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December 1, 2025

Dr. Steven Corsi, Chief Executive Officer
Nebraska Department of Health and Human Services
301 Centennial Mall South
Lincoln, Nebraska 68509

Dear Dr. Corsi:

This letter is provided pursuant to American Institute of Certified Public Accountants (AICPA) Auditing Standards AU-C Section 265.A18, which permits the early communication of audit findings due to their significance and the urgent need for corrective action. The audit work addressed herein was performed as part of the fiscal year ended June 30, 2025, Statewide Single (Single) audit. This communication is based on our audit procedures through November 24, 2025. Because we have not completed our fiscal year 2025 Single audit, additional matters may be identified and communicated in our final reports.

In planning and performing our audit through November 24, 2025, of the State of Nebraska's (State) compliance with the types of compliance requirements identified as subject to audit in the U.S. Office of Management and Budget (OMB) *Compliance Supplement* that could have a direct and material effect on each of the State's major Federal programs for the year ended June 30, 2025, in accordance with auditing standards generally accepted in the United States of America (GAAS), the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States (Government Auditing Standards), and the audit requirements of Title 2 U.S. Code of Federal Regulations Part 200, Uniform Administrative Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance), we are considering the State's compliance with the applicable types of compliance requirements as described in the OMB *Compliance Supplement* for the year ended June 30, 2025. We are also considering the State's internal control over compliance relevant to the audit in order to determine our auditing procedures for the purpose of expressing our opinions on compliance and to test and report on internal control over compliance in accordance with Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the State's internal control over compliance.

Our consideration of internal control over compliance was for the limited purpose described in the second paragraph above and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies in internal control over compliance; therefore, material weaknesses or significant deficiencies may exist that were not identified. However, as discussed below, based on the audit procedures performed through November 24, 2025, we identified a certain deficiency in internal control over compliance that we consider to be a significant deficiency.

A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a Federal program on a timely basis. A material weakness in internal control over compliance is a deficiency, or a combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a Federal program will not be prevented, or detected and corrected, on a timely basis.

A significant deficiency in internal control over compliance is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a Federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance. We consider the following comment to be a significant deficiency.

This comment will also be reported in the State of Nebraska's Statewide Single Audit Report Schedule of Findings and Questioned Costs.

Draft copies of this letter were furnished to the Agency to provide management with an opportunity to review and to respond to the comments and recommendations contained herein. The formal response received has been incorporated into this letter. The response was not subjected to the other auditing procedures applied in the engagement to audit compliance and, accordingly, we express no opinion on it. A response that indicates corrective action has been taken was not verified at this time, but it will be verified in the next audit.

The following is our interim communication comment and recommendation for the year ended June 30, 2025.

1. **Program:** AL 93.778 – Grants to States for Medicaid – Allowability

   Grant Number & Year: 2405NE5MAP, FFY 2024; 2505NE5MAP, FFY 2025

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

   Criteria: 45 CFR § 75.302(a) (October 1, 2024) states, "Each state must expend and account for the Federal award in accordance with state laws and procedures for expending and accounting for the state's own funds." Per 45 CFR § 75.403 (October 1, 2024), costs must be reasonable, necessary, and adequately documented.

   Title 471 NAC 15-003.02(H) requires that the provider perform the personal assistance services noted on the service plan, accurately document services provided in the EVV (Electronic Visit Verification) system, and confirm that services were received as authorized according to Agency procedures.

   Title 471 NAC 15-005.02(A) states that the provider can provide services to only one client at a time, and services will not be paid unless performed during the actual hours noted in the EVV system.

   Title 471 NAC 15-005.01(A) states that the provider will comply with all EVV billing requirements.

   A good internal control plan requires procedures to ensure services provided agree to the service needs assessment or individual support plan and service authorization.

