and the nursing home was paid for 16 bedhold days instead of 15. This resulted in an overpayment of $169 for the additional day.

- For one client, the nursing home reported 20 nursing home days and 11 hospital days. Claims Processing entered this as 12 nursing home days and 19 hospital days. We noted there are no controls to check for data entry errors in nursing home turnaround claims.

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 where the bedhold days for one hospitalization were split between two months thus allowing a nursing home to be paid for more than 15 bedhold days.

COMMENTS AND RECOMMENDATIONS
(Continued)

6. Payments for Bedholding (Concluded)

Our testing of 15 clients included 9 clients with over 15 consecutive hospital days. For 6 of the 9 clients, payment to the nursing facility was overpaid for bedhold days, a 67% error rate. A similar finding was noted in our prior report.

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

> We recommend HHSS 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.

Department's Response: MMIS edits suspend nursing facility bed hold claims in excess of 15 days within a given month. If it is determined the bed hold days are allowable by virtue of being related to more than one hospitalization, the suspension is manually overridden and the claim is processed. MMIS is not currently able to suspend excessive bed hold claims which span consecutive months (e.g., 8 days at the end of month A followed by 8 days at the beginning of month B) and, during the period of the audit, information submitted by nursing facilities with the turnaround documents specified the number of bedhold days but did not detail the actual bedhold dates. Subsequent to the audit period, nursing facilities have been directed to submit bedhold dates. This information allows staff to manually review cases for which bed hold days were claimed on the last day of the month to ensure that the 15-day limit is not improperly exceeded in the following month.

The Department is in the process of procuring a new management information system that may provide enhanced capabilities to track bedhold days electronically. In the interim, we can instruct nursing facility providers to indicate the dates of the entire hospital stay on the turnaround rather than the days that apply to the current month's billing. We will also create a computer run to identify bedhold days per client per month. This will enable us to match month-to-month claims and systematically identify clients who exceeded 15 bedhold days in adjacent months. A refund from the facility will be requested if it is determined the claim is excessive.

Of the seven specific case situations detailed in the audit report, the first citation was paid correctly as the 18 bedhold days reimbursed were associated with two separate hospitalizations. The last citation reflects a data entry error only which did not result in any improper payments. We concur that the remaining five citations contained days paid in error. However, it is important to note that occurrences of bedhold claims for the same client in adjacent months are rare. While the audit results indicate a high percentage <u>of the cases reviewed</u> were paid in error, the total universe of these situations is quite small and the procedures we will put in place should correct processing of these rare instances.

7. Transportation Services

The State covers nonemergency medical transportation for Medicaid recipients to receive transportation services for such things as doctor's appointments and family therapy. These services are provided by taxi companies or other commercial transport firms and are provided for local, as well as long-distance transport. Total transportation services paid for the fiscal year 2005 was $12,341,134. Transportation is an optional Medicaid service.

Good internal control requires policies and procedures designed to ensure transportation claims are reasonable. Good internal control also requires adequate procedures to ensure these claims are paid according to contracted rates. This was a comment in the fiscal year 1999 audit.

We were unable to verify the payment amount or rate was correct for three of six transportation claims tested:

- Two claims tested did not have adequate supporting documentation to verify the claims were paid according to contract. The recipients of these claims were enrolled in Managed Care mental health/substance abuse. Although the Mental Health Managed Care contractor authorizes the trip, they do not authorize or approve the amount billed by the provider. The providers for these claims have contracts with HHSS; however, the mileage or other detailed information was not identified on the original claim in order to verify if the claim was paid according to the contract. These two claims totaled $776.

- One claim tested for transporting a recipient to a doctor's appointment and did not have adequate supporting documentation to verify the claim amount of $66.

Nonemergency procedure codes in MMIS are identified either as trip codes or per mile codes. Medicaid instructs the provider which codes they are to use when submitting transportation service claims. These codes were entered with a maximum amount allowed per line of coding per claim. It was noted one procedure code had a maximum amount of $3,000 and another with a maximum amount of $200. Any transportation claim submitted, using these procedure codes would be allowed to process for payment as long as the amount billed was at the maximum amount or below. There was no review of transportation claims.

We also tested transportation claims during our review of Aged and Disabled (AD) Waiver. The AD Waiver services offer eligible persons a choice between entering a Nursing Facility (NF) or receiving supportive services in their homes.

We noted one transportation provider was paid twice for the same services. We also noted services for this same provider appeared unreasonable.

7. Transportation Services (Continued)

- One claim tested paid the provider for duplicate services. Medicaid and the Social Services Block Grant both paid the transportation provider for the same services provided to the client. Total payments paid by both Medicaid and Social Services Block Grant during fiscal year 2005 were $1,025. It was also noted this claim was overpaid by $10. This was caused by excessive mileage claimed for the various trips billed.

- Another claim tested paid the provider for transporting a client out-of-town for a doctor's visit. The same service could have been provided in the client's hometown. Total payments to transport the client between Lincoln and Omaha for doctor's visits during fiscal year 2005 were $874. Although a Medicaid recipient may choose their physician, we do not feel it is reasonable for taxpayers to pay transportation costs to another city.

We also tested one journal entry which transferred transportation costs from the Social Services Block Grant to Medicaid. The document was for one month of expenditures and transferred $406,912. We noted:

- Five of seven claims tested were not paid in accordance with contractual agreements.

- Four of seven claims tested did not have documentation to support the transportation was a reasonable and necessary Medicaid expense. Department staff indicated that providers were not required to submit supporting documentation (i.e. detailed claims for each service provided) unless specifically requested by the local office. Providers only submit a bill for each recipient with total units at each rate of service.

Without adequate policies and procedures, there is an increased risk of fraud to occur. There is also an increased risk of loss or misuse of State and Federal funds when claims are not paid according to contract. Also, without adequate supporting documentation, the claims cannot be properly reviewed to determine whether the claim is reasonable and necessary.

> We recommend the Department implement policies and procedures to ensure claims are paid per the contracted amount. We also recommend transportation claims be reviewed on a regular basis to ensure they are reasonable, necessary, and paid by the correct program.

Department's Response: In response to the citations of inability to verify payment amount or rate, we concur with the audit findings.

7. Transportation Services (Continued)

Department's Response, Concluded:
The Public Service Commission (PSC) approves a vast array of rates and charges for transportation providers which include holiday fees, wait times charges, after hour charges, origination fees, etc. These rates and charges vary by both provider and PSC authorized service area. During the period under audit, the Department followed PSC terms for rates and charges by the transportation providers. Given the variety of rates and charges, the existing claim processing system could not handle varied transportation claims. In lieu of costly programming and programming updates, the Department mandates transportation providers, as it mandates all Medicaid providers, to maintain records and documentation for Departmental audit purposes.

Further, because transportation claims are not covered by HIPAA, there is no standardized form for submission of transportation claims.

A 2004 legal interpretation that HHSS is not required to follow PSC-approved rates is enabling the Department to establish uniform rates and charges for Medicaid transportation providers. Once uniformity in rates and charges is established, Medicaid transportation providers will be requested to provide uniform detail on claims submission. This uniformity coupled with the proposed flexibility of the new MMIS should enable the Department to match rates and charges to the level of detail requested by the Office of the Auditor.

The audit comments note that the Medicaid managed care contractor does not authorize or approve the amount billed by the transportation provider. This is consistent with the federal definition of a Specialty Physician Case Management (SPCM) organization. As an SPCM organization, the managed care organization only approves the necessity of the trip, and is not involved in the billing or claims processing of transportation claims.

In regard to findings related to transportation for waiver clients, the Department generally disagrees with the audit report, with the exception of a duplicate payment identified for one claim. In that instance, a payment refund has been requested. We do not concur with other audit citations of unreasonable or incorrect reimbursement, failure to follow contractual agreements, and inadequate documentation. Claims processing has been handled in accordance with appropriate state and federal regulations and contract provisions.

In the case of disagreement with audit findings, case specific information that documents the validity of payments is available. This information can be provided or HHSS staff are willing to meet upon request.

7. Transportation Services (Concluded)

APA's Response: The Department had entered into a contractual agreement with two transportation providers. The two claims tested for these providers did not agree with the rates specified in the contract.

All findings were discussed with HHSS staff during fieldwork. Also, the May 11, 2006, exit conference agenda specifically stated, "It is your responsibility to ensure we have been provided the correct information during our examination. If you feel that any of our comments are incorrect, please indicate so now. Do not wait until the draft report is issued to say our information is incorrect." The draft report was issued May 23, 2006, and the Department responded June 8, 2006. We have not received any documentation from the Department to indicate our comments are incorrect.

8. Retroactive Settlement Payments Incorrectly Calculated

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 and days-disallowed paid claims. Title 45 CFR 92.20 requires fiscal control and accounting procedures adequate to ensure expenditures are in accordance with regulations. To be allowable, Medicaid costs for medical services must be for an allowable service rendered and provided on behalf of eligible individuals.

The Department pays the regional centers for services based on a prospective rate that is adjusted to actual after year-end cost reports are received. We noted two of three retroactive settlement payments made to Hastings Regional Center and one of three retroactive settlement payments made to Lincoln Regional Center did not agree with Medicaid days covered per MMIS.

- Payment for Hastings Regional Center for fiscal year 2003 included claims which consisted of 80 duplicate days and 27 days that were disallowed. These errors resulted in a Federal overpayment of $32,255. This overpayment amount in conjunction with calculation errors resulted in a $83,052 underpayment to the provider.

- Payment for Hastings Regional Center for fiscal year 2004 included claims which consisted of 128 days that were disallowed. These errors resulted in a Federal original overpayment of $46,720. This overpayment amount in conjunction with calculation errors resulted in a $19,651 underpayment to the provider.

- Payment for Lincoln Regional Center for fiscal year 2004 included claims which consisted of 31 days that were disallowed. The inclusion of these days resulted in a Federal funds overpayment of $8,132 for the retroactive settlement payment and an original overpayment of $9,567.

Without proper internal control over claims, the risk of loss or misuse of funds increases.

8. Retroactive Settlement Payments Incorrectly Calculated (Concluded)

We recommend the Department review claims prior to payment to ensure the amount is correct and prevent duplicate and unallowable claim payments. We further recommend the errors noted be corrected.

Department's Response: We agree with this finding. The claims data used did have the correct days, and this adjustment will be made.

9. Recipient Share of Cost

Share of cost is the recipient's excess income amount per month to be used for medical services; the amount is determined based on each recipient's income. This amount is required to be paid each month by the recipient for medical services prior to Medicaid paying. Good internal controls require procedures to ensure each Medicaid recipient's share of cost is applied to appropriate claims to reduce Medicaid's cost.

We noted that two of fourteen claims tested which required share of cost, did not have the recipient's share of cost applied to the claims. One recipient had a share of cost requirement of $923 per month for services provided from May through July 2004. Recipient's share of cost for May and June was not applied, which resulted in an overpayment of $1,846. Another recipient had a share of cost requirement of $640 per month for June 2004. The claim for services was paid in July 2004 and the recipient's share of cost was not applied, which resulted in an overpayment of $640.

Without proper controls, there is an increased risk for possible misuse or loss of State and Federal funds.

We recommend the Department implement procedures to ensure payment amounts are correct and to ensure the recipient's share of cost is appropriately applied.

Department's Response: The report indicated that two of fourteen claims did not have recipient's share of cost applied to the claim. The Department disagrees with part of this finding. One claim paid correctly according to the eligibility information in the MMIS. One claim was processed incorrectly due to an error during review of the claim. The Department has taken steps to improve processing for claims with share of cost, with the resulting implementation of an MMIS edit in November 2005. This edit sets a unique indicator for share of cost and provides more specific information for the review process.

10. Personal Assistance and Chore Services

Good internal control requires adequate procedures to ensure payments are proper, accurate, reasonable, and necessary. Title 471 NAC 15-003.02 states that personal services provided in excess of 40 hours per seven-day period are not allowable without prior authorization from Central Office.

Medical personal assistance services are an optional Medicaid benefit to allow eligible clients to receive supportive services in their home rather than entering a nursing facility. Personal assistance may include services such as basic personal hygiene, nutrition, housekeeping, and transportation for medical treatment. Total payments for Personal Assistance and Chore services during fiscal year 2005 were $28,964,658.

We tested 15 Personal Assistance/Chore Services payments and noted the following:

- We noted both providers tested, who worked over forty hours a week, did not have documentation of prior authorization. One provider tested worked more than forty hours a week in all thirteen weeks we reviewed. The weekly hours worked ranged from 42 to 103. The other provider worked 95 hours each week for the two weeks selected for testing.

- Two payments tested did not agree to provider timesheets. One provider's timesheet showed 28 hours worked but the claim listed 26. The other provider was not paid for 35 hours of service provided. This results in an underpayment of $129.

- Five payments tested included duplicate hours claimed for more than one client or included payments to a provider for the same hours another provider also claimed. One provider claimed the same 42 hours during January and February 2005 for two clients. The cost of these 42 hours amounts to $399. Another provider was paid for 82 hours in October through December 2004 from two different funds for the same services provided. These 82 hours were billed and paid from both Medicaid (Program 348) and the Social Services Block Grant (Program 347). Total amount paid from Medicaid was $558. Another provider had two payments that were for duplicate hours listed on two different client's timesheets, resulting in duplicate payments of $37. Lastly, one provider claimed the same 4 hours as another provider for the same client. This results in a duplicate payment of $40. Total amount of overpayments found during testing, caused by duplicate hours, was $1,034. The total amount of provider payments tested was $48,209.

- Six payments tested did not appear reasonable based the total hours worked during the time period tested. One provider claimed 226 hours during a 15 day period. Another

10. Personal Assistance and Chore Services (Continued)

provider worked 95 hours a week starting at 6:15 am and ending the day at 8:30 pm. The only breaks listed on the timesheets were 5 minute breaks for driving time to the next client. One provider claimed a total of 331, 422, and 419 hours during the months of October 2004, April 2005, and May 2005, respectively. During April and May 2005, the provider cared for four different individuals. Lastly, one provider exceeded the weekly hours of service authorized. The provider exceeded these hours by 23.5 in one month. This results in an overpayment of $212.

- Four payments tested did not have adequate supporting documentation to indicate payment was reasonable. One provider did not list the start and stop times for providing services to the two clients they cared for. The timesheets listed only the total hours for the day worked. According to the timesheets, the provider claimed 14 hours of service to the two clients each day. Another provider did not list the start/stop time when they took the client to the doctor's office. Total time claimed for these trips was 15.5 hours. One provider did not include the nature of services provided to the client for four of seven days. Lastly, one provider did not have the client's signature on the timesheets as required.

Of the 15 claims tested, 10 had one or more exceptions noted, a 66% error rate. Noncompliance with regulations and lack of appropriate payment procedures increases the risk for errors and fraud to occur and not be detected.

> We recommend the Department implement procedures to ensure payments to providers are proper.

Department's Response: This audit finding lumped together services delivered through two separate programs: the Personal Assistance Services (PAS) Program and the Aged and Disabled Waiver Program. Each of these areas is governed by different state and federal regulations, so our responses will address each area separately.

Regarding the Aged and Disabled Waiver program findings, we do not concur with 3 out of the 5 instances cited. After review, it was determined that no providers billed in excess of the authorized amounts or for services that were not provided. Providers had billed appropriately as outlined in NAC 480-5006 Provider Standards. According to these regulations, clients are not required to sign calendars and providers are not required to indicate "start and stop times" on the billing documents. It is the Medicaid providers' responsibility to maintain supporting documentation.

10. Personal Assistance and Chore Services (Concluded)

Department's Response, Concluded:
One finding is technically correct but does not indicate an incorrect billing. The provider billed for more hours in one week but less in another week than authorized, but appropriate services were actually rendered. The Services Coordinator will change the authorizations from weekly to monthly in order to accommodate necessary adjustments to meet the client's emergencies.

Regarding the PAS findings, the Department does not concur with citations related to services provided in excess of 40 hours, underpayment of providers, and overpayment related to provider qualifications. The policy cited by the auditors on maximum hours was incorrectly applied in the audit report to providers rather than to individual clients; regulations limit the number of hours authorized per client rather than the number of hours a provider may work.

We do concur with audit findings related to overpayment/ duplicate/ unreasonable payments to providers. HHSS is in the process of moving the PAS program to NFOCUS, with an expected completion date in late fall 2006. This change will reduce staff and provider errors in authorization and billing processes. All assessment, authorization and claims payment processes will be available to the staff electronically. This includes an electronic billing preprint for providers that will decrease provider billing errors. In addition, HHSS will be monitoring service providers to identify areas where improvements are needed in staff and provider processes. The monitoring will include specific monitoring for provider overpayments.

In the case of disagreement with audit findings, case specific information that documents the validity of payments is available. This information can be provided or HHSS staff are willing to meet upon request.

11. Early Intervention Program

Title 45 CFR 92.20 Standards for Financial Management Systems, states "Accurate, current and complete disclosure of the financial results of financially assisted activities must be made in accordance with the financial reporting requirements of the grant or subgrant." Good internal control also requires adequate review to ensure expenses reported are accurate and are not duplicated.

The Department had a contract with Omaha Public Schools (OPS) for six Department employees to work at the OPS office and provide service coordination services. OPS billed the Department for service coordination expenses monthly. The Department bills OPS monthly for the salaries, benefits, and travel expenses for the six employees. Total service coordination expenses paid to OPS for fiscal year 2005 were $484,716. Total payroll expenses for the six employees charged back to OPS were $259,969.

COMMENTS AND RECOMMENDATIONS
(Continued)

11. Early Intervention Program (Concluded)

We noted service coordination expenses for the Early Intervention Program were reported twice on the Federal CMS 64 report. The payroll for these six employees were reported as administration expenditures and then reported again as service coordination aid expenditures when OPS was paid for service coordination, thus resulting in duplicate reporting on the Federal report.

Without adequate controls, there is an increased risk of inaccurate or duplicate reporting of expenses, which could lead to Federal sanctions.

> We recommend the Department implement procedures to ensure expenditures are accurately stated and not duplicated.

Department's Response: We agree that the Omaha Early Intervention Payroll costs were inadvertently reported as an administrative cost on the CMS-64. The correction was reported on the CMS-64 for the quarter ended March 31, 2006.

12. Mental Health Practitioners

Good internal control requires adequate policies and procedures to ensure claims are reasonable and accurate.

