ADVISORY REPORT OF THE
NEBRASKA
HEALTH AND HUMAN SERVICES SYSTEM
MEDICAID MANAGED CARE PROGRAM
FOR THE FISCAL YEAR ENDED JUNE 30, 2000

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
MEDICAID MANAGED CARE PROGRAM

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NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
MEDICAID MANAGED CARE PROGRAM

BACKGROUND

The Managed Care Plan Act, codified at Neb. Rev. Stat. Sections 68-1048 to 68-1064 R.R.S. 1996, requires the Department of Health and Human Services Finance and Support (Department) to develop a comprehensive and coordinated health care program delivered in a cost-effective and efficient manner in accordance with federal regulations. The Managed Care Plan was implemented in 1995 and includes the following components:

1. Benefits Package
   a. Mental Health & Substance Abuse (MH/SA)
   b. Medical/Surgery
      i. Health Maintenance Organization (HMO)
      ii. Primary Care Case Management (PCCM) Network
2. Enrollment Broker Services (EBS)
3. Data Management Services
4. Other Contracted Services
   a. Actuarial Services
   b. External Quality Review Organization (EQRO)

MENTAL HEALTH AND SUBSTANCE ABUSE

First Option Corporation-Nebraska (Options)

Options is responsible for providing mental health and substance abuse services to Medicaid recipients throughout the State of Nebraska. Payment is based on a monthly capitated rate. During fiscal year 2000, the State paid $59,378,824 to Options; there were 140,513 Medicaid recipients enrolled at June 30, 2000.

MEDICAL/SURGERY

The Managed Care Program requires Medicaid recipients in Douglas, Sarpy, and Lancaster Counties to enroll in a Health Maintenance Organization or Primary Care Case Management plan for their primary care services. Certain Medicaid recipients such as those residing in Nursing Homes and in Intermediate Care Facilities are excluded from the Managed Care Program.

HEALTH MAINTENANCE ORGANIZATION (HMO)

United Health Care of the Midlands Share Advantage

Exclusive Healthcare, Inc. Wellness Option

The HMO is an organization that has contracted with the State to deliver the Basic Benefit Package to qualified recipients per a monthly capitated rate. The Basic Benefit Package does not include services such as dental care and prescription drugs, which are paid by the Department through Medicaid fee-for-service.

BACKGROUND
(Continued)

HMO	Fiscal Year 2000 Payments	Enrollees at June 30, 2000
United Health Care	$ 29,468,793	19,351
Exclusive Health Care	$ 17,769,774	12,060

PRIMARY CARE CASE MANAGEMENT NETWORK (PCCM)

Administered by Blue Cross/Blue Shield (BC/BS)

The PCCM is a network of contracted primary care physicians (PCP's). Each PCP is paid $2 per Medicaid client per month for case management services. The Basic Benefit Package services provided by PCP's in the PCCM Network are reimbursed on a fee-for-service basis. The PCP submits claims directly to the Department who approves the claims and then pays the PCP at the Medicaid rate. Blue Cross/Blue Shield (BC/BS) serves as Network Administrator and is responsible for the development, oversight, and operation of the PCCM Network and all related administrative expenses. The Network Administrator receives a negotiated fee for its services based on the number of enrollees in the PCCM.

At June 30, 2000 there were 26,594 Medicaid recipients enrolled in PCCM. BC/BS received $1,450,393 in fiscal year 2000 for Network Administration services. Physicians in the PCCM received a total of $628,710 for case management services during fiscal year 2000. The total for Basic Benefits services paid to PCP's for PCCM Medicaid recipients was not available as the fees were paid through the same system as Medicaid recipients not enrolled in the Managed Care program.

ENROLLMENT BROKER SERVICES (EBS)

Lincoln/Lancaster County Health Department (Access Medicaid)

The Enrollment Broker is responsible for the following functions: initial client marketing, education and outreach, enrollment activities, health assessment, health services coordination, public health nursing, Helpline, client advocacy, and satisfaction surveys. For fiscal year 2000, the Enrollment Broker was Lincoln/Lancaster County Health Department (Access Medicaid). The EBS assists clients in selecting their PCP's and medical/surgical plans, and in accessing and understanding all facets of the Managed Care Program. During fiscal year 2000, Access Medicaid was paid $2,086,450 for EBS.