   Section 1903(l)(5)(A) of the Social Security Act states the following:

   > *The term "electronic visit verification system" means, with respect to personal care services or home health care services, a system under which visits conducted as part of such services are electronically verified with respect to –*
   >
   > *(i) the type of service performed;*
   > *(ii) the individual receiving the service;*
   > *(iii) the date of the service;*
   > *(iv) the location of service delivery;*
   > *(v) the individual providing the service; and*
   > *(vi) the time the service begins and ends.*

   Public Law 114-255, § 12006 (December 13, 2016) ("21st Century Cures Act") provides, as is relevant, the following:

   > *(a) In General. Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by inserting after subsection (k) the following new subsection:*

"(l)(1) Subject to paragraphs (3) and (4), with respect to any amount expended for personal care services or home health care services requiring an in-home visit by a provider that are provided under a State plan under this title (or under a waiver of the plan) and furnished in a calendar quarter beginning on or after January 1, 2019 (or, in the case of home health care services, on or after January 1, 2023), unless a State requires the use of an electronic visit verification system for such services furnished in such quarter under the plan or such waiver, the Federal medical assistance percentage shall be reduced—

''(A) in the case of personal care services—

"(i) for calendar quarters in 2019 and 2020, by .25 percentage points;
"(ii) for calendar quarters in 2021, by .5 percentage points;
"(iii) for calendar quarters in 2022, by .75 percentage points; and
"(iv) for calendar quarters in 2023 and each year thereafter, by 1 percentage point[.]

Neb. Rev. Stat. § 28-512 (Reissue 2016) creates the offense of "theft by deception." That statute says the following, in relevant part:

A person commits theft if he obtains property of another by deception. A person deceives if he intentionally:

(1) Creates or reinforces a false impression, including false impressions as to law, value, intention, or other state of mind; but deception as to a person's intention to perform a promise shall not be inferred from the fact alone that he did not subsequently perform the promise; or

(2) Prevents another from acquiring information which would affect his judgment of a transaction; or

(3) Fails to correct a false impression which the deceiver previously created or reinforced, or which the deceiver knows to be influencing another to whom he stands in a fiduciary or confidential relationship[.]

Further, Neb. Rev. Stat. § 28-911 (Reissue 2016) prohibits "abuse of public records," as follows:

(1) A person commits abuse of public records, if:

(a) He knowingly makes a false entry in or falsely alters any public record; or

(b) Knowing he lacks the authority to do so, he intentionally destroys, mutilates, conceals, removes, or impairs the availability of any public record; or

(c) Knowing he lacks the authority to retain the record, he refuses to deliver up a public record in his possession upon proper request of any person lawfully entitled to receive such record; or

(d) He makes, presents, or uses any record, document, or thing, knowing it to be false, and with the intention that it be taken as a genuine part of the public record.

(2) As used in this section, the term public record includes all official books, papers, or records created, received, or used by or in any governmental office or agency.

(3) Abuse of public records is a Class II misdemeanor.

Condition: During testing of personal assistance service (PAS) and personal care service claims, we noted the following:

- Services provided lacked adequate supporting documentation. This included providers being able to submit claims without the verification of the location the services were provided.

- Services billed exceeded the number of hours authorized.

- PAS and personal care services appeared to be claimed at the same time the provider was working at another job, resulting in apparently fraudulent billings and payments.

- The PAS and other employment hours exceeded 24 hours in one day for one client, which is not possible.

- The PAS and personal care providers had the ability to edit the billable start and end times in the EVV system.

- The Agency authorized a PAS provider to perform services for three clients, totaling up to 118 hours a week, which is unreasonable.

- Providers billed for unfeasible scenarios, such as the supposed performance of duties that were supposed to be done once a week but were billed as being done every day.

Similar findings have been noted in prior audits since 2014.