We reviewed three Provisional Licensed Mental Health Practitioners (PLMHP) and three Licensed Mental Health Practitioners (LMHP) for claims paid during July 2004. During our review, we noted the following for claims paid for dates of service of July 1, 2004, to July 31, 2004:

PLMHP

- One received payments for the month totaling $14,415 and MMIS processed 115 claims for this provider. On July 7, 2004, the provider had 9 individual patient therapy sessions and 3 family therapy sessions. The provider received $749 from Medicaid for services on this day. There were two recipients each from three families claimed on this day.
- Another received $12,965 for the month and MMIS processed 166 claims for this provider.
- Another received $14,983 and MMIS processed 73 claims for this provider. On July 7, 2004, the provider had 7 individual patient therapy sessions and 4 family therapy sessions. The provider received $719 from Medicaid for services on this day. There were two recipients from one family claimed on this day.

12. Mental Health Practitioners (Continued)

LMHP

- One received $20,610 for the month and MMIS processed 134 claims for this provider. On July 7, 2004, the provider had 5 individual patient therapy sessions and 4 family therapy sessions. The provider received $585 from Medicaid for services on this day. There were two recipients from one family claimed on this day.
- Another received $3,638 and MMIS processed 25 claims for this provider.
- Another received $10,032 and MMIS processed 67 claims for this provider. On July 7, 2004, the provider had 4 individual patient therapy sessions and 5 family therapy sessions. The provider received $591 from Medicaid for services on this day. There were three recipients from one family claimed on this day.

PLMHP and LMHP are not doctors; they must have a licensed physician approve claims submitted. The Department did not have adequate procedures to ensure these claims were reasonable or accurate. Claims submitted do not indicate start and stop times for counseling sessions. There were no procedures to ensure PLMHP and LMHP were not billing for both family and individual therapy for the same session.

Without adequate policies and procedures, there is an increased risk of fraud to occur. There is also an increased risk of possible loss or misuse of State and Federal funds.

> We recommend the Department implement policies and procedures to ensure claims submitted are reasonable and accurate.

Department's Response: The Department disagrees that internal controls can prevent all fraudulent billing and payment. The Department agrees that additional monitoring and clarification was warranted; procedural and policy adjustments have been made and are ongoing.

The internal controls that the Department has to ensure claims submitted by Mental Health Practitioners are reasonable and accurate include various methods.

For the 3 Provisional Licensed Mental Health Practitioners (PLMHP) and 3 Licensed Mental Health Practitioners (LMHP) noted in the report, the bulk of the claims were for managed care clients. Those services are prior authorized by Magellan, the Department's mental health managed care contractor. In addition to the clinical judgment used by Magellan in the prior authorization process, all PLMHP's and LMHP's must be supervised by licensed physicians or psychologists. The supervising practitioner must provide a mental health assessment of the patient, initially and annually thereafter, as well as supervise the ongoing treatment plan of the patient. When the medical necessity of services is questioned, the supervising physician can be requested to provide more information, as well as Magellan can perform a clinical review.

12. Mental Health Practitioners (Concluded)

Department's Response, Concluded:
In addition to prior authorization, claims go through various audits and edits prior to payment. There is also opportunity for all providers to be reviewed post-pay through the SURS (Surveillance and Utilization Review) Unit's customary review of aberrant profiles of services billed to Medicaid. Mental health and substance abuse practitioners have been identified as an area in which SURS has increased the pre- and post-payment reviews. The activities you've identified, potential upcoding and/or billing of more than one time-related service for the same time period, have been identified and are areas in which the SURS Unit and MFCU are actively pursuing cases.

To assist providers, SURS and MFCU staff, a provider bulletin is planned to go out this month to require mental health providers to document the actual start and end times of therapeutic services, who is involved in the session and their relationship to the client, as well as other documentation requirements.

13. Lack of Segregation of Duties Over Receipts

Good internal control requires a plan of organization, procedures, and records designed to safeguard assets and provide reliable financial records.

A lack of segregation of duties exists in receivables for overpayments from providers. HHSS receives checks for Third Party Liability, Casualty, Estate Recovery, and Other Overpayments from providers. One employee, who handles the Other Overpayments from providers, receives the checks, makes the adjustments in MMIS, and reviews the entries made in MMIS. This employee is involved in all the key processes of MMIS receivables from providers.

A lack of segregation of duties increases the risk of possible errors or irregularities to occur.

> We recommend the Department implement procedures in order to ensure an adequate segregation of duties exists for collections of overpayments.

Department's Response: Financial Services agrees with the finding. The current procedure will be modified to segregate the duties as recommended no later than July 1, 2006.

14. Provider Agreements Not on File

Title 471 NAC 2-001.01 states, "A provider is an individual or entity that furnishes Medicaid goods or services under an approved agreement with the Department." Title 471 NAC 2-001.03 states, "Each provider is required to have an approved agreement with the Department." A

14. Provider Agreements Not on File (Concluded)

provider agreement must be signed and on file with the Department before payment for services is made. Good internal control requires approved provider agreements be maintained on file by the Department.

We noted 5 of 127 provider claims tested did not have agreements on file for services provided. Without valid provider agreements there is an increased risk for errors or abuse to occur.

> We recommend the Department maintain provider agreements to ensure payments are proper.

Department's Response: The audit finding indicates five reviewed claims did not have provider agreements on file. Provider agreements are maintained in paper files, sorted by type of provider and provider name. Files are periodically sent to storage. The provider agreements noted were originally signed in 1985, 1986, 1992, 1999, and 2000. The five provider agreements noted in the audit were not located in the designated storage boxes. We are confident that these agreements exist, but were misfiled due to the manual nature of the filing system. The Department is already in the process of establishing a new process that will improve accessibility to provider agreements. Beginning in January, 2006, new provider agreements are being scanned and are viewable on a document imaging system. Provider agreements still on location at the State Office Building are also being scanned as time permits.

15. NIS Security

Good internal control requires segregation of duties so no one individual can prepare and post their own documents, and an employee cannot prepare a document that has no approval authorization.

Our review of NIS security authorizations at June 30, 2005, noted 14 employees could prepare and approve their own transactions on NIS; 8 of these were corrected in July 2005. We also noted 11 employees had NIS user security to prepare transactions, but no one was set up on NIS for batch approval of these transactions.

When individuals can prepare and approve the documents they have prepared, there is a lack of segregation of duties and an increased risk of inappropriate transactions. When individuals have the ability to prepare documents, but there is no one set up to approve and post any documents they prepare, there is an increased risk documents may be posted if a statewide approval was processed.

15. NIS Security (Concluded)

> We recommend the Department review NIS security to ensure no one can process and approve their own transactions, and everyone authorized to prepare transactions has a second individual authorized to post the transactions.

Department's Response: All security changes have been made except for three staff that must retain this security to do their job.

16. Outstanding Warrants

Good internal control requires follow up on outstanding warrants.

The Department did not follow up on outstanding warrants. There was no formal or written policy regarding the follow up on outstanding warrants by the Department of Administrative Services (DAS); therefore, it is the responsibility of HHSS Department of Finance and Support to follow up on any outstanding warrants. This was a comment in a prior report.

Without adequate procedures to follow up on outstanding warrants, there is an increased risk for fraud to occur.

> We recommend the Department implement procedures to review and follow up on outstanding warrants.

Department's Response: The Department has had no cost-effective way in which to follow up on outstanding warrants, given the volume of warrants, the dollar amounts, and range of issue dates, including many that would clear in the routine course of business. The Department began working with the Treasurer's office and DAS in the summer of 2005 to identify a practical way of following up on outstanding warrants. As a result of that collaboration, on May 11, 2006, DAS delivered to the Department electronic data that could be sorted by issue date and amount. The Department has begun its follow up according to identified criteria that will allow the process to be done in a cost-effective manner.

17. CAFR and Statewide Single Audit Findings

The following items related to Medicaid were noted during the State of Nebraska Comprehensive Annual Financial Report (CAFR) and Statewide Single audits for the fiscal year ended June 30, 2005:

COMMENTS AND RECOMMENDATIONS
(Continued)

17. CAFR and Statewide Single Audit Findings (Concluded)

- **Finding #05-65-02 – General Computer Controls**
  The APA contracted with an accounting firm to perform an assessment of the general computer controls of those applications and systems supporting financial reporting and disclosure for the State of Nebraska. It was noted that NFOCUS user termination requests were not timely processed and five mainframe programmers are permitted access to the mainframe production environment. If proper segregation of duties are not implemented, the potential exists for critical information resources to be modified without proper and appropriate approval.

- **Finding #05-26-11 – Medicaid Eligibility**
  We noted 3 of 45 adult developmental disability Medicaid cases did not have an annual review during the fiscal year as required by Title 480 NAC 2-006.02 and good internal control.

- **Finding #05-26-12 – Medicaid Reporting**
  We noted adjustments to correct prior years' reporting errors were not made in a timely manner as required by good internal control. The total Federal share of expenditures over-reported to the Federal regulatory agency was $66,858,662.

The complete findings along with Management responses are presented in the State of Nebraska Single Audit report for the fiscal year ended June 30, 2005.

Department's Response: Findings related to the separate CAFR and Statewide Single Audits have been responded to previously in separate correspondence.

18. Reconciliation of Bank Records to the Nebraska Information System

During the audit of the Comprehensive Annual Financial Report (CAFR) of the State of Nebraska, the Auditor of Public Accounts (APA) noted the absence of reconciliation between the Nebraska State Treasurer's actual bank statements and Nebraska accounting records (in both the Nebraska Information System (NIS) and the Nebraska Accounting System (NAS), system before NIS). This has been an issue for the Department of Administrative Services Accounting Division (State Accounting) for many years. The APA's previous comments noted monthly reconciliations have not been completed in a timely manner and reconciliations performed have shown significant unknown variances between the bank records and the accounting records, with the bank being short compared to the accounting records. Although State Accounting continues to work on correcting the reconciliation of bank records to NIS, the APA continues to note areas where improvement is still needed in the reconciliation process to ensure NIS integrity and operational efficiency. Specifically, the APA noted the status of the reconciliation process as of December 19, 2005, to be as follows:

COMMENTS AND RECOMMENDATIONS
(Continued)

18. Reconciliation of Bank Records to the Nebraska Information System (Concluded)

State Accounting has worked on the reconciliation process, but continued progress is needed. State Accounting's reconciliation process has developed into a very detailed process of analyzing bank activity, compared to activity recorded on NIS, to identify reconciling items. State Accounting has completed their reconciliation process for the months of July of 2004 and May, June, and July of 2005. The APA has reviewed these reconciliations. The months of May, June, and July show variances of $3,425,381, $3,405,702, and $3,405,862, respectively. Again, the reconciliations show the bank being short compared to the accounting records. Per inquiry of management, State Accounting has started the reconciliation process for various months of the fiscal year ended June 30, 2006; however, the reconciliation process has not been a continuous monthly process and no monthly reconciliation has been completed since July of 2005.

Good internal control requires a plan of organization, procedures, and records designed to safeguard assets and provide reliable financial information. Without a timely and complete reconciliation of bank records to the NIS, there is a greater risk for fraud and errors to occur and to remain undetected.

Although State Accounting has worked on the reconciliation process, the process is still not done in a timely manner. The reconciliation continues to reflect unknown variances and shortages. Complete and timely reconciliation procedures between bank records and accounting records are required to provide control over cash and accurate financial information.

We recommend State Accounting continue their reconciliation process, in a more timely manner, and on at least a monthly basis, to ensure all financial information is correct on NIS. We also recommend, when a consistent cash variance between the bank records and the accounting records is obtained (based on at least six months of reconciliations), DAS submit their plan for adjusting NIS to the Governor and the Legislature so they may take appropriate action to correct NIS and resolve the variances noted.

This issue is the responsibility of State Accounting; however, as the variances have not been identified by fund or agency, this issue directly affects all Nebraska State agencies' financial information and must be disclosed in this report.

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NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
PROGRAM 348 - MEDICAL SERVICES/AID

INDEPENDENT ACCOUNTANT'S REPORT

Nebraska Health and Human Services System
Lincoln, Nebraska

We have examined the accompanying schedule of revenues, expenditures, and changes in fund balances of the Nebraska Health and Human Services System - Program 348 - Medical Services/Aid (Program) for the fiscal year ended June 30, 2005. The Program's management is responsible for the schedule of revenues, expenditures, and changes in fund balances. Our responsibility is to express an opinion based on our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants, and the standards applicable to attestation engagements contained in *Government Auditing Standards* issued by the Comptroller General of the United States, and accordingly, included examining, on a test basis, evidence supporting the schedule of revenues, expenditures, and changes in fund balances and performing such other procedures as we considered necessary in the circumstances. We believe that our examination provides a reasonable basis for our opinion.

In our opinion, the schedule referred to above presents, in all material respects, the revenues, expenditures, and changes in fund balances of the Nebraska Health and Human Services System - Program 348 - Medical Services/Aid for the fiscal year ended June 30, 2005, based on the accounting system and procedures prescribed by the State of Nebraska Director of Administrative Services as described in Note 1.

In accordance with *Government Auditing Standards*, we have also issued our report dated May 11, 2006, on our consideration of the Nebraska Health and Human Services System - Program 348 - Medical Services/Aid's internal

control over financial reporting and our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an attestation engagement performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our examination.

This report is intended solely for the information and use of the Program and the appropriate Federal and regulatory agencies. However, this report is a matter of public record and its distribution is not limited.

Pat Reding, CPA

May 11, 2006 Assistant Deputy Auditor

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
PROGRAM 348 - MEDICAL SERVICES/AID
SCHEDULE OF REVENUES, EXPENDITURES, AND CHANGES IN FUND BALANCES
For the Fiscal Year Ended June 30, 2005

	General Fund 10000	HHS Finance & Support Cash Fund 22600	Nebraska Health Care Fund 22640	ICF/MR Reimbursement Protection Fund 22680
REVENUES:				
Appropriations	$ 462,778,455	$ -	$ -	$ -
Taxes	-	-	-	3,357,698
Intergovernmental	-	-	-	-
Miscellaneous	5,154	-	-	7,040
TOTAL REVENUES	462,783,609	-	-	3,364,738
EXPENDITURES:				
Operating	-	-	-	-
Government Aid	462,778,455	352,500	4,765,896	-
TOTAL EXPENDITURES	462,778,455	352,500	4,765,896	-
Excess (Deficiency) of Revenues Over (Under) Expenditures	5,154	(352,500)	(4,765,896)	3,364,738
OTHER FINANCING SOURCES (USES):				
Deposit to General Fund	(5,154)	-	-	-
Deposit to/from Common Fund	-	-	-	-
Operating Transfers In	-	352,500	4,765,896	-
Operating Transfers Out	-	-	-	(3,364,738)
TOTAL OTHER FINANCING SOURCES (USES)	(5,154)	352,500	4,765,896	(3,364,738)
Net Change in Fund Balances	-	-	-	-
FUND BALANCES, JULY 1, 2004	-	-	-	-
FUND BALANCES, JUNE 30, 2005	$ -	$ -	$ -	$ -
FUND BALANCES CONSIST OF:				
General Cash	$ -	$ -	$ -	$ -
Due to Fund	-	-	-	-
Long-Term Investments	-	-	-	-
TOTAL FUND BALANCES	$ -	$ -	$ -	$ -

The accompanying notes are an integral part of the schedule.

UNMC Medical Education Rev Fund 25160	Federal Fund 40000	Federal Clearing Fund 42600	Nebraska Tobacco Settlement Fund 62630	Nebraska Medicaid Intergovt Trust Fund 62640	**Totals (Memorandum Only)**
$ -	$ -	$ -	$ -	$ -	$ 462,778,455
-	-	-	-	-	3,357,698
-	872,464,247	-	-	(2,409)	872,461,838
-	8,716	57,470	47,724,148	53,964,053	101,766,581
-	872,472,963	57,470	47,724,148	53,961,644	1,440,364,572
-	-	-	94,438	113,461	207,899
12,567,008	872,472,963	1,161,611	-	-	1,354,098,433
12,567,008	872,472,963	1,161,611	94,438	113,461	1,354,306,332
(12,567,008)	-	(1,104,141)	47,629,710	53,848,183	86,058,240
-	-	-	-	-	(5,154)
12,567,008	-	-	-	-	12,567,008
-	-	-	-	-	5,118,396
-	-	-	(23,500,000)	(34,852,500)	(61,717,238)
12,567,008	-	-	(23,500,000)	(34,852,500)	(44,036,988)
-	-	(1,104,141)	24,129,710	18,995,683	42,021,252
-	-	1,253,851	140,586,793	159,636,825	301,477,469
$ -	$ -	$ 149,710	$ 164,716,503	$ 178,632,508	$ 343,498,721
$ -	$ -	$ 2,586,270	$ 484,088	$ 140,504	$ 3,210,862
-	-	(2,436,560)	-	-	(2,436,560)
-	-	-	164,232,415	178,492,004	342,724,419
$ -	$ -	$ 149,710	$ 164,716,503	$ 178,632,508	$ 343,498,721

NOTES TO THE SCHEDULE

For the Fiscal Year Ended June 30, 2005

1. Criteria

The accounting policies of the Nebraska Health and Human Services System - Program 348 - Medical Services/Aid are on the basis of accounting as prescribed by the State of Nebraska Department of Administrative Services (DAS).

Per Neb. Rev. Stat. Section 81-1107(2) R.S.Supp., 2004, the State of Nebraska Director of Administrative Services duties include "The keeping of general accounts and the adoption and promulgation of appropriate rules, regulations, and administrative orders designed to assure a uniform and effective system of accounts and accounting, the approval of all vouchers, and the preparation and issuance of warrants for all purposes."

The Nebraska Information System (NIS) is the official accounting system prescribed by DAS for the State of Nebraska. Policies and procedures are detailed in NIS manuals and Nebraska Accounting System Concepts published by DAS and available to the public. The financial information used to prepare the schedule of revenues, expenditures, and changes in fund balances for the Program was obtained directly from the NIS. NIS records accounts receivable and accounts payable as transactions occur. As such certain revenues are recorded when earned and expenditures are recorded when a liability is incurred, regardless of the timing of related cash flows. The accounts payable liability recorded on NIS, and thus recorded as expenditures, as of June 30, 2005, includes only those payables posted to NIS before June 30, 2005, and not yet paid as of that date. The amount recorded as expenditures as of June 30, 2005, **does not** include amounts for goods and services received before June 30, 2005 which had not been posted to NIS as of June 30, 2005.