DATA MANAGEMENT SERVICES

Medstat Group

The Medstat Group provides data retrieval for reporting purposes. The Department paid $1,276,620 to Medstat during fiscal year 2000.

BACKGROUND
(Continued)

ACTUARIAL SERVICES
William Mercer, Inc.

Federal regulations require that capitated payments to a contractor cannot exceed the cost to the agency of providing those same services on a fee-for-service basis to an actuarially-equivalent non-enrolled population group. Contracts with HMO's must specify the actuarial basis for computation of the capitation fees. The Department paid $311,474 to William Mercer, Inc. during fiscal year 2000 for these actuarial services.

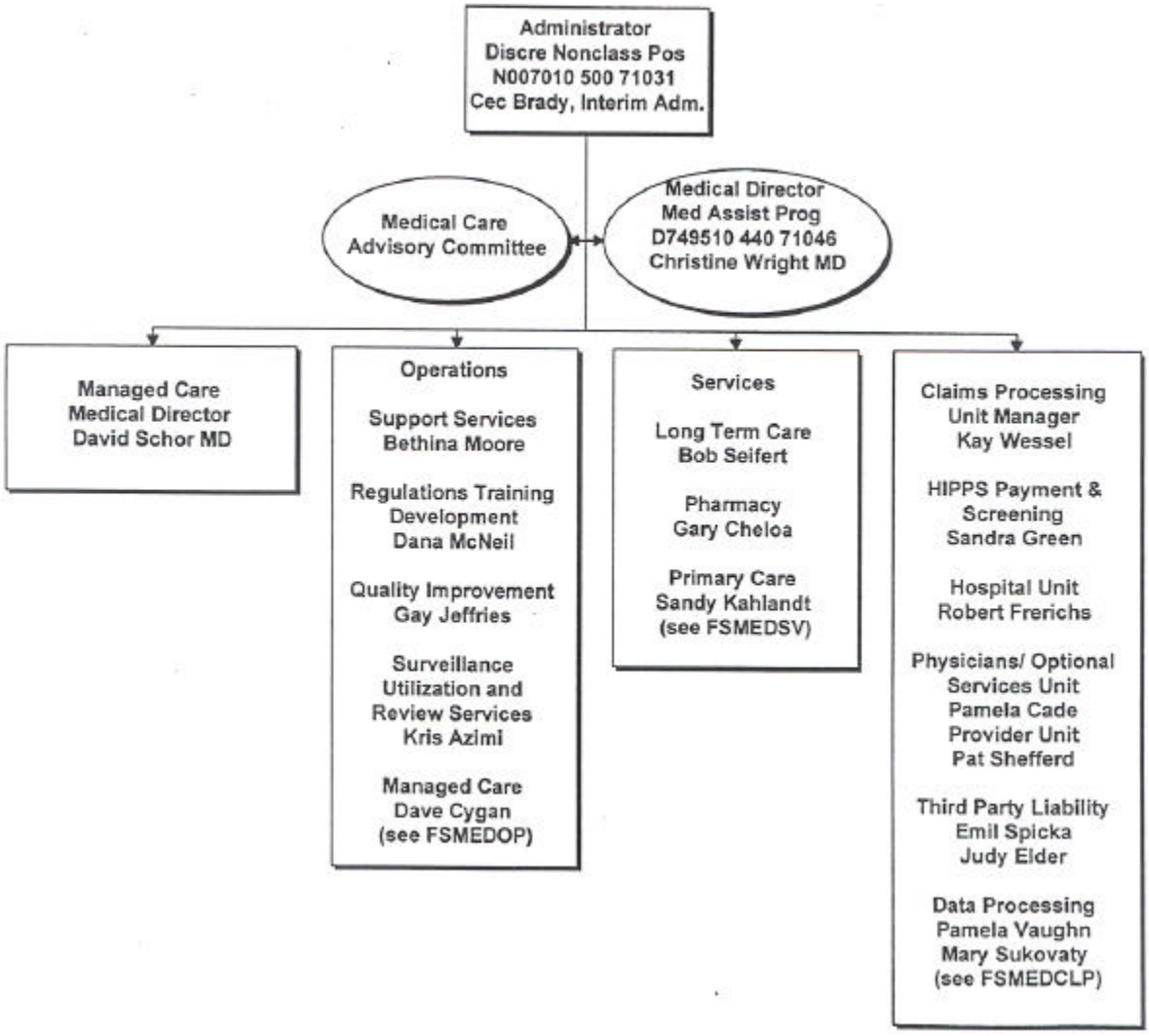
EXTERNAL QUALITY REVIEW ORGANIZATION
Sunderbruch/Iowa Medical Foundation