Repeat Finding: 2024-053

Questioned Costs: $11,136 known ($11, 2405NE5MAP; $11,125, 2505NE5MAP)

Statistical Sample: No

Context: The Agency offers personal assistance services (assistance with hygiene, mobility, housekeeping, etc.) to Medicaid recipients with disabilities and chronic conditions. The services to be provided are based on individual needs and criteria that must be determined in a written service needs assessment (SNA). The Agency also offers personal care services under the Aged and Disabled (AD) Waiver to recipients with disabilities. These services enable the participants to carry out tasks that they are unable to perform because of their disabilities.

The Agency implemented an electronic visit verification (EVV) system for PAS providers on January 3, 2021, as required by Section 12006(a) of the 21st Century CURES Act, passed by Congress in 2016. The EVV system electronically captured and verified provider visit information and providers were required to submit claims to the Agency electronically through this application.

We judgmentally selected four providers and a PAS agency based on high total dollars. For those providers, we selected one week of claims for testing, and one month of claims for the PAS agency for testing. We also randomly selected five PAS payments for testing and, from there, one week of claims was tested.

In addition to the billing issues identified for the weeks tested, we noted two of these providers had outside employment that conflicted with the PAS hours billed. We expanded testing for these two providers. We identified $13,044 in potentially fraudulent payments made to the providers during fiscal year 2025. In addition to the potentially fraudulent payments related to hours claimed while at another job, we noted $6,315 payment errors related to other issues. Total Federal share questioned costs were $11,136. The Federal share of payments tested totaled $18,927.

	Potentially Fraudulent Provider Payments			*Other Questioned Costs*			*Total Questioned Costs*		
Provider #	**Federal Share**	**State Share**	**Total**	**Federal Share**	**State Share**	**Total**	**Federal Share**	**State Share**	**Total**
1	$ 6,273	$ 4,633	$ 10,906	$ 41	$ 30	$ 71	$ 6,314	$ 4,663	$ 10,977
2	1,230	908	2,138	837	618	1,455	2,067	1,526	3,593
3				688	508	1,196	688	508	1,196
4				544	401	945	544	401	945
5				1,445	1,067	2,512	1,445	1,067	2,512

Provider #	Potentially Fraudulent Provider Payments: Federal Share	State Share	Total	Other Questioned Costs: Federal Share	State Share	Total	Total Questioned Costs: Federal Share	State Share	Total
6				11	8	19	11	8	19
7				26	19	45	26	19	45
8				11	8	19	11	8	19
9				28	21	49	28	21	49
10				2	2	4	2	2	4
Totals	**$ 7,503**	**$ 5,541**	**$ 13,044**	**$ 3,663**	**$ 2,682**	**$ 6,315**	**$ 11,136**	**$ 8,223**	**$ 19,359**

The total Federal share of PAS claims paid for the fiscal year was $6,212,765, and the State share of PAS claims paid for the fiscal year was $4,334,744.

The following information describes issues noted with each provider.

Judgmental Testing

Provider #1

For the initial week tested, the provider was authorized a total of 39.75 hours per week for a PAS client and 40 hours per week for a client who received personal care services through the AD Waiver program. The provider did not follow the SNA when billing for tasks for the PAS client. The SNA authorized some tasks to be completed seven days a week, but the provider billed on only three days. For example, the provider was authorized to receive assistance on and off the toilet six times per day for seven days per week, but the provider performed services on only three days. We consider the services billed on the other four days to be overpayments. We identified 18.5 hours that were overbilled. We did not question costs for these hours because they were included in the hours questioned as potential fraud described below.

The provider used the Global Positioning System (GPS) verification method for the initial week tested, and we noted that some of the times billed did not seem reasonable for both the PAS and personal care clients. For example, the provider billed 22.5 hours from 10:39 a.m. on June 1, 2025, to 9:00 a.m. on June 2, 2025, for the personal care client. We also noted three instances during the week where the provider changed the end times of the visit – most likely to avoid exceeding the service authorization. The claim form in the EVV system included the scheduled end time, the actual service end time, and the billable service end time. The ability to edit the billable start and stop times recorded in the EVV system, with no secondary review, places doubt on whether the services were performed as billed. These two clients lived with the provider making it convenient to clock in and out as the provider pleased. See the table below:

Date	Client	GPS Start	GPS End	Billable Start	Billable End
6/3/2025	2 – Personal Care	10:08 a.m.	11:57 p.m.	No change	6:08 p.m.
6/4/2025	2 – Personal Care	9:37 a.m.	11:16 p.m.	No change	7:18 p.m.
6/7/2025	1 – PAS	11:06 a.m.	11:59 p.m.	No change	10:59 p.m.