The Program had accounts receivable not included in the Schedule of $19,515,037 from Drug Rebates and $10,312,630 from Third-Party Liabilities due primarily from insurance companies. DAS did not require the Program to record their receivables on the NIS system and these amounts are not reflected in revenues or fund balances on the Schedule.

The fund types established by NIS that are used by the Program are:

10000 – General Fund – accounts for all financial resources not required to be accounted for in another fund.

20000 – Cash Funds – account for revenues generated by specific activities from sources outside of State government and the expenditures directly related to the generation of the revenues. Cash funds are established by State statutes and must be used in accordance with those statutes.

NOTES TO THE SCHEDULE
(Continued)

1. **Criteria** (Continued)

40000 – Federal Funds – account for all federal grants and contracts received by the State. Expenditures must be made in accordance with applicable federal requirements.

60000 – Trust Funds – account for assets held by the State in a trustee capacity. Expenditures are made in accordance with the terms of the trust.

The major revenue object account codes established by NIS used by the Program are:

Appropriations – Appropriations are granted by the Legislature to make expenditures and to incur obligations. The amount of appropriations reported as revenue is the amount of expenditures.

Taxes – Compulsory charges levied by a government for the purpose of financing services performed for the common benefit. Taxes recorded as revenue for the Program consists of the intermediate care facility for the mentally retarded tax.

Intergovernmental – Revenue from other governments in the form of grants, entitlements, shared revenues, payments in lieu of taxes, or reimbursements.

Miscellaneous – Revenue from sources not covered by other major categories, such as investment income, Tobacco Settlement proceeds, and the nursing facility Inter-governmental Transfers.

The major expenditure object account titles established by NIS used by the Program are:

Operating – Expenditures related to investment activities of the Trust Funds.

Government Aid – Payment of Federal and/or State money to governmental subdivisions, State agencies, local health and welfare offices, individuals, etc., in furtherance of local activities and accomplishment of State programs.

Other significant object account codes established by NIS and used by the Program include:

Assets – Resources owned or held by a government that have monetary value. Assets include cash accounts and long term investments. Cash accounts are included in fund balance and are reported as recorded on NIS. Long term investments (investments) are stated at fair value based on quoted market prices. Law or legal instruments may restrict these investments. Investments are under the control of the State Treasurer or other administrative bodies as determined by law.

NOTES TO THE SCHEDULE
(Continued)

1. Criteria (Concluded)

Liabilities – Legal obligations arising out of transactions in the past that must be liquidated, renewed, or refunded at some future date. Accounts payable transactions increase expenditures and decrease fund balance.

Other Financing Sources – Deposits to common funds and operating transfers.

2. State Agency

The Nebraska Health and Human Services System - Program 348 - Medical Services/Aid (Program) is a State agency established under and governed by the laws of the State of Nebraska. As such, the Program is exempt from State and Federal income taxes. The schedule includes all funds of the Program. The Program is administered by the HHSS Department of Finance and Support.

The Nebraska Health and Human Services System - Program 348 - Medical Services/Aid is part of the primary government for the State of Nebraska.

3. Totals

The Totals "Memorandum Only" column represents an aggregation of individual account balances. The column is presented for overview informational purposes and does not present consolidated financial information because interfund balances and transactions have not been eliminated.

4. Investments

Neb. Rev. Stat. Section 72-1246 R.R.S. 2003 authorizes the State Investment Officer to invest the State's funds in accordance with the prudent person rule, subject to the direction of the Nebraska Investment Council. Neb. Rev. Stat. Section 71-7607 R.S.Supp., 2004 requires money in the Nebraska Medicaid Intergovernmental Trust Fund available for investment to be invested by the State Investment Officer. Neb. Rev. Stat. Section 71-7608 R.S.Supp., 2004 requires money in the Tobacco Settlement Trust Fund available for investment to be invested by the State Investment Officer. Additional information regarding investments of the State can be found in the State of Nebraska's Comprehensive Annual Financial Report (CAFR) for the fiscal year ended June 30, 2005.

NOTES TO THE SCHEDULE
(Continued)

5. Transfers

ICF-MR: 2004 Neb. Laws LB 841 required each intermediate care facility for the mentally retarded (ICF-MR) to pay a tax equal to six percent of its revenue. Total tax collected plus interest earned for the fiscal year ended June 30, 2005, was $3,364,738. Per LB 841, the tax proceeds were distributed $55,000 to the Department for administration of the Fund; $1,351,167 to the General Fund for the State share of rate increase paid to ICF-MRs for the cost of the tax; $300,000 for a one-time increase in payment to non-state-operated ICF-MR; $312,000 for payment to providers of community-based services for the purpose of reducing the waiting list of persons with developmental disabilities; and $1,346,571 money remaining in the Fund after the required allocations transferred to the General Fund.

IGT and Tobacco Settlement: Neb. Rev. Stat. Section 71-7611 R.S.Supp., 2004 requires the State Treasurer to transfer $50,000,000 annually from the Nebraska Medicaid Intergovernmental Trust (IGT) Fund and the Nebraska Tobacco Settlement Trust Fund to the Nebraska Health Care Cash Fund. The State Investment Officer shall advise the State Treasurer on the amounts to be transferred from each fund. For the fiscal year ended June 30, 2005, the State Treasurer transferred $26,500,000 from the Medicaid IGT Fund and $23,500,000 from the Tobacco Settlement Fund. Of this amount, $4,765,896 was transferred to Program 348 Fund 22640 per 2004 Neb. Laws LB 1089 for the continuation of behavioral health provider rate increases, and the remainder was transferred to other Programs within Fund 22640.

Additional transfers from the Medicaid IGT Fund were: Per 2004 Neb. Laws LB 1083A, $2,500,000 to the Behavioral Health Services Fund, Program 038; per 2004 Neb. Laws LB 1089, $352,500 was transferred to the Health and Human Services Cash Fund; per 2004 Neb. Laws LB 1091 $5,420,000 to the Health and Human Services Cash Fund; and $80,000 was transferred to the Attorney General Child Protection Fund.

6. Government Aid

In June 2004, the Department transferred $7,000,000 from the Federal Fund to the General Fund by reducing aid expenditures paid from the General Fund and charging the expenditures to the Federal Fund. It appeared the Department did not have sufficient General Funds remaining in the 2004 allotment to cover the expenses. In July 2004, the Department reversed the journal entry and "paid back" the Federal Fund; however, journal entries were subsequently prepared so that $3,500,000 was repaid in August, $1,750,000 was repaid in October, and the remaining $1,750,000 was repaid in April 2005. As noted, these transactions were recorded in the government aid account; therefore, government aid expenditures for fiscal year 2005 are overstated by $7,000,000 in the General Fund and are understated in the Federal Fund.

NOTES TO THE SCHEDULE
(Continued)

6. Government Aid (Concluded)

The Department records refunds and adjustments in the Federal Clearing Fund until the proper disposition can be determined. Monies are then transferred to the original fund from where the expenditure was made. From the period March 2003 through October 2004, the Department accounted for these funds as an adjustment to expenditures in the Federal Clearing Fund, and not as a liability (Due to Fund), nor were the monies correctly transferred. In April 2005, the Department initiated a journal entry to correct the balance of the Federal Clearing Fund and transfer the monies to the proper fund; however, the Department adjusted the Federal Clearing Fund expenditure account rather than adjusting the fund balance. As a result, the financial statement includes $1,161,611 of aid expenditures in the Federal Clearing Fund, which should have been recorded as an adjustment to the fund balance. Therefore, total aid expenditures are overstated on the financial statement.

Adjustments to fund balance transactions are those recorded directly to a fund's asset account or equity account rather than through a revenue or expenditure account.

7. Deposits to Common Fund

The State made a disproportionate share (DSH) payment of $12,567,008 to the University of Nebraska Medical Center (UNMC) on June 17, 2005. The University then deposited $12,567,008 to the UNMC Medical Education Revolving Fund. On June 22, 2005, the Department prepared a journal entry which transferred the money from the UNMC Fund to the State General Fund. Neb. Rev. Stat. Section 85-134 R.S.Supp., 2004, established the UNMC Medical Education Revolving Fund to be administered by the Department of Health and Human Services Finance and Support. The Fund shall be used to fund medical education.

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NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
PROGRAM 348 - MEDICALSERVICES/AID

REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN EXAMINATION OF THE SCHEDULE OF REVENUES, EXPENDITURES, AND CHANGES IN FUND BALANCES PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

Nebraska Health and Human Services System
Lincoln, Nebraska

We have examined the accompanying schedule of revenues, expenditures, and changes in fund balances of the Nebraska Health and Human Services System - Program 348 - Medical Services/Aid for the fiscal year ended June 30, 2005, and have issued our report thereon dated May 11, 2006. We conducted our examination in accordance with attestation standards established by the American Institute of Certified Public Accountants and the standards applicable to attestation engagements contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

Internal Control Over Financial Reporting

In planning and performing our examination, we considered the Nebraska Health and Human Services System - Program 348 - Medical Services/Aid's internal control over financial reporting in order to determine our procedures for the purpose of expressing our opinion on the schedule of revenues, expenditures, and changes in fund balances, and not to provide an opinion on the internal control over financial reporting. However, we noted certain matters involving the internal control over financial reporting and its operation that we consider to be reportable conditions. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control over financial reporting that, in our judgment, could adversely affect the Nebraska Health and Human Services System - Program 348 - Medical Services/Aid's ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial schedule. Reportable conditions are described in the Comments Section of the report as Comment Number 2 (Questionable Accounting Practices), Comment Number 3 (Reconciliation Procedures Should be Improved), Comment Number 4 (Incorrect Payments to Providers),

Comment Number 7 (Transportation Services), Comment Number 12 (Mental Health Practitioners), Comment Number 15 (NIS Security), Comment Number 17 (CAFR and Statewide Single Audit Findings), and Comment Number 18 (Reconciliation of Bank Records to the Nebraska Information System).

A material weakness is a reportable condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements caused by error or fraud in amounts that would be material in relation to the financial schedule being examined may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control that might be reportable conditions and, accordingly, would not necessarily disclose all reportable conditions that are also considered to be material weaknesses. However, of the reportable conditions described above, we consider Comment Number 2 (Questionable Accounting Practices) and Comment Number 4 (Incorrect Payments to Providers) to be material weaknesses.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Nebraska Health and Human Services System - Program 348 - Medical Services/Aid's schedule of revenues, expenditures, and changes in fund balances, is free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial schedule amounts. However, providing an opinion on compliance with those provisions was not an objective of our examination, and, accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

We also noted certain additional items that we reported to management of the Nebraska Health and Human Services System - Program 348 - Medical Services/Aid in the Comments Section of this report as Comment Number 1 (Questionable Financing Arrangements), Comment Number 5 (Claims Paid After Recipient's Death), Comment Number 6 (Payments for Bedholding), Comment Number 8 (Retroactive Settlement Payments Incorrectly Calculated), Comment Number 9 (Recipient Share of Cost), Comment Number 10 (Personal Assistance and Chore Services), Comment Number 11 (Early Intervention Program), Comment Number 13 (Lack of Segregation of Duties Over Receipts), Comment Number 14 (Provider Agreements Not on File), and Comment Number 16 (Outstanding Warrants).

This report is intended solely for the information and use of the Program and the appropriate Federal and regulatory agencies. However, this report is a matter of public record and its distribution is not limited.

Pat Reding, CPA

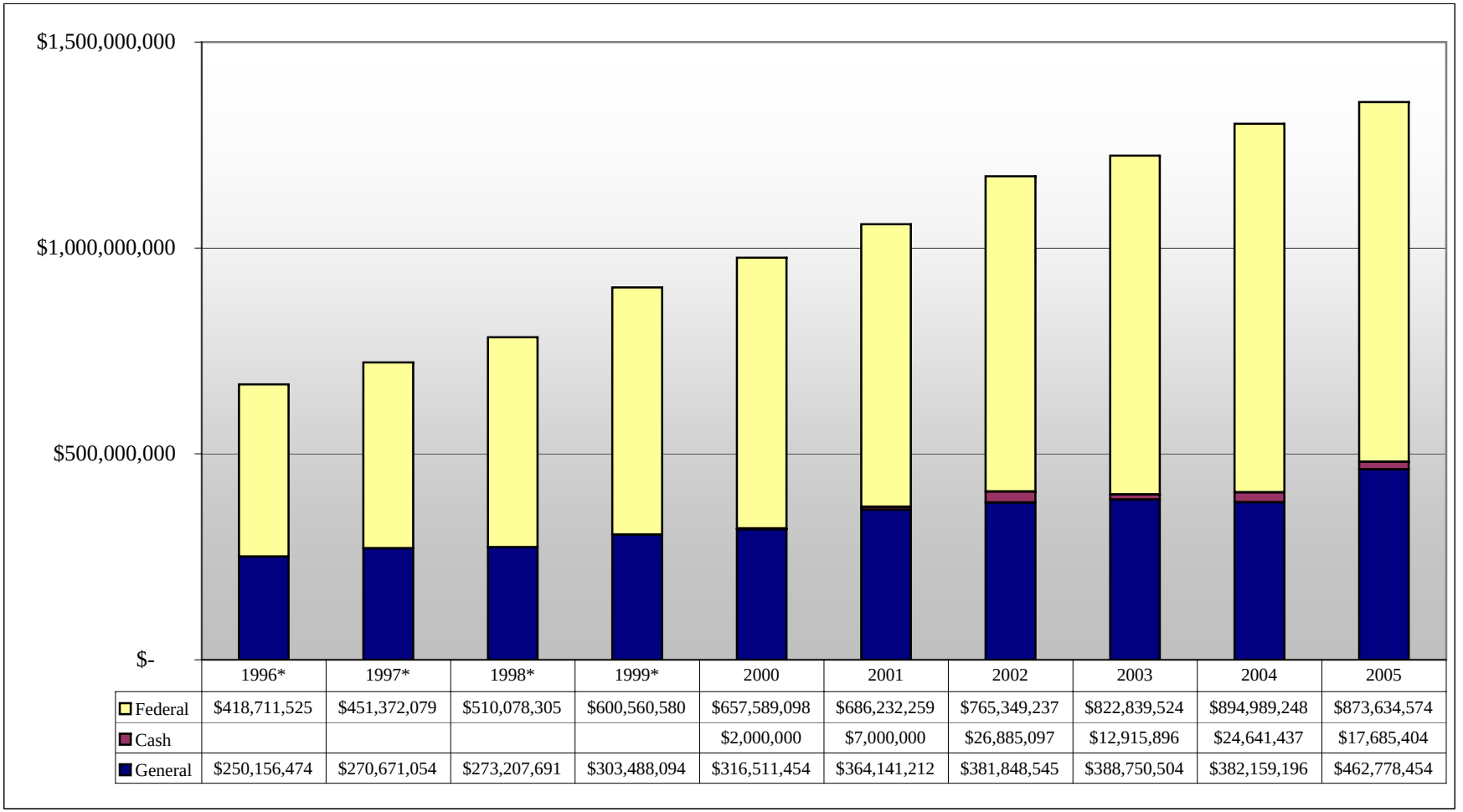
May 11, 2006 Assistant Deputy Auditor

STATISTICAL SECTION

Our examination was conducted for the purpose of forming an opinion on the schedule of revenues, expenditures, and changes in fund balances. Statistical Section information is presented for purposes of additional analysis. Such information has not been subjected to the procedures applied in the examination of the schedule of revenues, expenditures, and changes in fund balances, and, accordingly, we express no opinion on it.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
PROGRAM 348 - MEDICAL SERVICES/AID

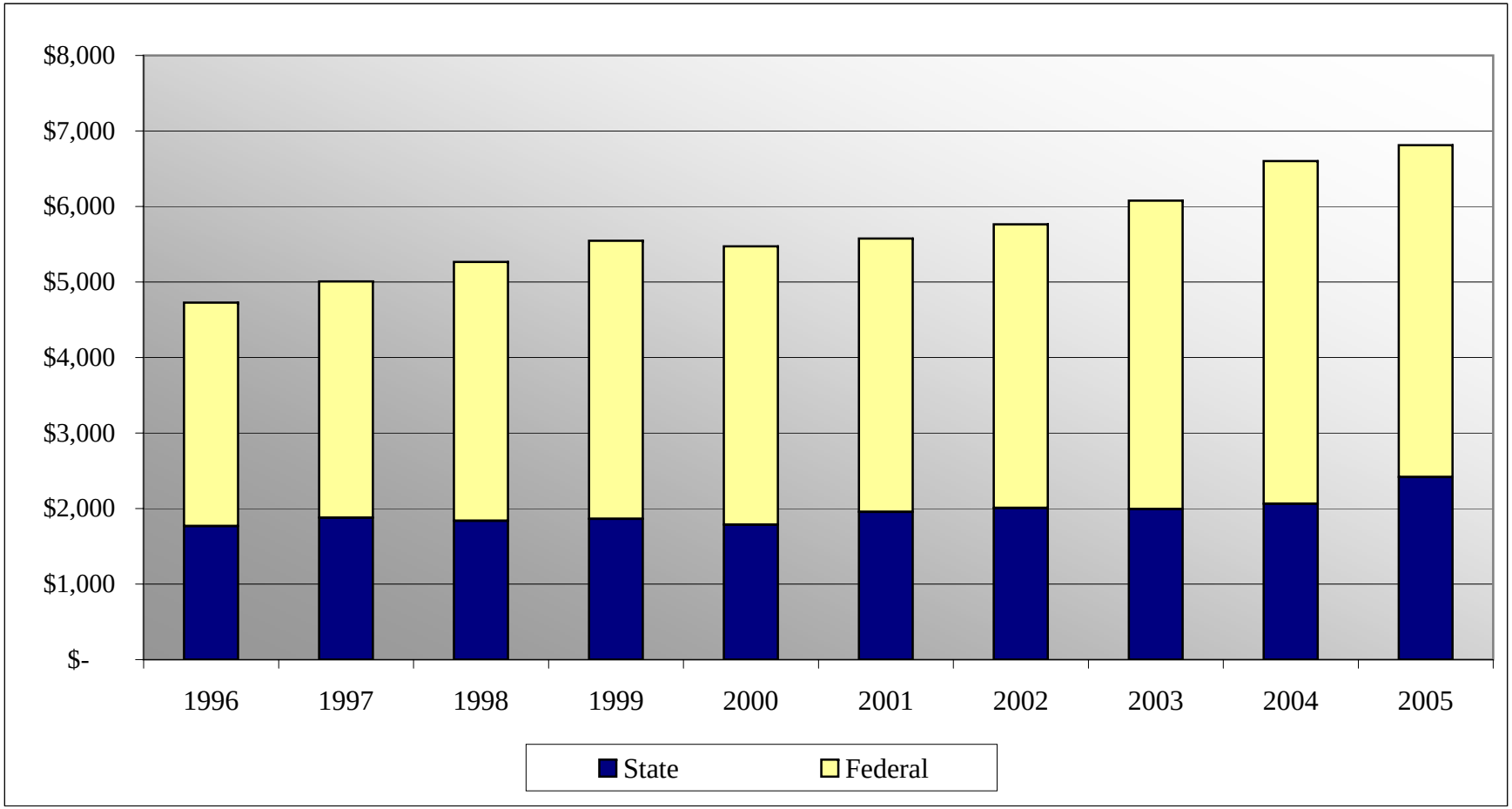
PROGRAM 348 EXPENDITURES BY FUND TYPE



	1996*	1997*	1998*	1999*	2000	2001	2002	2003	2004	2005
Federal	$418,711,525	$451,372,079	$510,078,305	$600,560,580	$657,589,098	$686,232,259	$765,349,237	$822,839,524	$894,989,248	$873,634,574
Cash					$2,000,000	$7,000,000	$26,885,097	$12,915,896	$24,641,437	$17,685,404
General	$250,156,474	$270,671,054	$273,207,691	$303,488,094	$316,511,454	$364,141,212	$381,848,545	$388,750,504	$382,159,196	$462,778,454

* 1996 thru 1999 includes Program 349 Long-Term Care which is no longer a separate program.
Source: DAS Budgetary Reports.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
PROGRAM 348 - MEDICAL SERVICES/AID
AVERAGE ANNUAL COST PER MEDICAID ELIGIBLE



Note: Number of eligibles per HHSS Department of Finance and Support and includes Program 348 and Program 344 (CHIPS).