The Department monitors the quality of care provided by the medical/surgical and MH/SA plan through an annual, independent, external review. This review is comprised of the following five components: 1) Analysis of claims data, eligibility data, and enrollment broker files; 2) annual on-site evaluation of each managed care vendor's quality assurance plan; 3) annual member satisfaction survey; 4) annual provider survey of accessibility and timeliness of care; and 5) cost effectiveness evaluation of Managed Care versus Medicaid. The Department paid $871,756 to Sunderbruch for these services in fiscal year 2000, of which $129,729 was directly related to Managed Care.

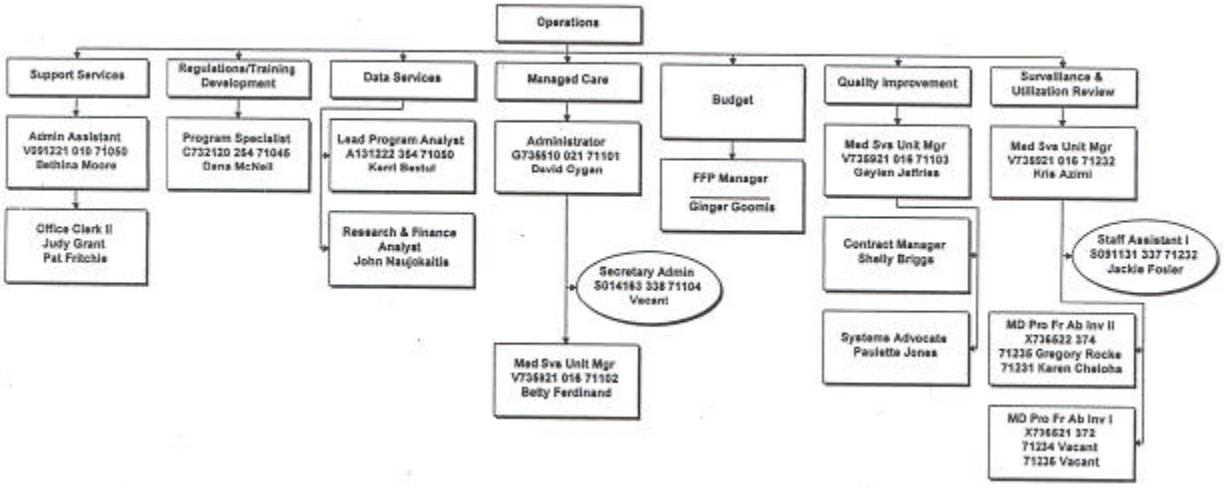
MISSION STATEMENT

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

ORGANIZATIONAL CHARTS



ORGANIZATIONAL CHARTS



STATE OF NEBRASKA
AUDITOR OF PUBLIC ACCOUNTS

P.O. Box 98917
State Capitol, Suite 2303
Lincoln, NE 68509
402-471-2111, FAX 402-471-3301
www.auditors.state.ne.us

Kate Witek
State Auditor
kwitek@mail.state.ne.us

Deann Haeffner, CPA
Deputy State Auditor
haeffner@mail.state.ne.us

Don Dunlap, CPA
Asst. Deputy Auditor
aud1010@
vmhost.cdp.state.ne.us

Pat Reding, CPA
Asst. Deputy Auditor
aud1008@
vmhost.cdp.state.ne.us

Mary Avery
SAE/Finance Manager
MaryJAvery@aol.com

Dennis Meyer
Budget Coordinator
dmeyer@mail.state.ne.us

Mark Avery
Subdivision Audit
Review Coordinator
mavery@mail.state.ne.us

Robert Hotz, JD
Legal Counsel
robhotz@mail.state.ne.us

Stephen Curtiss, Director
Health and Human Services
Finance and Support
P.O. Box 95026
Lincoln, Nebraska 68509-5026

Dear Mr. Curtiss:

We have studied the policies and procedures related to the Nebraska Health and Human Services System – Medicaid Managed Care Program for the fiscal year ended June 30, 2000. Our study was made under the authority of Neb. Rev. Stat. Section 84-304, R.S. Supp., 2000, which authorizes the examination of agency records. This advisory report provides the results of that study and is intended for the information of the Nebraska Health and Human Services System: however, this report is a matter of public record and its distribution is not limited.