The provider not only billed for 79.5 hours of PAS and personal care services in the week tested but also worked full-time for a family counseling business. Due to all of these issues, we reviewed the claims submitted for a three-month period from March 31, 2025, through June 25, 2025. We obtained employment records from the family counseling business and compared the PAS and personal care billings to the employment records. During this comparison of records, we noted also that the provider was billing independent living services through the Home and Community-Based Services (HCBS) Waiver. We identified 70 days during which PAS, personal care hours, and independent living services overlapped with times that the provider was recorded as having been working for the family counseling business. For 45 days out of the three months, the total Medicaid and employment hours exceeded 24 hours, which is impossible. See examples for two days in the table below:

Date	Employer	Time	Hours Worked
5/11/2025	Family Counseling Services	7:00 a.m. – 11:15 p.m.	16.25
5/11/2025	Medicaid	11:18 a.m. – 11:59 p.m.	12.75
		Total Hours	**29**
5/12/2025	Family Counseling Services	7:00 a.m. – 10:00 p.m.	15
5/12/2025	Medicaid	12:00 a.m. – 12:00 p.m.	12
5/12/2025	Medicaid	2:24 p.m. – 11:59 p.m.	9.5
		Total Hours	**36.5**

The visits were completed through a device using GPS. As stated earlier, the PAS and personal care clients lived with the provider. The independent living services were provided remotely. The services would not be allowed to be provided at the same time the provider was working another job. Based on some of the times the PAS and waiver services began and ended, another individual may have aided the provider in falsely claiming that PAS and waiver services were performed, as the provider could not have been in two places at once. We questioned 690 hours as potential fraud, totaling $10,906 ($6,273 Federal Share and $4,633 State Share). The total amount paid to the provider for the period tested was $13,847; therefore, we questioned nearly the entire amount paid to the provider for overlapping hours. The table below contains examples of the overlapping hours:

Family Counseling Business			EVV Visit Form and Claim Documentation		
Date	**Start Time**	**End Time**	**Start Time**	**End Time**	**Hours Billed**
4/7/2025	12:00 p.m.	5:00 p.m.	12:01 p.m.	5:00 p.m.	5
5/12/2025	7:00 a.m.	12:00 p.m.	12:00 a.m.	12:00 p.m.	12
5/31/2025	8:00 a.m.	1:00 p.m.	8:00 a.m.	1:00 p.m.	5
6/10/2025	5:00 p.m.	10:00 p.m.	5:01 p.m.	11:40 p.m.	6.75

The following chart summarizes the potential fraud questioned costs by program:

Service Type	Hours Overlapped	Federal Share Questioned Costs	State Share Questioned Costs
Personal Assistance Services	318.50	$ 2,748	$ 2,029
Personal Care Services	352.25	$ 3,242	$ 2,394
Independent Living	19.25	$ 283	$ 210
Totals	**690**	**$ 6,273**	**$ 4,633**

We also noted other billing issues. In one case, the provider double billed a PAS service on April 30, 2025. The visit form on April 30 had a clock-in time of 3:03 p.m. and a clock-out time of 12:03 a.m. on May 1, 2025. Upon crossing from one day to another, the visit generated two claim forms in the EVV system. The first claim had an end time of 11:59 p.m., and the second claim form had the start time of midnight or 24:00 on the next day. In this case, the provider changed the billable start and end times for both claims and was able to double bill 4.75 hours, resulting in $41 in Federal share questioned costs.