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
PROGRAM 348 - MEDICAL SERVICES/AID
MEDICAID EXPENDITURES BY TYPE AND FUNDING SOURCE
Fiscal Year Ended June 30, 2005

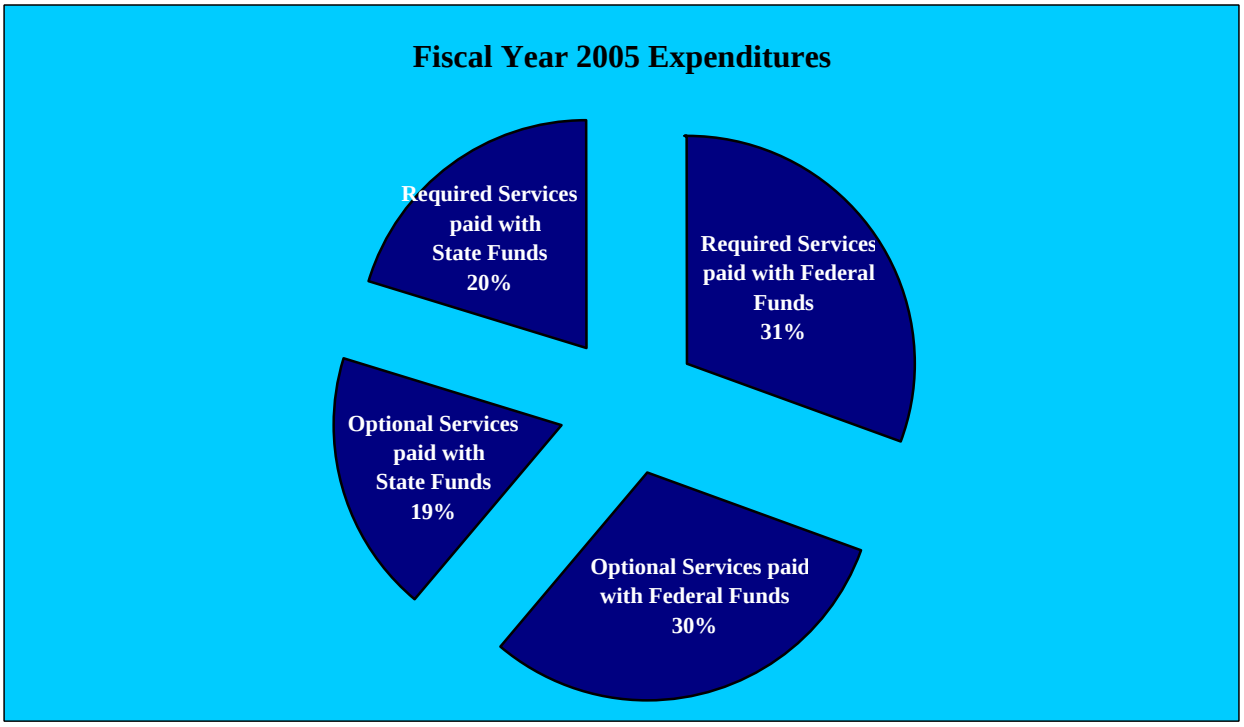
	Total for the Fiscal Year Ended June 30, 2005		
	Federal	State	Total
Aid Expenditures Reported to CMS:			
Inpatient Hospital	$ 89,134,000	$ 59,908,138	$ 149,042,138
Mental Health Facilities	3,080,164	2,081,877	5,162,041
Nursing Facilities	166,384,421	112,210,036	278,594,457
Intermediate Care Facility - MR - Public	23,922,435	16,152,880	40,075,315
Intermediate Care Facility - MR - Private	10,847,014	7,322,456	18,169,470
Physicians	41,530,500	27,101,138	68,631,638
Outpatient Hospital	32,628,126	20,858,420	53,486,546
Drugs	101,953,902	67,790,590	169,744,492
Drug Rebate	(23,032,183)	(15,214,985)	(38,247,168)
Dental	14,900,750	10,050,701	24,951,451
Other Practitioners	5,745,838	3,873,198	9,619,036
Clinic Services	2,953,758	1,990,687	4,944,445
Lab & Radiology	8,009,954	5,354,089	13,364,043
Home Health Services	11,577,035	7,812,816	19,389,851
Sterilizations	808,063	89,785	897,848
EPSDT (Health Check)	3,894,391	2,628,000	6,522,391
Rural Health Clinics	1,393,099	940,563	2,333,662
Insurance Premiums	41,110,163	27,535,040	68,645,203
Managed Care	38,343,510	25,899,175	64,242,685
Home & Community Based	101,914,639	68,789,452	170,704,091
Personal Care Services	6,578,461	4,441,058	11,019,519
Targeted Case Management	12,326,572	8,324,333	20,650,905
Primary Care Case Management	492,660	332,822	825,482
Hospice Benefits	3,220,283	2,173,107	5,393,390
Federally Qualified Health Center	2,732,090	861,083	3,593,173
Other (transportation, physical & speech therapy, etc)	25,423,176	17,155,939	42,579,115
Managed Care Special Needs Waiver	44,390,157	29,912,045	74,302,202
Mental Health Managed Care Waiver	72,452,060	48,906,048	121,358,108
Prior Quarters Adjustment	(49,819,133)	(32,149,033)	(81,968,166)
Third Party Liability Collections	(7,633,225)	(5,270,290)	(12,903,515)
Fraud Collections	(277,137)	(187,440)	(464,577)
Intergovernmental Transfer	40,714,126	27,652,350	68,366,476
Other Collections & Reductions	(10,551,445)	(6,944,709)	(17,496,154)
Total Medicaid Reported	817,148,224	548,381,369	1,365,529,593
Adjusted for Prior Reporting Error	49,819,133	32,149,033	81,968,166
Less IGT funds returned to General Fund		(25,792,710)	(25,792,710)
Net Expenditures	866,967,357	554,737,692	1,421,705,049
SOURCES:			
Federal Funds	872,472,963		872,472,963
State General Funds			
Program 348 Appropriations		462,778,455	462,778,455
Other Program Appropriations		79,185,212	79,185,212
Cash Fund 22600 & 22640 (LB 407)		5,118,396	5,118,396
Dept of Corrections		297,213	297,213
Escheat Warrants		63,724	63,724
Total Sources	872,472,963	547,443,000	1,419,915,963
VARIANCE (Over/(Under) Paid):	$ 5,505,606	$ (7,294,692)	$ (1,789,086)

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
PROGRAM 348 - MEDICAL SERVICES/AID
MANDATORY AND OPTIONAL SERVICES
For the Fiscal Year Ended June 30, 2005

The Federal government requires State Medical programs to cover certain medical services in order to obtain Federal matching funds. Examples of mandatory services include:

Medicaid Mandatory Services

- Nursing Facilities/age 21 or older
- Inpatient Hospital
- Physicians' Services
- Outpatient Hospital & Clinics
- Family Planning
- Home Health Services
- Laboratory and X-ray
- EPSDT
- Medical Supplies
- Nurse Practitioner

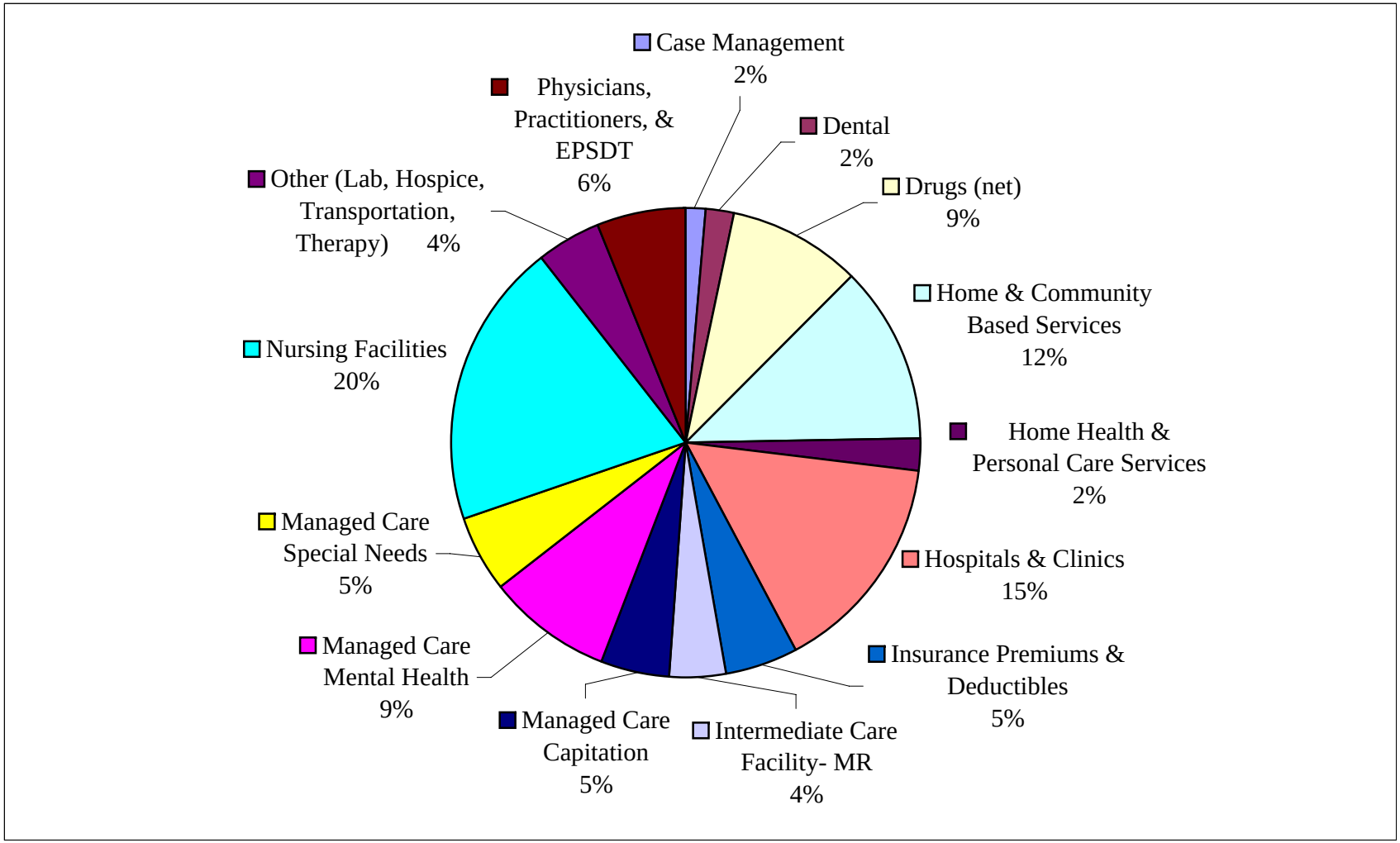


The Federal government allows Medicaid programs to cover certain medical services and makes Federal matching funds available. Examples of optional services include:

Medicaid Optional Services

- Drugs
- ICF-MR
- Dental Services
- Home & Community Based
- Rehabilitation Services
- Personal Care Services
- Medical Transportation
- Vision Related Services
- Speech Therapy
- Physical Therapy
- Mental Health Services
- Occupational Therapy
- Chiropractic Services
- Optometric Services
- Podiatric Services
- Hospice Services

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
PROGRAM 348 - MEDICAL SERVICES/AID
AID EXPENDITURES BY VENDOR TYPE
For the Fiscal Year Ended June 30, 2005



NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
PROGRAM 348 - MEDICAL SERVICES/AID
SCHEDULE OF MEDICAID AID EXPENDITURES PER FEDERAL REPORTS
Fiscal Years Ended June 30, 1995 Through 2005

	1995	1996	1997	1998	1999	2000
Aid Reported to HCFA/CMS:						
Inpatient Hospital	$ 137,612,109	$ 112,379,993	$ 106,586,054	$ 96,414,481	$ 109,011,544	$ 102,527,561
Mental Health Facilities	3,688,598	1,989,326	3,148,750	6,633,465	5,594,964	3,815,215
Nursing Facilities excl IGT	193,960,744	208,441,962	219,632,335	234,631,901	243,883,163	254,497,186
Intergovernmental Transfer				45,285,950	90,571,899	91,061,827
ICF MR Public	22,066,842	22,590,832	24,083,151	28,579,952	29,056,812	33,007,024
ICF MR Private	12,848,080	13,548,347	11,926,146	14,326,920	14,466,855	14,848,926
Physicians	46,036,435	43,675,776	43,508,679	42,500,026	55,047,873	53,464,260
Outpatient Hospital	26,592,922	23,500,340	21,608,733	24,750,189	27,263,239	30,365,972
Drugs	62,878,857	71,077,249	81,003,337	92,141,713	113,255,312	137,455,138
Drug Rebate	(11,746,042)	(10,793,893)	(14,732,937)	(16,071,551)	(19,766,255)	(32,754,930)
Dental	7,253,651	7,391,500	7,800,861	8,896,137	14,415,098	17,245,791
Other Practitioners	3,284,176	2,946,377	4,070,479	6,790,630	8,217,801	9,251,933
Clinic Services *	16,081,662	11,224,082	5,848,920	3,025,489	4,097,848	12,656,503
Lab & Radiology	6,158,213	5,923,719	5,699,057	5,434,437	6,244,570	7,043,435
Home Health Services	13,149,749	13,438,972	13,126,082	14,502,096	16,359,594	17,038,252
Sterilizations	772,242	850,405	835,432	823,099	695,707	856,418
EPSDT Health Check	3,985,031	3,843,353	3,324,842	3,261,862	3,862,144	4,595,883
Rural Health Clinics	237,349	502,178	330,997	442,593	936,140	1,668,933
Insurance Premiums	28,669,828	29,686,878	34,785,281	34,408,768	36,454,444	39,875,706
Managed Care		49,113,503	71,480,975	70,155,410	81,742,353	107,316,938
Home & Community Based Waiver	41,281,554	52,282,766	71,953,023	72,032,650	89,743,270	102,282,062
Personal Care Services	4,015,636	3,907,046	4,927,514	5,089,590	6,525,428	6,951,174
Targeted Case Management	5,799,753	4,228,832	3,366,133	2,965,092	4,590,950	6,139,168
Primary Case Management				919,468	498,939	621,546
Hospice Benefits	319,928	337,790	519,507	1,498,145	945,976	1,189,018
Federally Qualified Health Center	891,894	888,778	880,533	1,145,336	797,221	781,835
Other	17,750,096	21,365,915	20,390,654	20,359,902	27,444,816	29,417,220
Prior Quarters Adjustments	1,383,971	982,557	27,976,514	(3,386,237)	(523,330)	4,439,857
Third Party Liability Collections	(4,801,231)	(5,105,975)	(5,683,852)	(6,131,229)	(5,506,856)	(12,281,405)
Fraud Collections	(272,319)	(148,673)	(296,656)	(297,236)	(124,601)	(726,458)
Other Collections & Reductions	(8,484,462)	(9,083,429)	(6,564,009)	(7,490,973)	(9,826,000)	(9,900,728)
Total Medicaid Aid Reported to CMS	631,415,266	680,986,506	761,536,535	803,638,075	955,976,918	1,034,751,260
Less IGT funds returned to General Fund				(17,584,534)	(34,906,410)	(35,623,387)
Net Expenditures	$ 631,415,266	$ 680,986,506	$ 761,536,535	$ 786,053,541	$ 921,070,508	$ 999,127,873

*Adjusted for reporting errors noted. See Notes to Schedule.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
PROGRAM 348 - MEDICAL SERVICES/AID