As a result of our study of the Managed Care Program, we noted certain issues which the Nebraska Health and Human Services System should consider relative to those procedures. These issues are included in the Comments and Recommendations section of our report. We compiled the accompanying financial data included in the schedules and charts section of our report. We did not audit and do not express an opinion or any other form of assurance on this data.

Pat Reding, CPA

Pat Reding
Audit Manager

June 20, 2001

SUMMARY OF COMMENTS

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

1. ***Contract Management:*** Documentation was not provided to support contract provisions were monitored and followed.

2. ***Annual Report:*** The statutorily-required annual report was not submitted in 1998, 1999, or 2000.

3. ***Contractor Payments:*** Payments for training expenses of $20,000 were not included in the written contract.

4. ***Closure Codes:*** Documentation was not adequate to support disenrollment for two of six cases tested.

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

Draft copies of this report were furnished to the Department 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. Responses have been objectively evaluated and recognized, as appropriate, in the report. Responses that indicate corrective action has been taken were not verified at this time.

We appreciate the cooperation and courtesy extended to our auditors.

COMMENTS AND RECOMMENDATIONS

1. Contract Management

Good internal controls require procedures to monitor contract provisions to ensure compliance with contract requirements.

The mental health managed care contract has a provision for profit reinvestment. Per the contract, profits (capitation payments minus the sum of actual claim costs and administrative cost allowance) in excess of a set percentage are required to be reinvested into local community-based mental health/substance abuse programs as agreed upon by the contractor and the Department. Our staff requested information regarding the profit reinvestment provision. Despite several requests over the course of several weeks, the Department failed to provide the information requested. On April 6, 2001, the Medicaid Managed Care Administrator replied to our request for documentation of the computation and activity for the reinvestment profits with the statement that ". . . we do not have the info . . . ." On May 9, 2001, the Department did provide a calculation that indicated there were no profits exceeding the percentage for fiscal year 2000, but did not provide documentation to support the calculation. Our staff contacted Options, and per Options the amount of profit reinvestment from July 1, 1999 to June 30, 2000 was $304,626. The Department also did not provide the beginning balance of the account, deposits, and disbursements for the fiscal year, or the ending balance. Our staff contacted the contractor and received the information as detailed on the Schedule of Profit Reinvestment Activity.

Poor management and inadequate monitoring of contract provisions increases the risk for loss or misuse of funds.

> We recommend the Department implement controls to ensure contract requirements are complied with. We further recommend documentation be maintained and made available to the auditors to support contract provisions have been monitored and followed.

Department's Response: Profit reinvestment monitoring - The purpose of the Profit Reinvestment provision was to reclaim any gross profits by ValueOptions in the mental health community. Under the old contract with ValueOptions, profit reinvestment was derived from the quarterly filings with the Nebraska department of Insurance (DOI). When the net income/loss line on the DOI report indicated a loss or deminimis profit, no calculations were performed.

Profit reinvestment is paid when indicated – The auditor's office has indicated the preferred methodology of ensuring profit reinvestment is paid when indicated is to review account balances, deposits and disbursements for the indicated transactions. Since payments are made infrequently, Managed Care will still prefer the more direct method of telephoning the recipient to ensure payment is made.

Auditors' Response: Documentation to support that contract provisions have been monitored, and followed, should be maintained by the Department and be readily available for inspection by management, State auditors, and Federal regulatory agencies.

COMMENTS AND RECOMMENDATIONS

2. Annual Report

Neb. Rev. Stat Section 68-1064 R.R.S. 1996 required the Department to annually submit a report to the Legislature and to the Managed Care Commission on the health care outcomes and cost effectiveness of the managed care system.