First Claim		Second Claim	
4/30/2025	4/30/2025	5/1/2025	4/30/2025
GPS Time	Billable Time	GPS Time	Billable Time
3:03 p.m. – 11:59 p.m.	3:03 p.m. – 11:59 p.m.	12:00 a.m. – 12:03 a.m.	3:05 p.m. – 7:50 p.m.

Overlapping hours were billed on May 25, 2025, between a personal care claim and the independent living claim. There are no additional questioned costs because the overlapping hours for independent living were questioned as potential fraud as they overlapped with the provider's outside employment. See the table below:

Program	Start Time	End Time	Hours Billed
Personal Care Services	5:00 p.m.	11:59 p.m.	7
Independent Living	7:45 p.m.	9:00 p.m.	1.25

The Agency has been aware of the provider's billing issue and continued to allow the provider to bill for services. On June 21, 2025, the Agency established Accounts Receivables for overbilling for PAS and AD Waiver services. The PAS overpayment totaled $17,008, and it included services provided from December 28, 2023, through May 2, 2025. The first PAS service date billed by the provider was December 28, 2023. One recoupment of $68 was applied towards the balance on August 2, 2025, and no other payments have been made. The AD Waiver overpayment totaled $4,078 and included weeks billed from March 17, 2024, through March 20, 2025, prior to the services we reviewed. As of October 20, 2025, $781 has been recouped from payments made to the provider, leaving a balance due of $3,297. The overpayments for both programs did not account for the potentially fraudulent payments made due to the provider having outside employment.

Finally, we noted the provider and her husband were foster parents to an Agency ward during the period reviewed beginning on June 7, 2025. The PAS and personal care clients were also residing in the home. Per narratives, the personal assistance client, the provider's daughter, was renting a room from the provider for $200 per month for rent and utilities. The personal care client was also a relative of the provider and was on the sex offender registry. Per the sex offender registry, he was convicted of felony sex trafficking of children in 2014. The provider's address listed on the sex offender registry was the same as that for the personal care client. This address was first reported on September 20, 2024, and was last verified as of July 10, 2025.

According to the case file, the personal care client first moved to the provider's residence on February 11, 2025, and he lived in his mother-in-law's cabin in the provider's backyard with no separate entrance, utilities, or address. The Agency was told the client had his own kitchenette, bathroom, and living area. He paid $400 per month for rent and utilities. The following is a picture of the cabin in which the client was residing:

The provider and her husband completed a home study through APEX Foster Care (APEX) on June 16, 2025, in order to be foster parents to a 14 year old girl. The home study did not disclose the personal care client as residing at the residence. The home study also noted that the PAS client was sleeping on the couch in order for the foster youth to have a room in which to sleep. Additionally, the home study noted that there were no outbuildings. The foster care regulations require the applicant and household members 18 years of age and older to submit background checks prior to licensing. Since the personal care client was not disclosed as a household member, he did not have a background check completed. On July 9, 2025, APEX sent a "Closure of Support Letter" to the provider, stating they would no longer be supporting the foster home effective July 23, 2025. The letter noted the provider's husband did not disclose an assault and battery charge from June 26, 2024, and there were concerns about the accuracy and honesty of reported household information.

The new agency supporting the foster family, Saint Francis Ministries, completed a home study on August 29, 2025. Again, the home study did not disclose the personal care client as residing at the residence. The home study noted that the PAS client now lived in Hastings, Nebraska. The home study also noted that there was a shed in the backyard where they kept their lawn equipment and four-wheeler. The shed is kept locked, and only the provider and her husband have a key. Based on this information, the personal care client must live in the home. The provider's husband disclosed the assault charge from 2024 where he broke a man's jaw in a fight after a hit and run incident. He was found guilty of misdemeanor assault and battery on June 26, 2024. Although a misdemeanor assault conviction does not prevent a prospective foster parent from being eligible to provide care, the Agency has the discretion to review convictions to determine eligibility. The background check also noted four Driving Under the Influence convictions prior to August 2013, two resisting arrest misdemeanor convictions, and three possession of marijuana convictions prior to September 22, 2005.