SCHEDULE OF MEDICAID AID EXPENDITURES PER FEDERAL REPORTS

Fiscal Years Ended June 30, 1995 Through 2005

	2001	2002	2003	2004	2005	% Change 1995 to 2005
Aid Reported to CMS:						
Inpatient Hospital	$ 114,356,383	$ 137,248,700	$ 140,968,938	$ 168,294,183	$ 164,872,385	20%
Mental Health Facilities	3,081,233	15,189,384	39,515,074	34,344,846	45,356,124	1130%
Nursing Facilities (excl. IGT)	277,457,979	336,496,562	303,425,724	281,629,951	280,659,826	45%
Intergovernmental Transfer (IGT)	86,220,382	101,168,664	58,586,661	81,257,952	68,366,476	100%
ICF MR Public	33,178,746	32,290,985	32,242,493	43,211,659	40,236,459	82%
ICF MR Private	14,852,997	16,163,071	16,807,691	16,870,708	18,249,259	42%
Physicians	51,042,010	64,042,619	71,963,362	72,872,862	73,937,902	61%
Outpatient Hospital	35,107,805	45,416,098	52,913,854	55,055,912	56,952,789	114%
Drugs	163,220,358	197,226,250	212,684,115	228,552,896	243,234,406	287%
Drug Rebate	(32,096,387)	(41,086,969)	(40,376,866)	(45,741,103)	(54,900,940)	367%
Dental	19,504,765	24,687,902	28,581,716	27,189,526	26,247,014	262%
Other Practitioners	9,979,997	12,380,662	14,446,464	23,880,705	11,970,878	265%
Clinic Services	11,339,890	27,763,783	54,289,903	48,841,075	53,664,181	234%
Lab & Radiology	8,028,790	10,661,829	12,555,493	13,205,895	13,904,387	126%
Home Health Services	18,554,630	18,861,191	20,804,737	19,921,430	22,447,135	71%
Sterilizations	899,661	1,254,071	1,475,088	1,225,278	915,905	19%
EPSDT (Health Check)	5,440,437	6,380,442	7,122,233	6,838,650	6,898,496	73%
Rural Health Clinics	2,418,307	2,441,485	2,294,385	2,602,576	2,336,060	884%
Insurance Premiums	43,319,259	49,376,900	53,632,649	57,351,468	69,031,512	141%
Managed Care	121,863,817	90,239,407	60,657,546	73,555,514	71,095,973	100%
Home & Community Based	128,846,693	150,860,114	152,125,539	162,565,149	170,738,910	314%
Personal Care Services	7,010,116	7,820,916	8,941,364	9,156,983	11,177,669	178%
Targeted Case Management	11,897,203	12,995,336	11,251,271	18,005,582	20,650,905	256%
Primary Care Case Management	653,024	839,242	875,532	952,812	893,252	100%
Hospice Benefits	1,294,798	2,805,382	4,699,633	5,440,709	5,393,390	1586%
Federally Qualified Health Center	2,002,365	2,839,516	3,233,736	2,434,059	3,655,296	310%
Other	31,922,741	37,410,660	48,191,345	46,033,983	50,376,356	184%
Prior Quarters Adjustment	1,524,194	(7,410,602)	(2,324,878)	7,100,556	(81,968,166)	
Third Party Liability Collections	(12,399,309)	(13,498,418)	(17,163,063)	(14,783,737)	(12,903,515)	169%
Fraud Collections	(617,123)	(1,407,874)	(23,513)	(30,275)	(464,577)	71%
Other Collections & Reductions	(9,868,955)	(13,501,935)	58,586,661	(13,277,650)	(17,496,154)	106%
Total Medicaid Aid Reported to CMS	1,150,036,806	1,327,955,373	1,412,984,887	1,434,560,154	1,365,529,593	116%
Adjusted for CHIPs Reporting Error	-				106,117,397	
Less IGT funds returned to General Fund	(34,160,515)	(40,922,725)	(23,715,880)	(29,311,736)	(25,792,710)	
Net Expenditures	$ 1,115,876,291	$ 1,287,032,648	$ 1,389,269,007	$ 1,405,248,418	$ 1,445,854,280	129%

NOTE: Starting 10/01/03, Managed Care Special Needs and Mental Health Waivers were reported as separate categories. For comparability these Waivers are included by service above rather than separate items. Special Needs Waiver totaled $74,302,202 and Mental Health Managed Care Waiver totaled $121,358,108 for fiscal year 2005.

NOTES TO THE SCHEDULE

For the Fiscal Years Ended June 30, 1995 through 2005

Nursing Facilities and Intergovernmental Transfer In April 1998, the Nebraska Health and Human Services System began an intergovernmental transfer (IGT) arrangement with government-operated nursing facilities. The arrangement involves creating a proportionate share pool to increase Medicaid dollars received from the Federal government. For additional information see accompanying charts regarding the IGT. The IGT is shown as a separate line item on the schedules.

Clinic Services Overclaim Due to an error in completing the report to the Federal regulatory agency in 1998 and 1999, payments for certain rehabilitation services were included in both clinic services and physician services. The amounts for clinic services have been adjusted on the schedules for these reporting errors.

Home and Community Based Waiver Medicaid offers, under a waiver, an array of community-based services to individuals who are eligible for ICF-MR services.

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.

Other Practitioners Includes practitioners for vision care, psychotherapy, chiropractic, podiatry, nursing, and midwife services.

Insurance Premiums Medicaid pays Medicare Part B premiums for clients 65 years of age or older or those who qualify under the Aged, Blind, and Disabled Program. Medicaid also 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.

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.

ICF-MR Intermediate Care Facilities-Mentally Retarded (ICF-MR) are reported to CMS separately for public Beatrice State Developmental Center (BSDC) and private facilities.

EPSDT (Health Check) Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) was established for individuals age 20 and younger eligible for medical assistance. The goal is to provide preventive health care through regular and periodic screening examinations.

CHIPS Medicaid incorrectly reported Children's Health Insurance Program (CHIPS) and the schedule has been adjusted. See the Statewide Single comment for additional information.

Other Other aid payments include medical supplies, speech therapy, physical therapy, occupational therapy, medical transportation, ambulance, prosthetic devices, and optical supplier services.

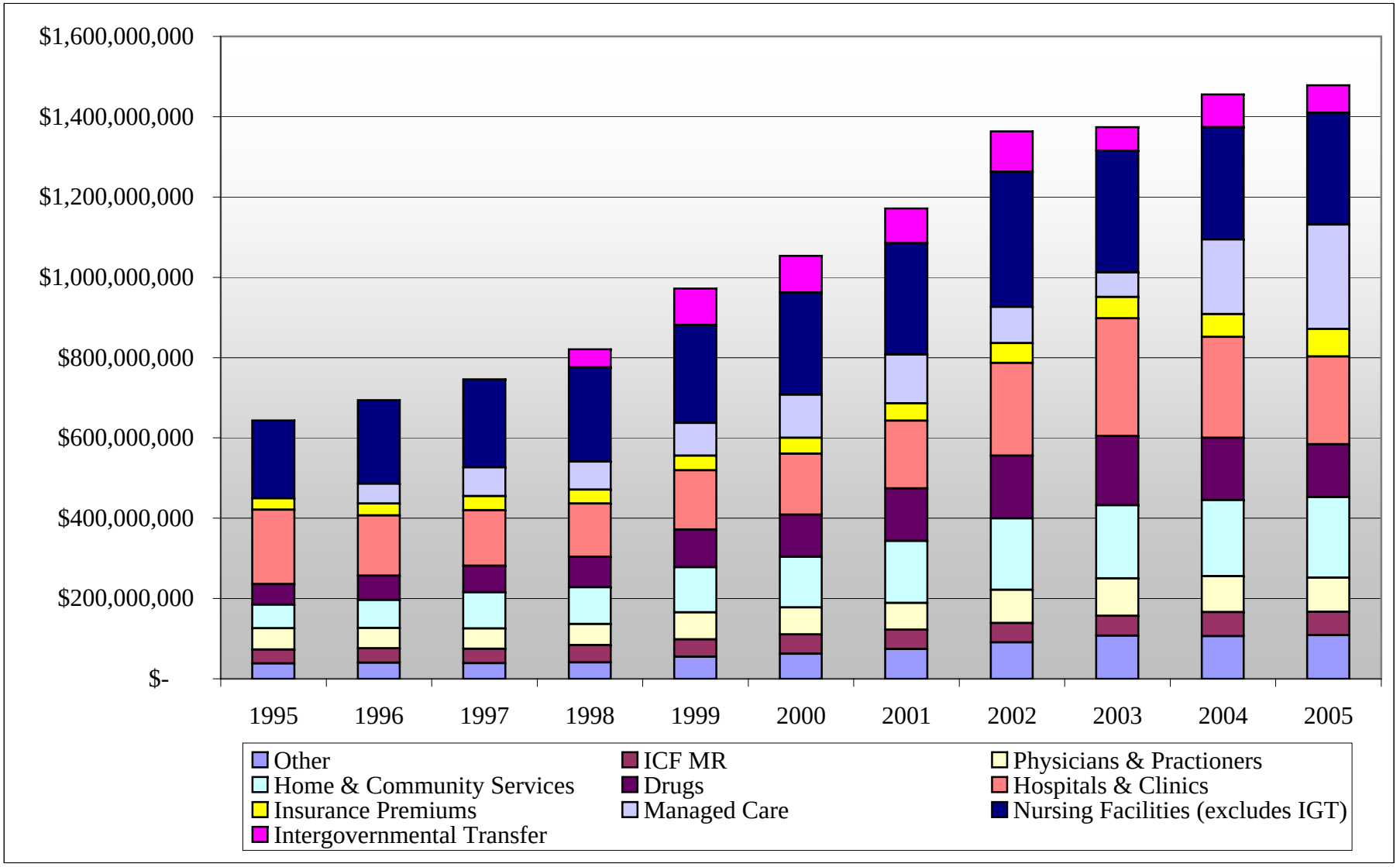
NOTES TO THE SCHEDULE
(Continued)

Third Party Liability Collections Collections from other sources, primarily insurance companies.

Fraud Collections Providers and/or recipients collections as a result of investigations by HHSS.

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.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
PROGRAM 348 - MEDICAL SERVICES/AID
MEDICAID AID EXPENDITURES BY SERVICE CATEGORY
For the Fiscal Years Ended June 30, 1995 Through 2005



NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
PROGRAM 348 - MEDICAL SERVICES/AID
***MEDICAID RECIPIENTS AND EXPENDITURES BY BASIS OF ELIGIBILITY AND TYPE OF SERVICE**
For the Fiscal Year Ended June 2005

	Avg Monthly Recipients*	Average Annual Expenditures by Recipient by Eligibility				
	ALL	AGED	BLIND	DISABLED	ADC Adult	CHILD
TOTAL-Unduplicated Recipients	151,433	17,674	214	25,701	18,910	88,935
TOTAL-Avg Annual Expenditures	$ 9,222	$ 20,652	$ 13,349	$ 21,934	$ 5,507	$ 4,058
By MEDICAL SERVICE						
INPATIENT HOSPITAL-Recipients	3,738	785	5	989	420	1,540
INPATIENT HOSPITAL-Expenditures	$ 39,829	$ 10,043	$ 54,657	$ 53,128	$ 52,334	$ 43,004
INPATIENT MENTAL-Recipients	552	1	-	30	3	520
INPATIENT MENTAL-Expenditures	$ 79,184	$ 219,568	$ -	$ 70,750	$ 30,069	$ 79,632
ICF for Mentally Retarded-Recipients	603	52	2	546	-	2
ICF for MR-Expenditures	$ 96,918	$ 94,401	$ 73,837	$ 97,160	$ -	$128,113
NURSING FACILITY-Recipients	7,624	6,421	8	1,184	6	6
NURSING FACILITY-Expenditures	$ 36,587	$ 34,082	$ 82,700	$ 49,365	$ 54,011	$118,161
PHYSICIANS SERVICES -Recipients	77,675	7,776	117	13,739	9,781	46,262
PHYSICIANS SERVICES-Expenditures	$ 1,226	$ 805	$ 1,472	$ 1,727	$ 1,560	$ 1,077
DENTAL SERVICES-Recipients	15,959	960	18	2,493	1,972	10,516
DENTAL SERVICES-Expenditures	$ 1,916	$ 1,938	$ 1,913	$ 2,044	$ 2,517	$ 1,771
OTHER PRACTITIONER-Recipients	16,134	3,899	31	5,066	1,676	5,462
OTHER PRACTITIONER-Expenditures	$ 1,150	$ 762	$ 1,212	$ 1,304	$ 1,248	$ 1,253
OUTPATIENT HOSPITAL-Recipients	25,871	5,219	47	6,550	3,372	10,684
OUTPATIENT HOSPITAL-Expend.	$ 2,814	$ 1,209	$ 3,951	$ 3,894	$ 3,976	$ 2,563
CLINIC SERVICES-Recipients	15,847	492	36	5,349	1,615	8,355
CLINIC SERVICES-Expenditures	$ 3,837	$ 1,685	$ 4,531	$ 4,575	$ 2,620	$ 3,722
HOME HEALTH-Recipients	2,229	784	7	1,036	45	358
HOME HEALTH-Expenditures	$ 14,410	$ 10,549	$ 9,402	$ 20,291	$ 4,606	$ 7,169
FAMILY PLANNING-Recipients	5,880		15	933	2,569	2,363
FAMILY PLANNING-Expenditures	$ 1,063	$ -	$ 576	$ 621	$ 936	$ 1,357
LAB AND RADIOLOGY-Recipients	11,663	481	24	2,419	2,588	6,151
LAB AND RADIOLOGY-Expend.	$ 1,245	$ 722	$ 1,432	$ 1,747	$ 1,552	$ 959
PRESCRIBED DRUGS-Recipients	83,916	15,643	162	20,808	9,550	37,752
PRESCRIBED DRUGS-Expenditures	$ 2,876	$ 3,928	$ 4,482	$ 5,477	$ 1,719	$ 1,293
MANAGED CARE-Recipients	20,921	160	18	1,698	3,505	15,540
MANAGED CARE-Expenditures	$ 3,340	$ 11,955	$ 10,402	$ 10,767	$ 4,548	$ 2,158
WAIVER SERVICES-Recipients	1,470	1,260	1	209	-	-
WAIVER SERVICES-Expenditures	$ 114,964	$ 28,727	$ 18,617	$634,252	$ -	$ -
OTHER CARE-Recipients	18,643	3,604	50	6,573	1,271	7,145
OTHER CARE-Expenditures	$ 2,562	$ 1,862	$ 3,222	$ 3,223	$ 1,993	$ 2,405
SCREENING SERVICES-Recipients	8,118	-	2	122	265	7,729
SCREENING SERVICES-Expenditures	$ 948	$ -	$ 742	$ 868	$ 947	$ 950

* Persons are average monthly unduplicated recipients. Within a month, a person is counted only once regardless of the number of times the service is utilized and counted only once in the total regardless of the number of different services received. The schedule reflects persons who actually received services, not the number of persons eligible for service. Includes Program 348 and Program 344. Expenditures are average annual expenditures per recipient.

SOURCE: HHSS Nebraska Medicaid General Information Report for Fiscal Year 2005

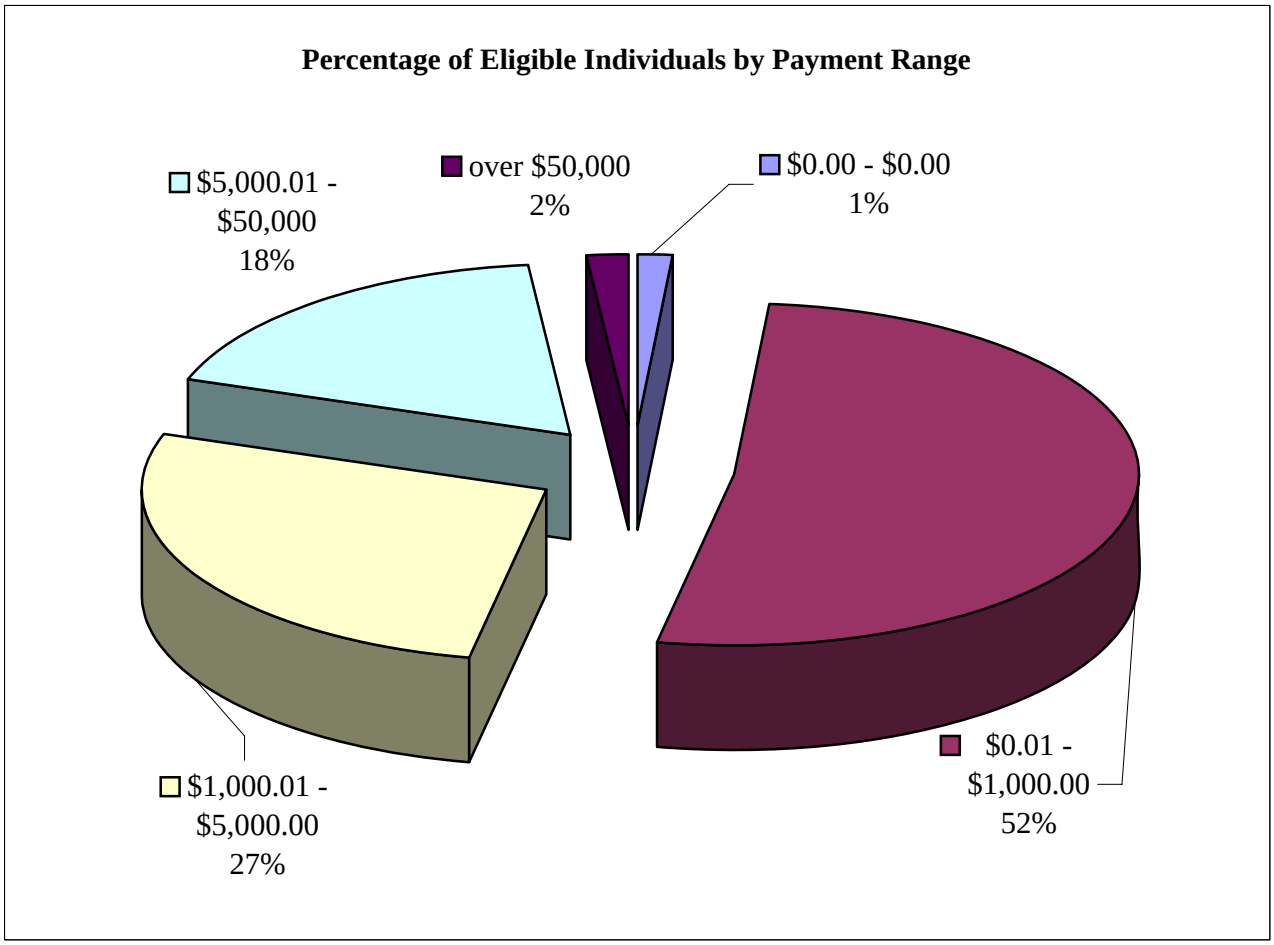
NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
PROGRAM 348 - MEDICAL SERVICES/AID