A report had not been submitted since March 1997. After our February request, the Department submitted a copy of the quarterly management reports for calendar year 2000. The reports were submitted March 9, 2001.

> We recommend the Department annually submit a report as required by Statute.

Department's Response: The Annual Report for calendar year 2000 was submitted to the legislature by the anticipated date following the close of calendar year 2000.

3. Contractor Payments

Sound business practice requires contracts be complete with all services and rates specified.

During fiscal year 2000, a $20,000 payment was made to The Medstat Group for training. The contract between the Department and The Medstat Group does not include any terms relating to training. Without a written contract there is an increased risk for loss or misuse.

> We recommend that only items included in contracts be paid to contractors and that contracts include within their scope all of the services which are anticipated to be provided.

Department's Response: The contract referenced in this provision is a data warehouse/decision support computer program. It is difficult with computer related contracts to differentiate between training and technical support. While technical support has always been covered, training has been added to the contract since this discrepancy was identified.

4. Closure Codes

The Managed Care program of the Department requires, with some exceptions, enrollment of all Medicaid recipients residing in Lancaster, Douglas, and Sarpy Counties. When a recipient moves out of one of these counties or is removed from the program for some other reason, a closure code is assigned to the case. Good internal control requires adequate documentation and the proper use of closure codes to ensure compliance with State and Federal regulations.

COMMENTS AND RECOMMENDATIONS

4. Closure Codes (Continued)

Two of six Managed Care cases tested which were disenrolled in April 2000 appear to have been assigned improper closure codes. These clients were disenrolled for either being "out of medical/surgical" or were "transferred out of District 7/8." However, both clients had addresses in Lincoln or Omaha per the NFOCUS computer system at the time of disenrollment. District 7 refers to Lancaster County and District 8 refers to Douglas and Sarpy counties. Medicaid Managed Care staff was unable to support the propriety of the assigned closure codes.

> We recommend the Medicaid Managed Care program implement procedures to ensure that closure codes are being assigned properly to closed cases.

Department's Response: We disagree with Finding #4, Closure Codes.

The closure codes for "out of medical/surgical" and "transferred out of District 7/8" are based on a change in the HHS administrative district office managing the case contained in NFOCUS and not address information. The following sections form Title 482 NAC, Nebraska Medicaid Managed Care, substantiate this interpretation. A copy of Title 482 NAC, and an explanation regarding closure codes, was provided to the auditors.

> *According to 482 NAC 2-001.01, Mandatory for the Basic Benefits Package, the client's managed care status (mandatory or excluded) is determined by an automated interface between the Department's eligibility system and the Managed Care File, and is based on information entered on the eligibility system by the Health and Human Services' local office staff, and known at the time of the managed care determination (see 482-000-2, NHC Determination Logic).*
>
> > *According to 482-000-2, NHC Determination Logic, coverage areas are defined by the HHS administrative district office managing the client's case.*
>
> *According to 482 NAC 2-000-2, Designated Coverage Area for the NHC Basic Benefits Package, for purposes of the Basic Benefits Package, the designated coverage area includes those mandatory clients who eligibility assistance case is managed by the Health and Human Services (HHS) office, primarily in Douglas and Sarpy Counties in the Eastern HHS District Office (commonly referred to as District 8), and in the Southeastern District Office, primarily in Lancaster County (commonly referred to as District 7).*
>
> *According to 482 NAC 2-004.01, Disenrollment Due to Eligibility Changes, disenrollment shall occur automatically in the following situations: 1) The client's Medicaid case is closed or suspended, 2) A sanction is impose on the client, or 3) The client is no longer mandatory for NHC. The Department shall notify the client, PCP and*

COMMENTS AND RECOMMENDATIONS

4. <u>Closure Codes</u> (Concluded)

medical/surgical plan of the disenrollment/waiver of enrollment. Disenrollment is prospective and is effective the first month possible, given system cut-off. See 482-000-14.

Pursuant to the regulations, the governing logic for disenrollment is the District ID number, not the county of residence as noted in the finding. If the correct regulation is applied to the clients tested, all clients and their documentation meet the criteria for disenrollment.