Not only was there a safety risk for having a registered sex offender living with the foster youth, but also the provider appeared to be purposefully deceitful in failing to disclose this information to the foster care agencies, knowing that doing so would result in the placement being denied. Once the Agency was aware of the situation, the foster youth was removed from the home on October 6, 2025. The provider and personal care client were also deceitful when they obtained services through the AD Waiver as well. The personal care client did not live in a cabin in the backyard with a separate kitchen, living area, and bathroom, but cleaning of these areas was authorized for the provider even though the living area, kitchen, and bathroom would have been shared with the provider's other family members, and these services should not have been authorized.

Provider #2
The provider was authorized 39.25 hours of service per week for one client and 26.75 hours of service per week for a second client. For the initial week tested of January 12, 2025, through January 18, 2025, the provider billed 40.5 hours and 27 hours of service, respectively. Additionally, none of the visits were completed through a device using GPS to track the location of the service, and no signatures were obtained from the clients.

We also noted that the provider was employed with a public school as a student bus driver. We obtained the provider's employment records and compared the PAS billings to the employment records for a three-month period from October 28, 2024, through January 31, 2025. The provider generally worked for the other employer between 6:00 a.m. to 5:30 p.m., Monday through Friday, which conflicted with hours being billed for personal assistance services. We identified 28 days during which PAS hours billed overlapped with times that the provider was working for the other employer. We questioned as potential fraud any PAS hours billed that overlapped with the provider's employment hours. In determining these overlapped hours, we did not factor in any travel time that may have occurred between the client's homes and the provider's place of employment; therefore, the possibility exists of additional fraudulent payments. We questioned 142.5 hours as potential fraud, totaling $2,138 (Federal share $1,230 and State share $908). The table below contains a few examples of overlapping hours billed by the provider:

Public School Employer			**EVV Visit Form and Claim**			
Date	**Start Time**	**End Time**	**Client**	**Start Time**	**End Time**	**Hours Billed**
10/29/2024	8:34 a.m.	5:29 p.m.	Client 1 Client 2	6:00 a.m. 12:00 p.m.	11:45 a.m. 5:00 p.m.	5.75 5
11/7/2024	8:23 a.m.	5:34 p.m.	Client 1 Client 2	6:00 a.m. 12:00 p.m.	11:45 a.m. 5:00 p.m.	5.75 5
11/14/2024	9:11 a.m.	5:36 p.m.	Client 1 Client 2	6:00 a.m. 12:00 p.m.	11:45 a.m. 5:00 p.m.	5.75 5
11/22/2024	10:33 a.m.	5:36 p.m.	Client 1 Client 2	6:00 a.m. 12:00 p.m.	11:00 a.m. 3:00 p.m.	5 3

The PAS claims for the additional weeks tested also did not use GPS to track the location; therefore, any hours that were not questioned due to potential fraud were questioned for not complying with the GPS location verification requirement. Federal questioned costs for not complying with the GPS requirements totaled $837.

On February 19, 2025, the Agency implemented system enhancements to the EVV system, including the required use of GPS or Interactive Voice Response (IVR) verification. The last large payment issued to the provider was on July 25, 2025, for service dates from February 1, 2025, through February 19, 2025. From July 26, 2025, through October 28, 2025, the provider has received only $338 in payments. It appears the EVV system enhancement may have prevented the provider from manually entering times into the EVV system for PAS services while performing outside employment.