RANGE OF PAYMENTS TO ELIGIBLE INDIVIDUALS

For the Fiscal Year Ended June 30, 2005

The following table shows the number of individuals by range of payments for the fiscal year

	July 2004 through June 2005				
Range of Payment	Eligible Individuals	% of Total	Average Payment per Individual	Payments	% of Total
$0.00 - $0.00	3,344	1.4%	$ -	$ -	0.0%
$0.01 - $100.00	27,957	11.4%	$ 45	$ 1,269,732	0.1%
$100.01 - $5,00.00	62,390	25.5%	$ 273	$ 17,024,337	1.4%
$500.01 - $1,000.00	36,227	14.8%	$ 719	$ 26,040,013	2.2%
$1,000.01 - $5,000.00	66,439	27.2%	$ 2,371	$ 157,547,296	13.2%
$5,000.01 - $10,000.00	20,805	8.5%	$ 7,026	$ 146,168,682	12.2%
$10,000.01 - $25,000.00	15,291	6.3%	$ 15,736	$ 240,618,580	20.1%
$25,000.01 - $50,000.00	8,239	3.4%	$ 35,486	$ 292,366,314	24.5%
$50,000.01 - $75,000.00	2,173	0.9%	$ 59,374	$ 129,019,223	10.8%
$75,000.01 - $100,000.00	712	0.3%	$ 85,173	$ 60,642,939	5.1%
$100,000.01 - $500,000.00	857	0.4%	$ 139,259	$ 119,345,314	10.0%
$500,000.01 - $1,000,000.00	4	> 0.1%	$ 624,406	$ 2,497,622	0.2%
over $1,000,000.00	1	> 0.1%	$ 2,516,773	$ 2,516,773	0.2%



Source: HHSS Research

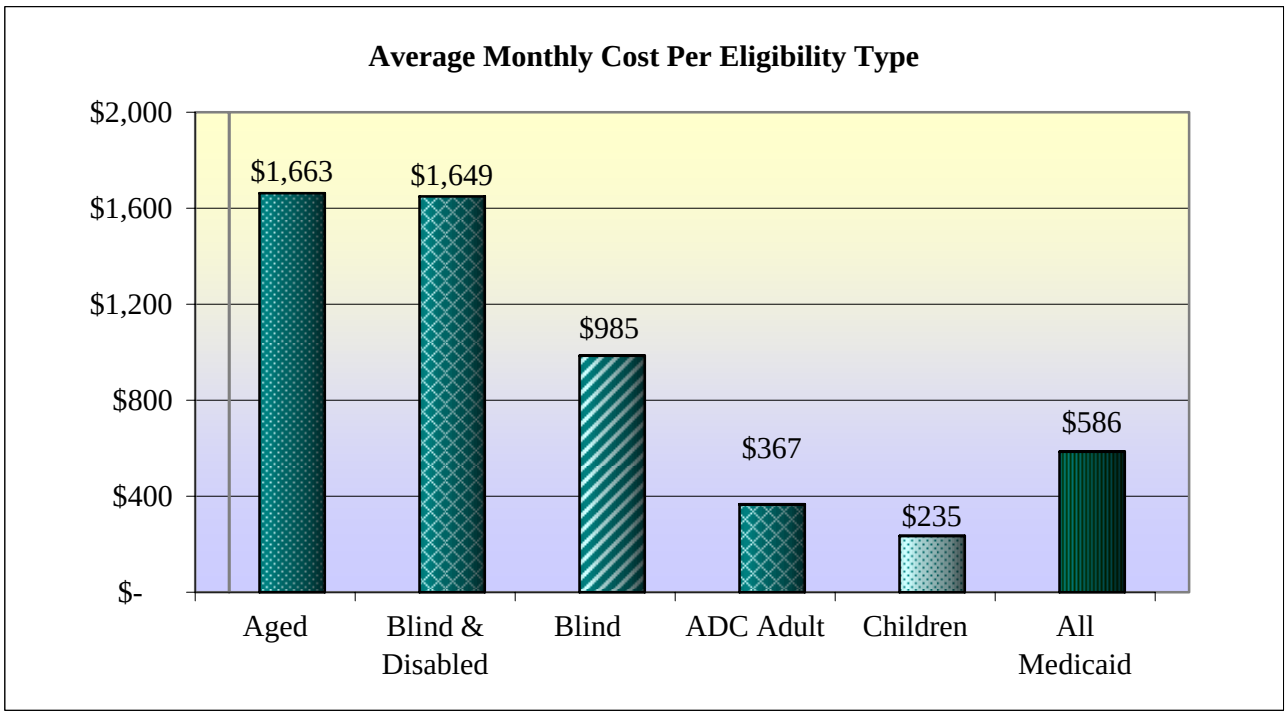
NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
PROGRAM 348 - MEDICAL SERVICES/AID
PAYMENTS BY SERVICE FOR TEN RECIPIENTS
For the Fiscal Year Ended June 30, 2005

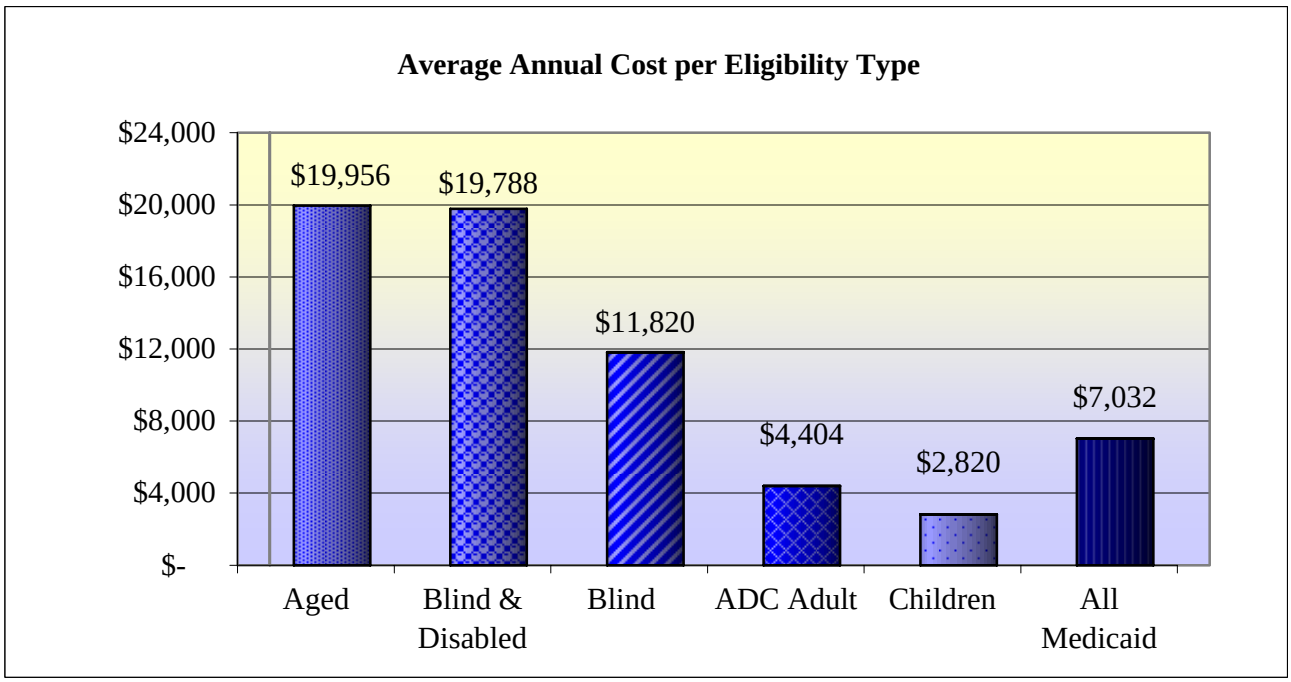
The following table represents payments made on behalf of recipients selected for detail testing during Fiscal Year 2005. The information provided is to give the reader an understanding of types of services and payments made for recipients selected. Crossover payments are those made after Medicare has paid their share of the claim.

Type of Service	Age 2 Female **Recipient 1**	Age 15 Male **Recipient 2**	Age 31 Female **Recipient 3**	Age 39 Female **Recipient 4**	Age 45 Male **Recipient 5**
Drugs	$ 9,079	$ 2,516,773		$ 475	$ 18,203
Practitioners/Supplier	259,724		3,202	1,326	701
Long Term Care					264,179
Dental					
EPSDT	264				
Crossover Practitioner/Supplier					1,190
Inpatient Hospital	6,386		645,027		
Outpatient Hospital	9,390				
Home Health	8,290				
Crossover Inpatient					
Crossover Outpatient					682
Aged and Disabled Waiver					
Medical Transportation					
Total for Fiscal Year	$ 293,133	$ 2,516,773	$ 648,229	$ 1,801	$ 284,954
	Preterm Infant	*Hemophilia Patient*	*Pregnancy Complications*		*Ventilator Dependent*

Type of Service	Age 49 Male **Recipient 6**	Age 62 Male **Recipient 7**	Age 78 Female **Recipient 8**	Age 81 Male **Recipient 9**	Age 81 Female **Recipient 10**
Drugs	$ 47	$ 5,195	$ 4,523	$ 11,571	$ 766
Practitioners/Supplier	3,159	4,495	11,167	171	
Long Term Care			1,884	25,801	219,934
Dental		330		21	
EPSDT					
Crossover Practitioner/Supplier				1,058	25
Inpatient Hospital			32,138		
Outpatient Hospital	3,173	4,084	1,070		
Home Health			227		
Crossover Inpatient				876	
Crossover Outpatient				1,225	163
Aged and Disabled Waiver		12,340	3,773	1,712	
Medical Transportation			163		
Total for Fiscal Year	$ 6,379	$ 26,444	$ 54,945	$ 42,435	$ 220,888
				Nursing Home Resident	*Ventilator Dependent*

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
PROGRAM 348 - MEDICAL SERVICES/AID
AVERAGE COST PER ELIGIBILITY TYPE
For the Fiscal Year Ended June 30, 2005





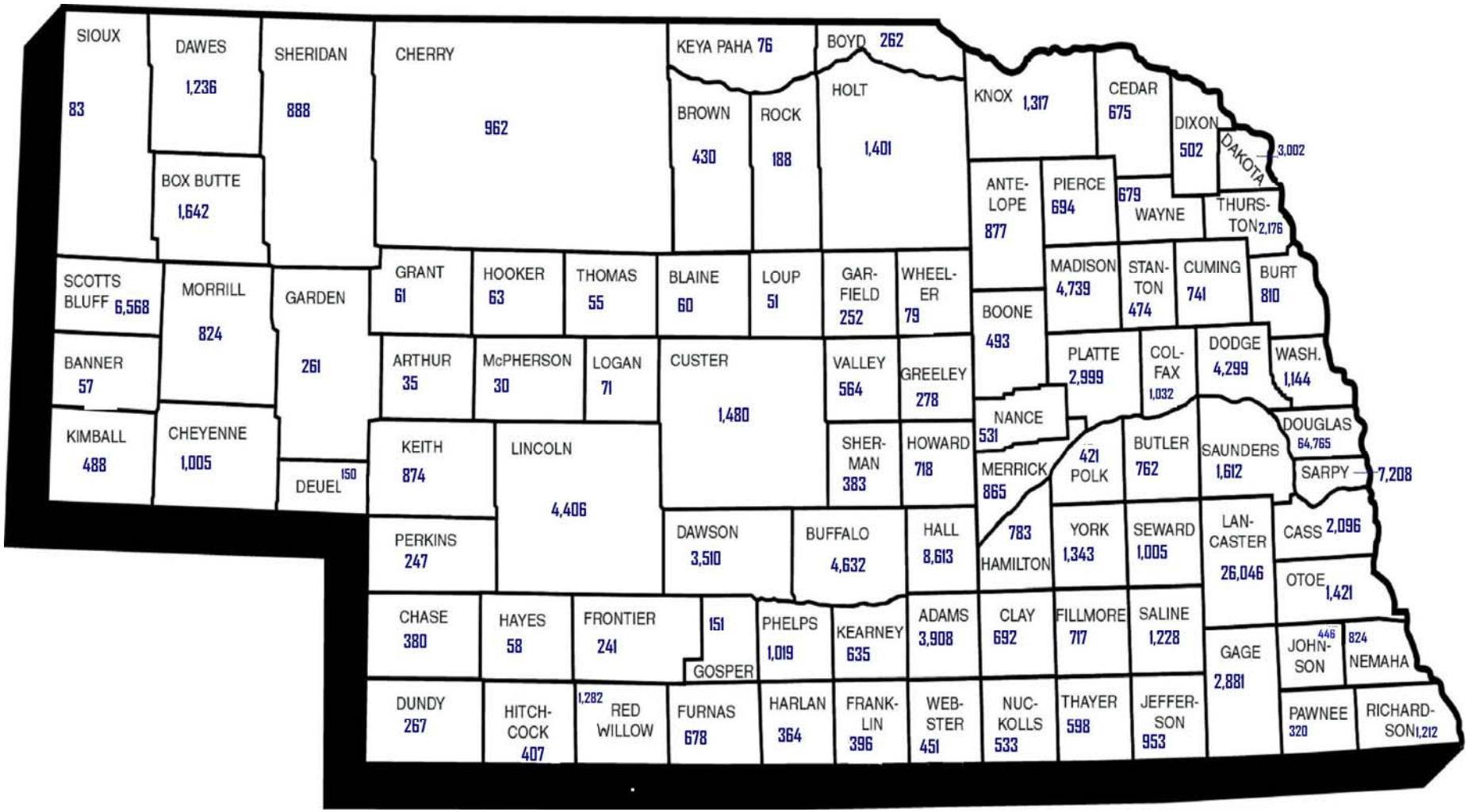
Note: Based on number of eligible individuals, whether or not they actually used services.

Source: HHSS Nebraska Medicaid General Information Report for Fiscal Year 2005.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
PROGRAM 348 - MEDICAL SERVICES/AID

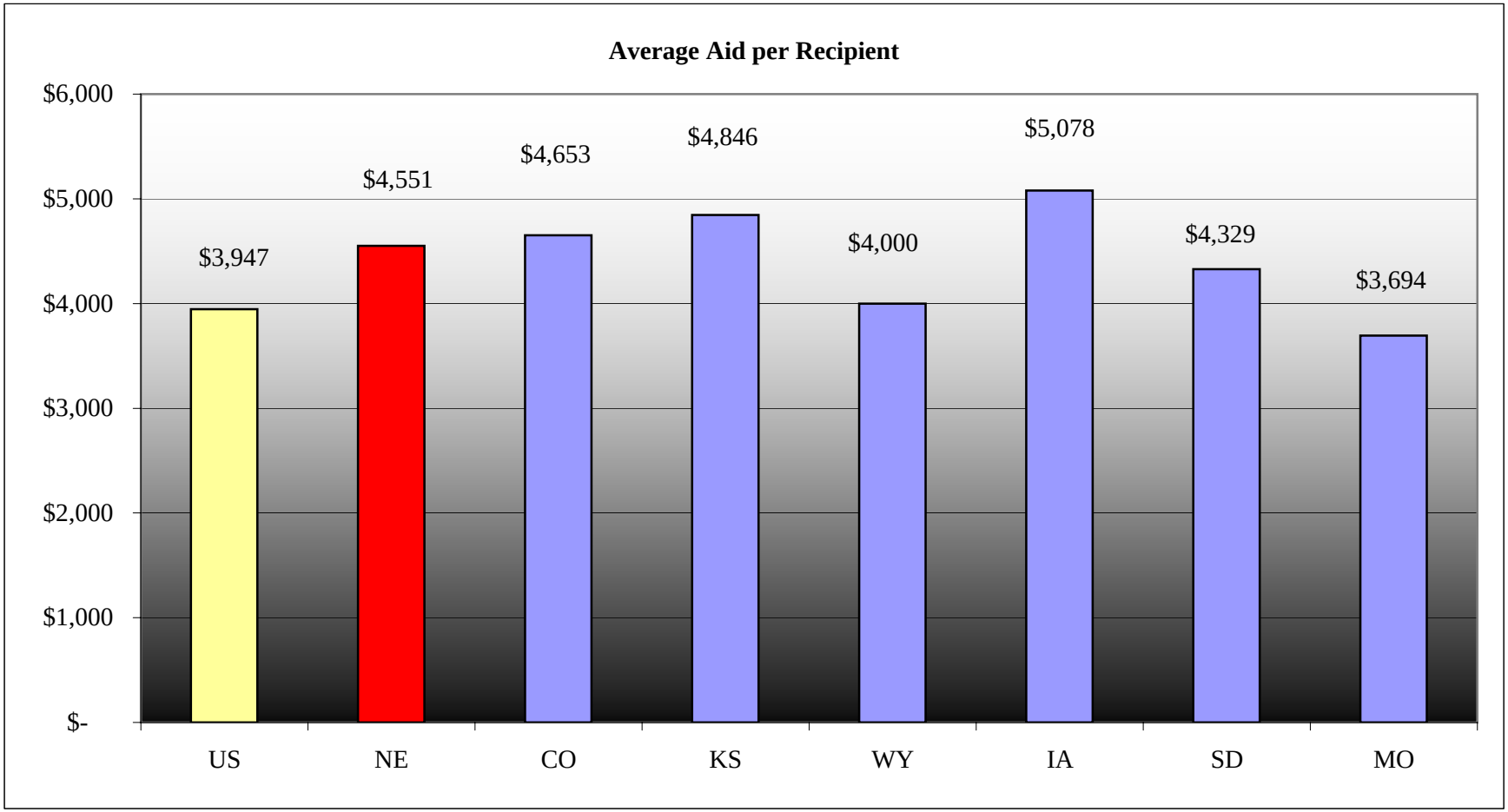
AVERAGE MONTHLY MEDICAID ELIGIBLE PERSONS BY COUNTY

For the Fiscal Year Ended June 30, 2005



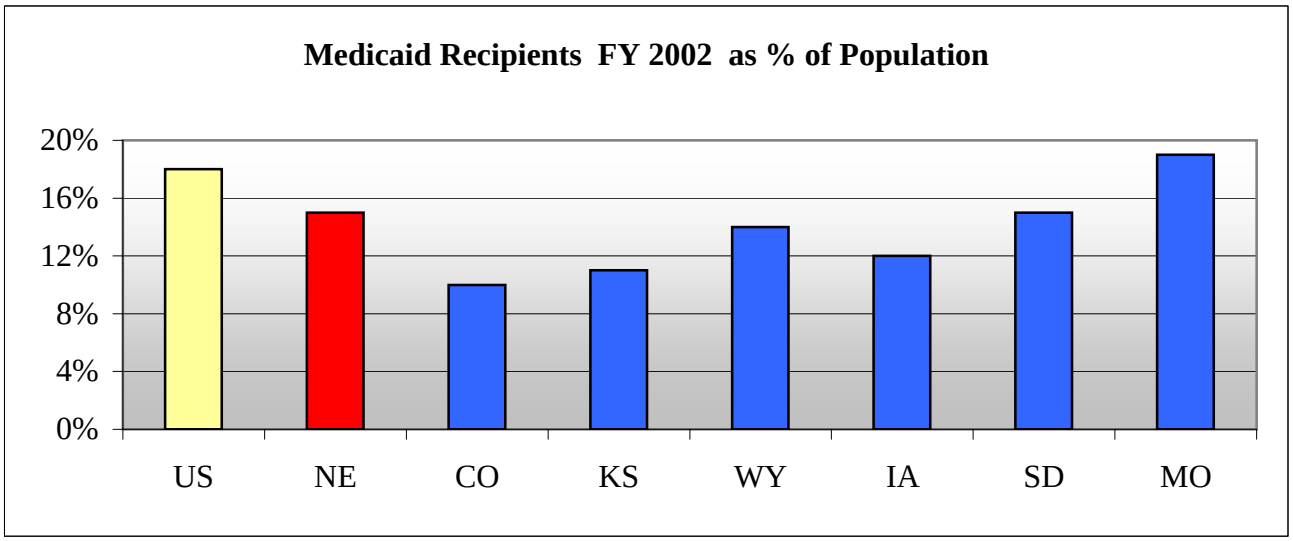
Source: HHSS Nebraska Medicaid General Information Report for Fiscal Year 2005. (Includes Program 348 and Program 344).

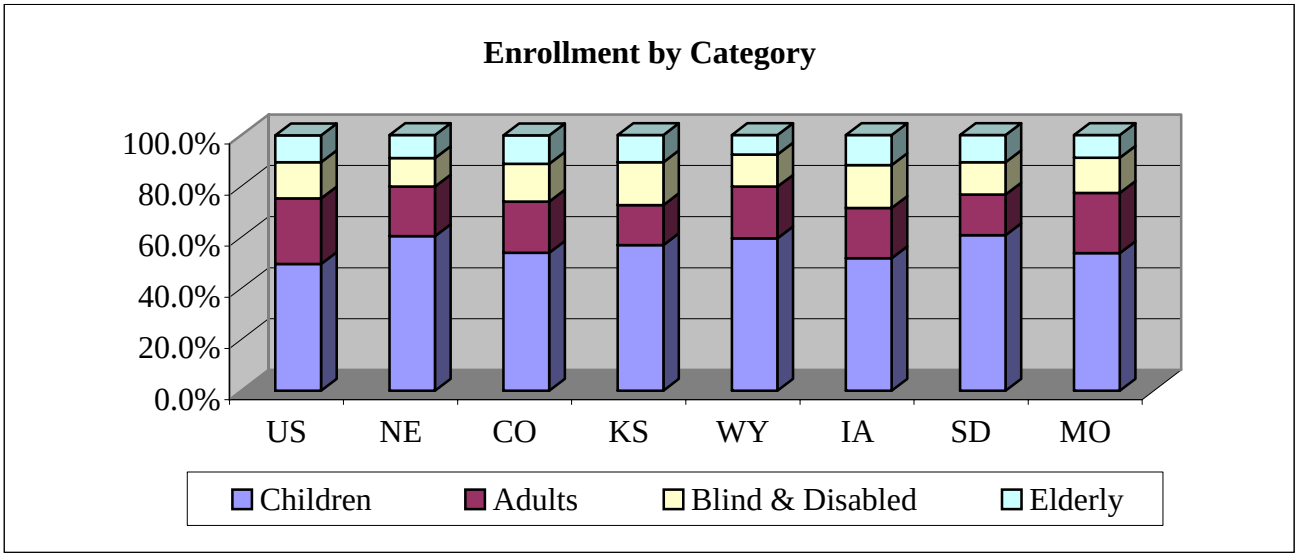
NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
PROGRAM 348 - MEDICAL SERVICES/AID
STATISTICS FOR U.S., NEBRASKA, AND SURROUNDING STATES

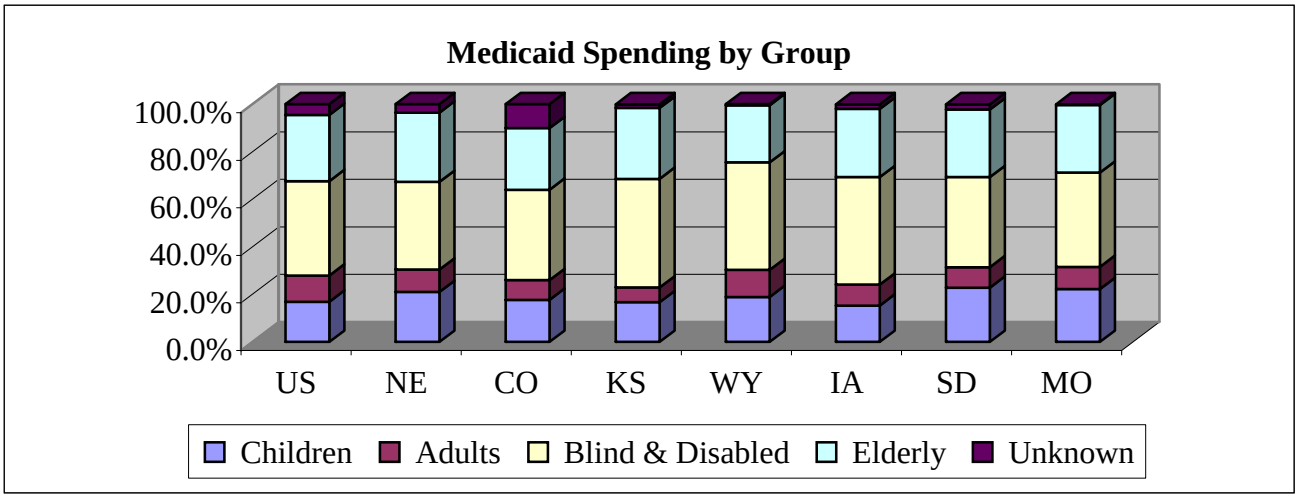


Source for charts of Medicaid Statistics for U.S., Nebraska, and Surrounding States is from the Kaiser Commission on Medicaid and the Uninsured and was the most current information at the time of our report. For additional information see www.kff.org.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
PROGRAM 348 - MEDICAL SERVICES AID
STATISTICS FOR U.S., NEBRASKA, AND SURROUNDING STATES







NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
PROGRAM 348 - MEDICAL SERVICES/AID
STATISTICS FOR U.S., NEBRASKA, AND SURROUNDING STATES

	Number							
	US	NE	CO	KS	WY	IA	SD	MO
Demographic Profile, 2003-3004								
Total Residents	290,286,350	1,720,360	4,473,700	2,659,930	489,570	2,909,030	749,270	5,611,440
Income								
Poor: Below Federal Poverty Level (FPL)	50,481,410	205,110	599,950	387,900	63,800	345,590	120,010	858,370
Near-Poor: 100% - 199% of the FPL	54,647,220	324,240	751,800	494,480	91,250	528,420	137,250	1,043,430
Non-Poor: 200% of the FPL and above	185,157,720	1,191,000	3,121,950	1,777,560	334,520	2,035,020	492,020	3,709,650
Median Annual Income, 2002-2004	$ 44,473	$ 44,623	$ 51,022	$ 43,725	$ 43,641	$ 43,042	$ 40,518	$ 43,988
Age								
Children (0-18)	77,796,940	471,960	1,217,690	731,280	125,510	738,950	204,640	1,478,070
Poor Children	18,039,980	64,170	195,050	140,810	23,700	114,440	44,060	305,200
Adults (19-64)	177,276,200	1,037,280	2,858,080	1,613,760	304,400	1,770,980	440,430	3,378,280
Poor Adults	27,797,390	116,910	357,560	214,150	35,240	195,050	63,900	473,200
Elderly (65+)	35,213,200	211,110	397,920	314,890	59,660	399,100	104,210	755,080
Poor Elderly	4,644,040	24,030	47,340	32,940	4,850	36,100	1,204	79,970
Non-Citizen	21,649,240	67,030	319,780	101,790	5,630	95,750	9,830	107,030
Population Living in Non-Metropolitan Areas	50,296,400	699,070	632,660	987,270	345,230	1,441,490	437,950	1,326,010
Medicaid Enrollment								
Total Enrollment FY 2002	51,419,500	265,800	438,600	305,100	69,800	358,600	113,800	1,098,600
Children	25,519,700	160,600	237,000	173,900	41,600	185,800	69,200	591,300
Adults	13,177,600	51,700	87,800	47,600	14,100	70,500	18,100	258,000
Blind & Disabled	7,307,700	29,600	65,100	51,300	8,800	60,400	14,400	148,400
Elderly	5,414,500	23,900	48,700	32,300	5,300	41,900	12,100	100,900
Medicaid Expenditures								
Total Medicaid Spending in Millions, FY 2004	$ 288,063	$ 1,459	$ 2,662	$ 1,792	$ 370	$ 2,278	$ 569	$ 6,189
Long Term Care (LTC)	$ 100,997	$ 680	$ 958	$ 718	$ 177	$ 1,002	$ 220	$ 1,719
Nursing Home	$ 46,501	$ 360	$ 424	$ 268	$ 61	$ 426	$ 118	$ 795
Home/Personal Care	$ 37,623	$ 228	$ 485	$ 380	$ 90	$ 325	$ 81	$ 642
Per Enrollee Medicaid Spending, FY 2002								
Total	$ 3,947	$ 4,551	$ 4,653	$ 4,846	$ 4,000	$ 5,078	$ 4,329	$ 3,694
Children	$ 1,400	$ 1,637	$ 1,694	$ 1,445	$ 1,275	$ 1,531	$ 1,661	$ 1,530
Adults	$ 1,782	$ 2,286	$ 2,148	$ 1,963	$ 2,271	$ 2,327	$ 2,395	$ 1,490
Blind & Disabled	$ 11,547	$ 15,644	$ 13,265	$ 13,383	$ 14,420	$ 13,901	$ 13,265	$ 10,862
Elderly	$ 10,971	$ 15,288	$ 12,055	$ 13,844	$ 12,682	$ 12,713	$ 11,841	$ 11,464

Source: The Kaiser Commission on Medicaid and the Uninsured.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
PROGRAM 348 - MEDICAL SERVICES/AID
STATISTICS FOR U. S., NEBRASKA, AND SURROUNDING STATES

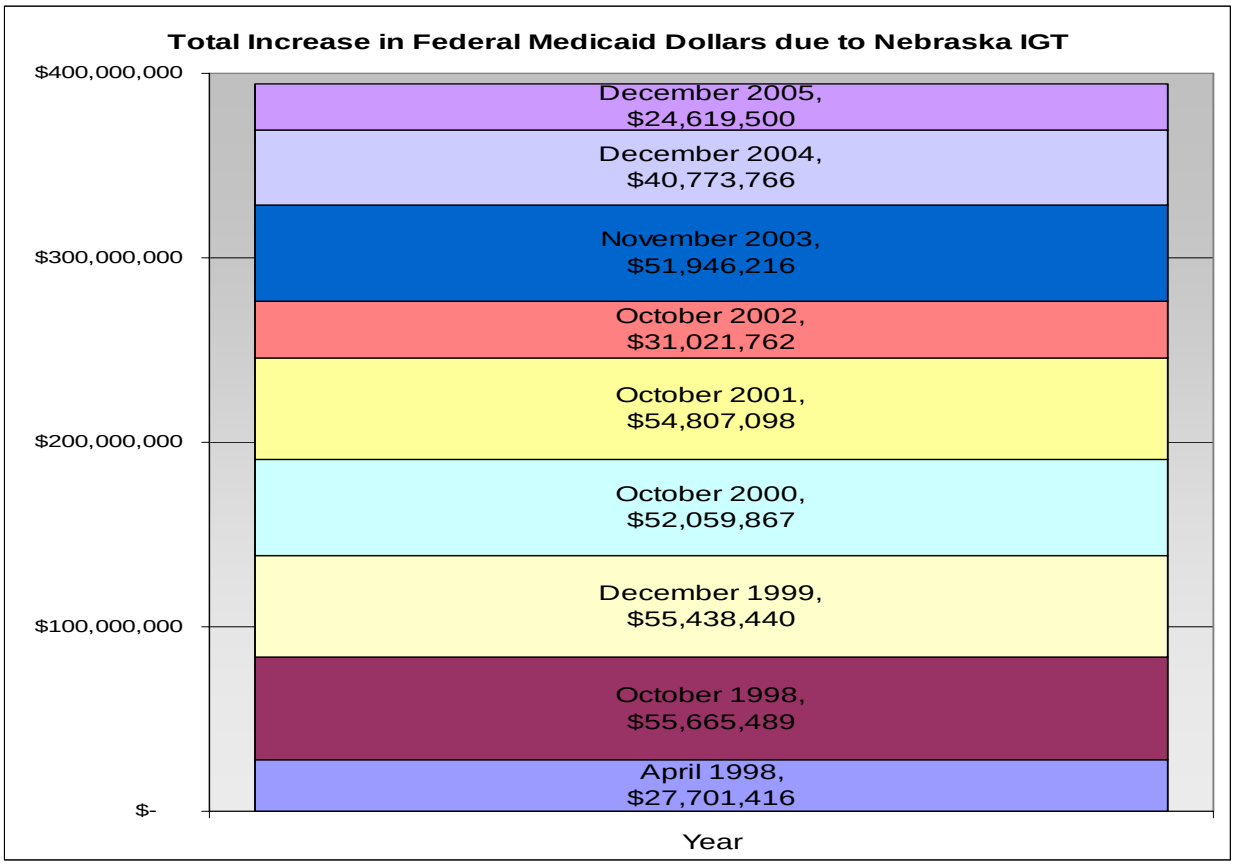
	Percent							
	US	NE	CO	KS	WY	IA	SD	MO
Demographic Profile, 2003-3004								
Income % of total Residents								
Poor: Below Federal Poverty Level (FPL)	17	12	13	15	13	12	16	15
Near-Poor: 100% - 199% of the FPL	19	19	17	19	19	18	18	19
Non-Poor: 200% of the FPL and above	64	69	70	67	68	70	66	66
Age								
Children (0-18) % of total residents	27	27	27	27	26	25	27	26
Poor Children % of total children	23	14	16	19	19	15	22	21
Adults (19-64) % of total residents	61	60	64	61	62	61	59	60
Poor Adults % of total adults	16	11	13	13	12	11	15	14
Elderly (65+) % of total residents	12	12	9	12	12	14	14	13
Poor Elderly % of total elderly	13	11	12	10	8	9	12	11
Non-Citizen % of total residents	7	4	7	4	1	3	1	2
Population Living in Non-Metropolitan Areas	17	41	14	37	71	50	58	24
Medicaid Enrollment								
Total Enrollment FY 2002 % of total residents	18	15	10	11	14	12	15	19
Children % of Medicaid Enrollees	49.6	60.4	54	57	59.6	51.8	60.8	53.8
Adults % of Medicaid Enrollees	25.6	19.5	20	15.6	20.2	19.7	15.9	23.5
Blind & Disabled % of Medicaid Enrollees	14.2	11.1	14.8	16.8	12.6	16.8	12.7	13.5
Elderly % of Medicaid Enrollees	10.5	9	11.1	10.6	7.6	11.7	10.6	9.2
% Enrolled in Managed Care, 2004	61.3	73.2	97.1	56.9	0	90.1	97.6	44.2
Medicaid Expenditures								
Long Term Care (LTC) % of total spending	35.1	46.6	36	40.1	47.9	44	38.7	27.8
Nursing Home % of LTC spending	46	52.9	44.3	37.3	34.2	42.5	53.6	46.2
Home/Personal Care % of LTC spending	37.3	33.5	50.6	53	50.8	32.4	36.8	37.3
Per Enrollee Medicaid Spending, FY 2002								
Children	16.9	21	17.7	16.7	18.9	15.3	22.8	22.2
Adults	11	9.4	8.3	6.2	11.4	8.8	8.6	9.4
Blind & Disabled	39.7	36.9	38	45.7	45.2	45.2	37.9	39.6
Elderly	27.9	29.1	25.9	29.8	24	28.7	28.4	28.4
Unknown	4.6	3.6	10.1	1.5	0.5	1.9	2.2	0.3
Other Medicaid Spending Measures								
Federal Matching Rate per State Dollar, FY2006	>50	59.7	50	60.4	54.2	63.6	65.1	61.9
General Fund Spending on Medicaid SFY2004	16.9	17.7	16.9	12.7	4.8	7.4	20	16.5

Source: The Kaiser Commission on Medicaid and the Uninsured.

NURSING FACILITIES INTERGOVERNMENTAL TRANSFERS

In April 1998, the Department began an intergovernmental transfer (IGT) arrangement with government-operated nursing facilities. The arrangement involves creating a proportionate share pool to increase Medicaid dollars received from the Federal government. The Department estimates the difference between the maximum Medicare rate and the Medicaid rate paid to all nursing facilities (governmental and private). This amount is then distributed to governmental nursing homes. The nursing homes, after keeping a participation fee, are required to transfer the remainder back to the Department. 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 Medicaid Intergovernmental Trust Fund. Funds from the IGT and interest earnings are utilized as directed by the Nebraska Health Care Fund Act.