Providers #3 – #5
Provider #3 was an individual who provided services to 3 clients. Provider #4 was an individual who provided services to 2 clients, and Provider #5 was an agency that provided services to 10 clients during the period we reviewed. For each provider, we noted that the hours billed did not follow the SNA. For example, the SNA included tasks that were to be provided every day of the week, but the provider provided the services less than seven days a week. Another example is that the provider would bill for services multiple times a week when the service was authorized only once per week. Additionally, Provider #5 billed for hours that exceeded the service authorizations. See the table below for a summary of the hours overbilled:

Provider #	Total Hours Billed	Hours Billed that Exceeded the Authorization	Hours Billed that Did Not Follow the SNA	Federal Share Questioned Costs
Provider #3	113	0	3.75	$ 32
Provider #4	67.25	0	63	$ 544
Provider #5				
- Client 1	82.25	.5	7.75	$ 71
- Client 2	54.25	.5	5.5	$ 52
- Client 3	93.5	.25	9	$ 80
- Client 4	68	1.75	5.5	$ 63
- Client 5	73.5	.5	5	$ 47
- Client 6	27.25	0	17.25	$ 149
- Client 7	108	0	40.5	$ 349
- Client 8	62.25	2.5	24.25	$ 231
- Client 9	100	.75	46	$ 403
Totals	**849.25**	**6.75**	**227.5**	**$ 2,021**

Additionally, we noted the following issues for Provider #3:

- The provider was authorized 39.75 hours per week for one client, 40 hours per week for another, and 38.25 hours per week for the third client, for a total of 118 hours. It is not reasonable to authorize 118 hours of service to be performed in a week. This would require the provider to perform services for more than 16 hours every day of the week.

- We also noted that two of the clients that Provider #3 served were the parents of the provider. These clients did not live with the provider; however, the provider stated that the start and end address for these two clients was that of the provider. Both of these clients were authorized services for cleaning the bathroom, kitchen, bedroom, and living room at the client's home. Services were not allowed and would not be reasonable at the provider's home. Per the Agency, "Since the two clients do not live with the provider none of the visits should have been scheduled nor can services be performed at the provider's address." All services billed for these two clients were questioned. It should be noted that we reviewed only one week, and there may be additional claims billed for services at the provider's home that would not be allowed. Federal share questioned costs were $656.

Random Sample Testing

We selected five PAS payments randomly for testing. We noted issues with all five PAS claims tested. The Federal payment errors for PAS claims totaled $78 for the sample. The total sample tested was $884, and the total population for the Federal share of PAS claims for the fiscal year totaled $6,212,765. Based on the sample tested, the dollar error rate for the sample was 8.82% ($78/$884), which estimates the potential dollars at risk for fiscal year 2025 to be $547,966 (dollar error rate multiplied by the population).

For three of the five providers, the hours billed by the provider exceeded the SNA. Additionally, for four of the five providers, the provider did not follow the SNA when billing for tasks provided. For example, the SNA included tasks that were to be provided every day of the week, but the provider performed the services fewer than seven days a week. Another example is that the provider would bill for services multiple times a week when the service was authorized for only once per week. See the table below for a summary of the hours overbilled:

Provider #	Total Hours Billed	Hours Billed that Exceeded the Authorization	Hours Billed that Did Not Follow the SNA	Federal Share Questioned Costs
Provider #6	40	0.25	1	$ 11
Provider #7	16.5	3	0	$ 26
Provider #8	15.75	0	1.25	$ 11
Provider #9	29.25	2	1.25	$ 28
Provider #10	2.5	0	0.25	$ 2
Totals	**104**	**5.25**	**3.75**	**$ 78**

Additionally, for Provider #7 we noted that there were three visits during the week tested that were not completed through a device using GPS. Two of these visits were services claimed from 5:15 a.m. to 6:15 a.m., and the third was from 7:30 p.m. to 8:35 p.m. The provider stated that GPS was not used due to a scheduling error and forgetting to clock in or clock out. The three non-GPS utilized visits exceeded the Agency's 10% allowance at the time of service for non-use of GPS. Additionally, we noted that the provider changed the service end date for one visit from 6:48 p.m. to 7:48 p.m., which appears unreasonable.

Cause: Procedures were not adequate to prevent and/or detect errors.

Effect: An inadequate review of PAS claims increases the risk of services provided not being in accordance with recipient needs, as well as a risk of services being billed but not provided. There is a significant risk for fraud or abuse to occur and not be detected. State and Federal funds appear to have been misspent.

Recommendation: We recommend the Agency implement procedures to ensure payments are allowable, adequately supported, and in accordance with State and Federal regulations. We further recommend the Agency immediately discontinue paying claims that are not in accordance with EVV/GPS requirements. Additionally, because this comment gives rise to concerns regarding possible violations of State statute, we are forwarding the information herein to the Nebraska Attorney General for further review.

Management Response: The Nebraska Department of Health and Human Services (DHHS) appreciates the work of the auditor's office and the opportunity to respond to this early management letter. DHHS agrees with the recommendations articulated in the early management letter.

Corrective Action Plan: DHHS and Medicaid and Long-Term Care (MLTC) have been actively implementing procedures and controls to ensure that payments are allowable, adequately supported, and in accordance with State and Federal regulations. As noted in the early management letter, the findings and conditions are consistent with findings from prior year(s) audits. As a result, the department had already taken significant actions throughout State Fiscal Year 2025 to implement several procedures and controls which are expected to mitigate the majority of the conditions observed in the audit. Specifically, in late

February 2025, MLTC implemented systematic controls to require that GPS/IVR visit verification and recipient signature is captured for visits to be submitted for claim payment. Additional changes included tightening down, or reducing, the radius of the geofence area for location verification.

Additionally, in late June 2025, the department implemented additional, significant procedures and controls which include the requirement of all PAS and Home and Community Based caregivers and providers obtain and use their unique National Provider Identifier (NPI) on all visits and claims for visits to be submitted for claim payment, new systematic controls that do not allow for unreasonable billing of units/hours in a day on both a client and caregiver level, and new controls that parse the client authorizations into weekly segments which create limits for the number of hours/units per week that can be billed for services for a client, based on the authorized amounts in the client assessment. DHHS and MLTC will continue to monitor data and claims and identify and evaluate opportunities to implement additional controls and procedures that ensure payments for these services are allowable and in accordance with State and Federal regulations.

In addition to the changes in MLTC, the following actions are being implemented by Child and Family Services (CFS).

CFS will collaborate with the Nebraska State Patrol to develop an automated process to compare the addresses of foster parents with the Sex Offender Registry on a quarterly basis to ensure that no registered sex offenders reside at the same household address as a ward of the state.

Additionally, Agency-Supported Foster Care contracts and Relative/Kinship Caregiver Agreements will be amended to include a requirement that caregivers report all criminal citations, charges, convictions, and any individuals who have moved into the home within five (5) business days to CFS.

Finally, Foster Care Regulations require background checks for all individuals in the foster home who are 18 years of age and older. There are certain crimes that make a person ineligible to provide foster care, while other criminal convictions fall under the discretionary category. To ensure consistency, CFS has centralized the review and approval of discretionary convictions that are not subject to mandatory exclusion.

Contact: Jeremy Brunssen, MLTC
Kathleen Stolz, CFS

Anticipated Completion Date: 6/30/2026 (ongoing)

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Our audit procedures are designed primarily on a test basis and, therefore, may not bring to light all weaknesses in policies or procedures that may exist. Our objective is, however, to use our knowledge of the Agency and its interaction with other State agencies and administrative departments gained during our work to make comments and suggestions that we hope will be useful to the Agency.

This interim communication is intended solely for the information and use of management, the Governor and State Legislature, others within the Agency, Federal awarding agencies, pass-through entities, and management of the State of Nebraska and is not suitable for any other purposes. However, this communication is a matter of public record, and its distribution is not limited.

Terence L. Heiser

Terence Heiser, CPA, CISA
Audit Manager

cc. Nebraska Attorney General