On January 12, 2001, the Federal regulatory agency for Medicaid issued revisions to the upper payment limitations that will significantly limit the aggregate Medicaid payments to government facilities. The new regulations include a transition period, during which the financial impact would be gradually phased in and become fully effective on October 1, 2008.

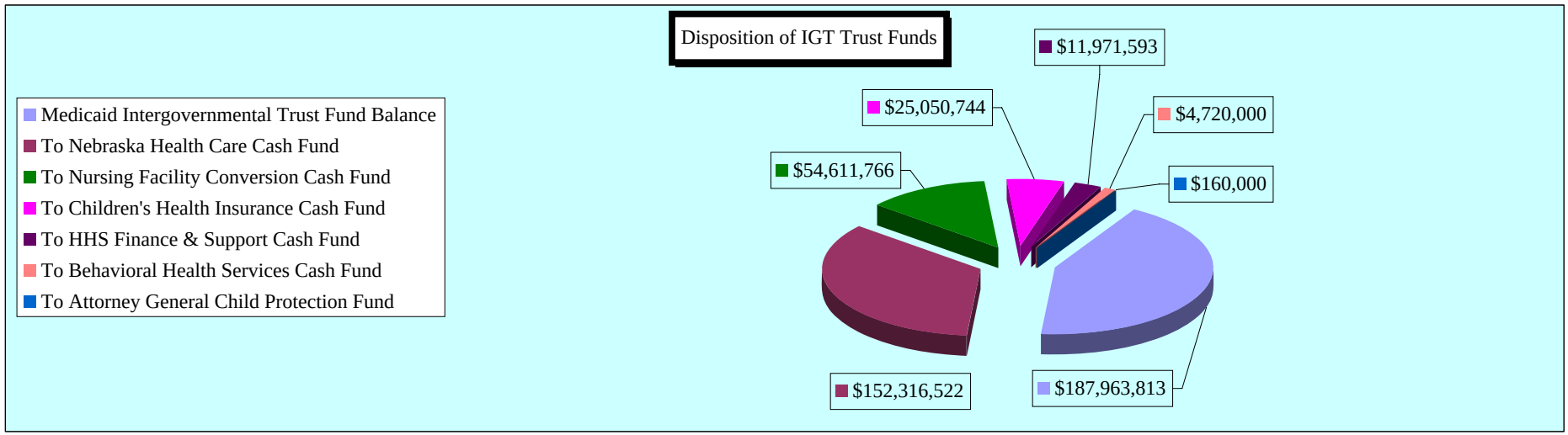


NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
PROGRAM 348 - MEDICAL SERVICES/AID
NURSING FACILITIES INTERGOVERNMENTAL TRANSFERS
April 1, 1998 through December 31, 2005

	State Share	Federal Share	Total
April 1998	$ 17,584,534	$ 27,701,416	$ 45,285,950
October 1998	34,906,410	55,665,489	90,571,899
December 1999	35,623,387	55,438,440	91,061,827
October 2000	34,160,515	52,059,867	86,220,382
October 2001	40,922,725	60,245,939	101,168,664
October 2002	23,715,880	34,870,781	58,586,661
November 2003	29,311,736	51,946,216	81,257,952
December 2004	27,592,710	40,773,766	68,366,476
December 2005	16,633,011	24,619,500	41,252,511
Total Increase in Medicaid due to IGT	260,450,908	403,321,414	663,772,322
Less Participation Fees to Nursing Facilities		(5,603,141)	(5,603,141)
Total Transferred Back to the State	260,450,908	397,718,273	658,169,181
State Share returned to General Fund	(260,450,908)		(260,450,908)
State Medicaid Matching Provided	$ -		
Federal Deferral on October 2001 IGT		(5,438,841)	(5,438,841)
Federal Return February 2003		(3,849,019)	(3,849,019)
Federal Funds to State		$ 388,430,413	388,430,413
Investment Income Medicaid Intergovernmental Trust Fund			44,886,748
Available Funds			433,317,161
Transfers to:			
Nursing Facility Conversion Cash Fund			(54,611,766)
Nebraska Health Care Cash Fund			(152,316,522)
Behavioral Health Services Cash Fund			(4,720,000)
Attorney General Child Protection Fund			(160,000)
HHSS Finance & Support Cash Fund			(11,971,593)
Children's Health Insurance Cash Fund			(25,050,744)
			(248,830,625)
Nebraska Medicaid Intergovernmental Trust Fund Balance, December 31, 2005			$ 184,486,536

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
PROGRAM 348 - MEDICAL SERVICES/AID
NURSING FACILITES INTERGOVERNMENTAL TRANSFERS
April 1998 through December 2005

	Cumulative April 1998 thru October 2002	November 2003	December 2004	December 2005	Total
Proportionate Share Pool	$ 472,895,383	$ 81,257,952	$ 68,366,476	$ 41,252,511	$ 663,772,322
Less: Participation Fee to Nursing Homes	(2,870,000)	(2,498,141)	(117,500)	(117,500)	(5,603,141)
Transfer Back to State	470,025,383	78,759,811	68,248,976	41,135,011	658,169,181
Deposit to General Fund to Repay Matching Dollars	(186,913,451)	(29,311,736)	(27,592,710)	(16,633,011)	(260,450,908)
Total Federal Funds returned to State	283,111,932	49,448,075	40,656,266	24,502,000	397,718,273
Adjustments back to Federal Funds for errors	(5,438,841)	(3,849,019)			(9,287,860)
Total	$ 277,673,091	$ 45,599,056	$ 40,656,266	$ 24,502,000	$ 388,430,413
Deposit to:					
Nebraska Medicaid Intergovernmental Trust Fund	$ 268,473,091	$ 45,599,056	$ 40,656,266	$ 24,502,000	$ 379,230,413
Health Care Cash Fund	9,200,000				9,200,000
Total	$ 277,673,091	$ 45,599,056	$ 40,656,266	$ 24,502,000	$ 388,430,413



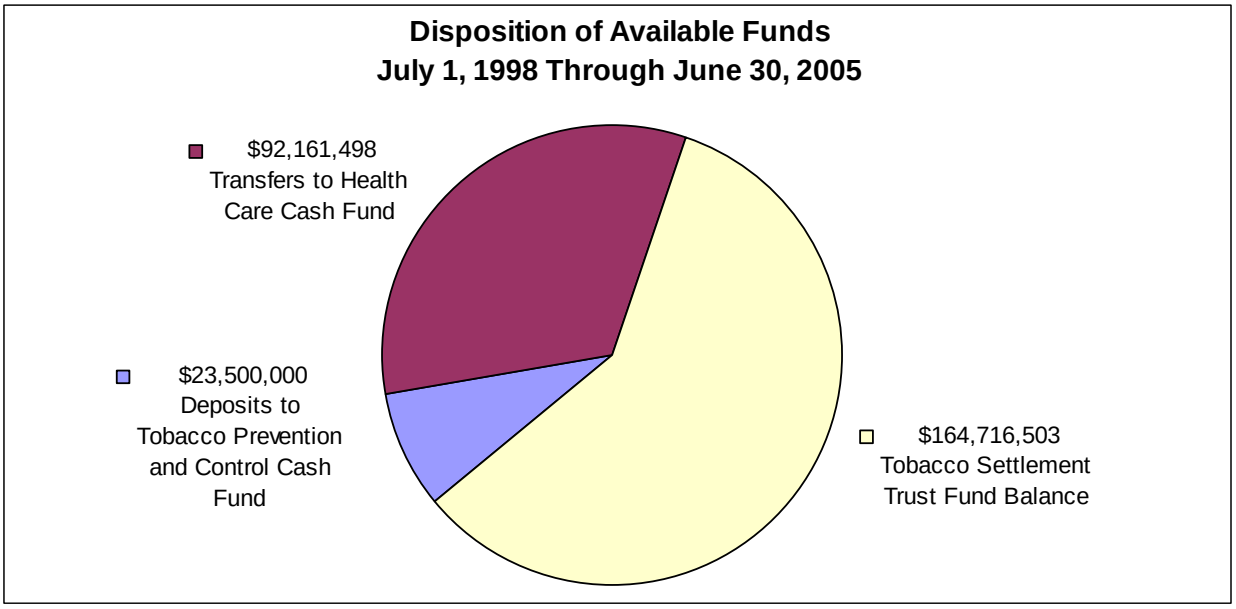
TOBACCO SETTLEMENT FUNDS

BACKGROUND

Nebraska was among a group of 46 states that agreed to a $246 billion settlement with the tobacco industry. The 1998 settlement was a result of the states' efforts to recoup money spent to care for ill smokers. Nebraska's share of the settlement is estimated at approximately $1.2 billion over a 25-year period.

In 1998, the State Legislature approved a plan distributing Nebraska's tobacco settlement funds to health care needs through a competitive grant process. The Legislature amended its plans for distributing the funds in 2000 by allocating $21 million over three years for tobacco use prevention and cessation efforts. In 2001, the Governor and Legislature approved LB 692, which authorized the distribution of $50 million annually to designated health care needs. The $50 million would be a combination of principal and interest from Nebraska's share of the tobacco settlement. Under LB 692, the tobacco settlement proceeds are allocated to behavioral health services, mental health and substance abuse treatment, juvenile services, minority health, developmental disabilities, emergency protective care, respite care, and biomedical research. LB 692 also provides for competitive health care grants and public health grants awarded by the Nebraska Health Care Council.

Tobacco settlement funds are deposited to the Tobacco Settlement Trust Fund, which is invested by the State Investment Office. Annually, the State Treasurer shall transfer a total of $50 million from the Nebraska Medicaid Intergovernmental Trust Fund and the Tobacco Settlement Trust Fund to the Nebraska Health Care Cash Fund. The State Investment Officer shall advise the State Treasurer on the amounts to be transferred from each fund.



NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
PROGRAM 348 - MEDICAL SERVICES/AID
TOBACCO SETTLEMENT FUNDS
Schedules of Activity
July 1, 1998 Through June 30, 2005

SETTLEMENT FUNDS RECEIVED JULY 1, 1998 THROUGH JUNE 30, 2005

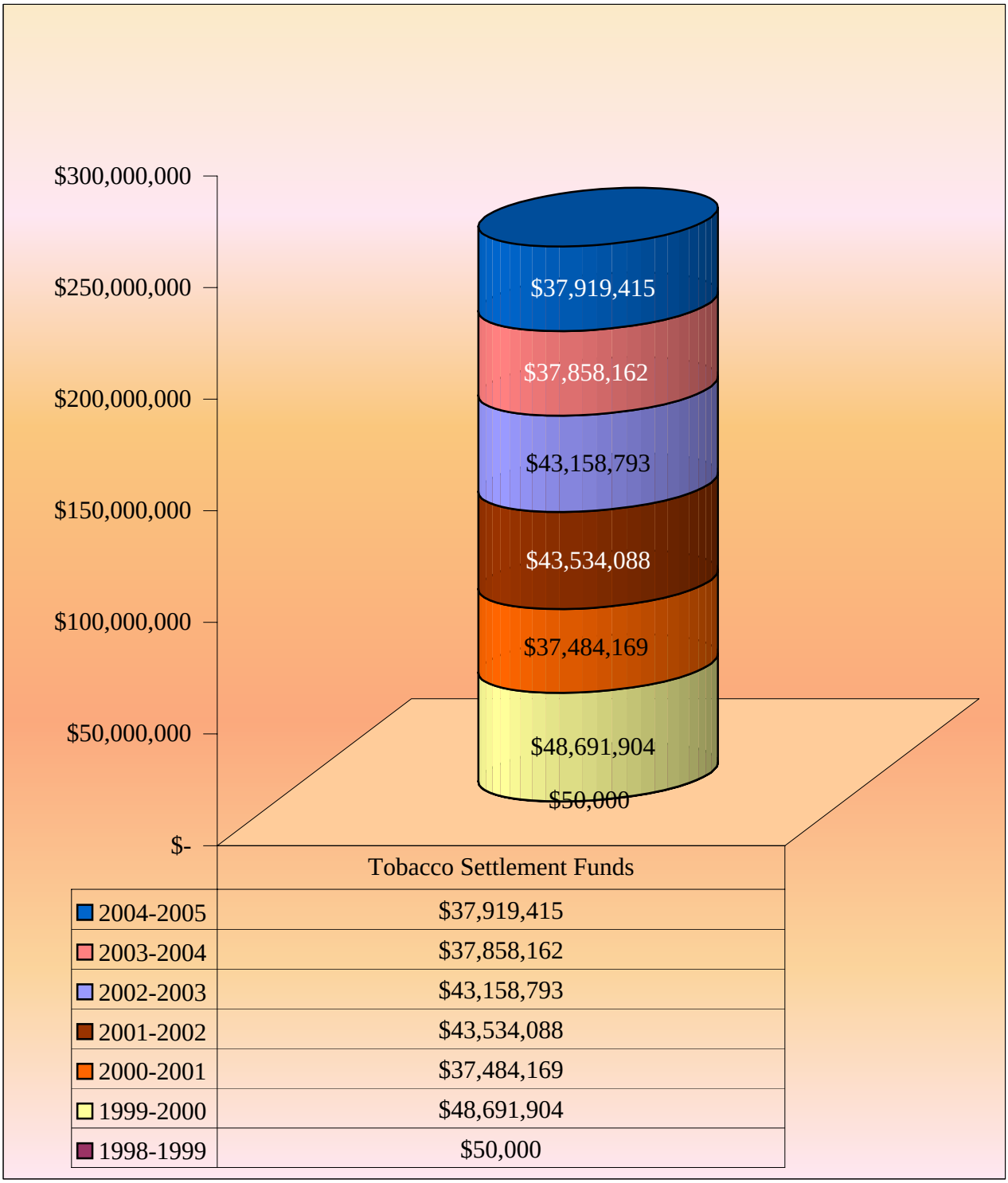
Received by Fiscal Year:		
1998-1999	$	50,000
1999-2000		48,691,904
2000-2001		37,484,169
2001-2002		43,534,088
2002-2003		43,158,793
2003-2004		37,858,162
2004-2005		37,919,415
	$	248,696,531
Deposited to:		
Tobacco Settlement Trust Fund	$	225,196,531
Tobacco Prevention and Control Cash Fund		23,500,000
	$	248,696,531

NEBRASKA TOBACCO SETTLEMENT TRUST FUND
Cumulative Activity Through June 30, 2005

	Fund 62630
Tobacco Settlement funds received	$ 225,196,531
Net Investment Income	31,681,470
Total Available	256,878,001
Transfers Out to Nebraska Health Care Cash Fund*	(92,161,498)
Ending Balance June 30, 2005	$ 164,716,503

* Prior to May 17, 2001, investment income earned was transferred to the Nebraska Health Care Cash Fund. After May 17, 2001, interest earned remained in the Tobacco Settlement Trust Fund and an annual transfer was made to the Nebraska Health Care Cash Fund. The transfer for the fiscal year ended June 30, 2005, was $23.5 million.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
PROGRAM 348 - MEDICAL SERVICES/AID
TOBACCO SETTLEMENT FUNDS
Settlement Funds Received
July 1, 1998 Through June 30, 2005



	Tobacco Settlement Funds
2004-2005	$37,919,415
2003-2004	$37,858,162
2002-2003	$43,158,793
2001-2002	$43,534,088
2000-2001	$37,484,169
1999-2000	$48,691,904
1998-1999	$50,000

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
PROGRAM 348 - MEDICAL SERVICES/AID
ICF- MR TAX
Fiscal Year Ended June 30, 2005

	Fiscal Year Ended June 30, 2005
From:	
BSDC	$ 2,326,302
Mosaic	1,031,396
Tax Collected	3,357,698
Interest earned	7,040
	3,364,738
To:	
Department Administration	(55,000)
Fund State portion of rate increase	(1,351,167)
Community based DD	(312,000)
One-time increase (State share)	(300,000)
Remaining to General Fund	(1,346,571)
	$ -

Net Effect in Dollars paid/received	State	Federal	Mosaic	Total
BSDC & Mosaic pay tax	$ (938,896)	$ (1,387,406)	$ (1,031,396)	$ (3,357,698)
State receives Tax	3,357,698			3,357,698
Rate increase to BSDC - Federal share	1,387,406	(1,387,406)		-
Rate increase to Mosaic	(412,271)	(619,125)	1,031,396	-
One-time rate increase to Mosaic	(300,000)	(450,000)	750,000	-
Additional received (paid)	$ 3,093,937	$ (3,843,937)	$ 750,000	$ -
	received	paid	received	

Net Effect Medicaid Reported	State	Federal	Total
BSDC tax	$ 938,896	$ 1,387,406	$ 2,326,302
Rate increase BSDC	938,896	1,387,406	2,326,302
Rate increase Mosaic	412,271	619,125	1,031,396
One-time increase Mosaic	300,000	450,000	750,000
	$ 2,590,063	$ 3,843,937	$ 6,434,000
			Total increase due to LB841

Per LB 841: "Each intermediate care facility for the mentally retarded shall pay a tax equal to six percent of its net revenue for the most recent State of Nebraska fiscal year." For fiscal year 2004-05, proceeds from the tax shall be allocated as follows (a) "First, fifty-five thousand dollars to the Department for administration of the fund; (b) Second, payment to intermediate care facilities for the mentally retarded for the cost of the tax; (c) Third, three hundred thousand dollars, in addition to any Federal medicaid matching funds, for increases in payments to non-state-operated intermediate care facilitites for the mentally retarded which shall be such facilities' only increase in payments for such fiscal year; (d) Fourth, three hundred twelve thousand dollars, in addition to any Federal medicaid matching funds, for payment to providers of community-based services for the purpose of reducing the waiting list of persons with developmental disablities; and (e) Fifth, any money remaining in the fund after the allocations required by subdivisions (2) (a) through (d) of this section have been made shall be transferred to the General Fund."

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
PROGRAM 348 - MEDICAL SERVICES/AID
COMMON ABBREVIATIONS AND ACRONYMS

CFR	Code of Federal Regulations
CHIPS	Children's Health Insurance Program
CMS	Center for Medicare and Medicaid Services (formerly HCFA)
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
HCFA	Health Care Finance Administration (Federal Regulatory Agency)
ICF-MR	Intermediate Care Facility-Mentally Retarded
IGT	Intergovernmental Transfer
MMIS	Medicaid Management Information System
NFOCUS	Nebraska Family On-Line Client User System
HHSS	Nebraska Health and Human Services System