Auditors' Response: Documentation was not provided to support the disenrollments were proper for the two specific cases noted.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
MEDICAID MANAGED CARE PROGRAM
SCHEDULE OF CONTRACTOR PAYMENTS
Fiscal Year Ended June 30, 2000

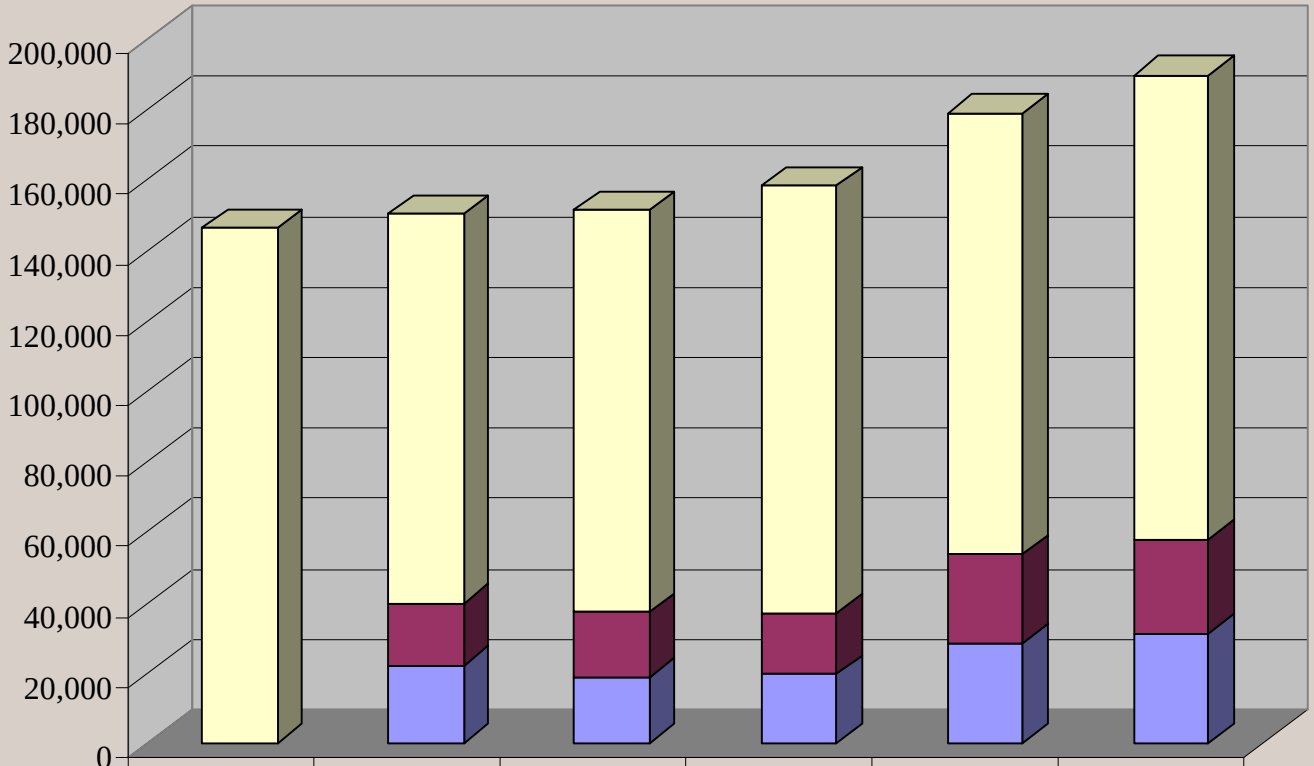
Contractor		Disbursements
Value Options	$	59,378,824
Exclusive Healthcare, Inc.		17,769,774
United Health Care of the Midlands		29,468,793
$2 Fee to PCP's in PCCM Network		628,710
Blue Cross/Blue Shield		1,450,393
Lincoln Lancaster County Health Department		2,086,450
William Mercer, Inc.		311,474
Sunderbruch/Iowa Medical Foundation		129,729
Medstat Group		1,276,620
Total	$	112,500,767

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
MEDICAID MANAGED CARE PROGRAM
SCHEDULE OF PROFIT REINVESTMENT ACTIVITY
Fiscal Year Ended June 30, 2000

Balance July 1, 1999	$	80,329
Excess of contracted administrative fee over allowed Service Center cost and Direct and Indirect Corporate Overhead allocations		304,626
Balance June 30, 2000	$	384,955

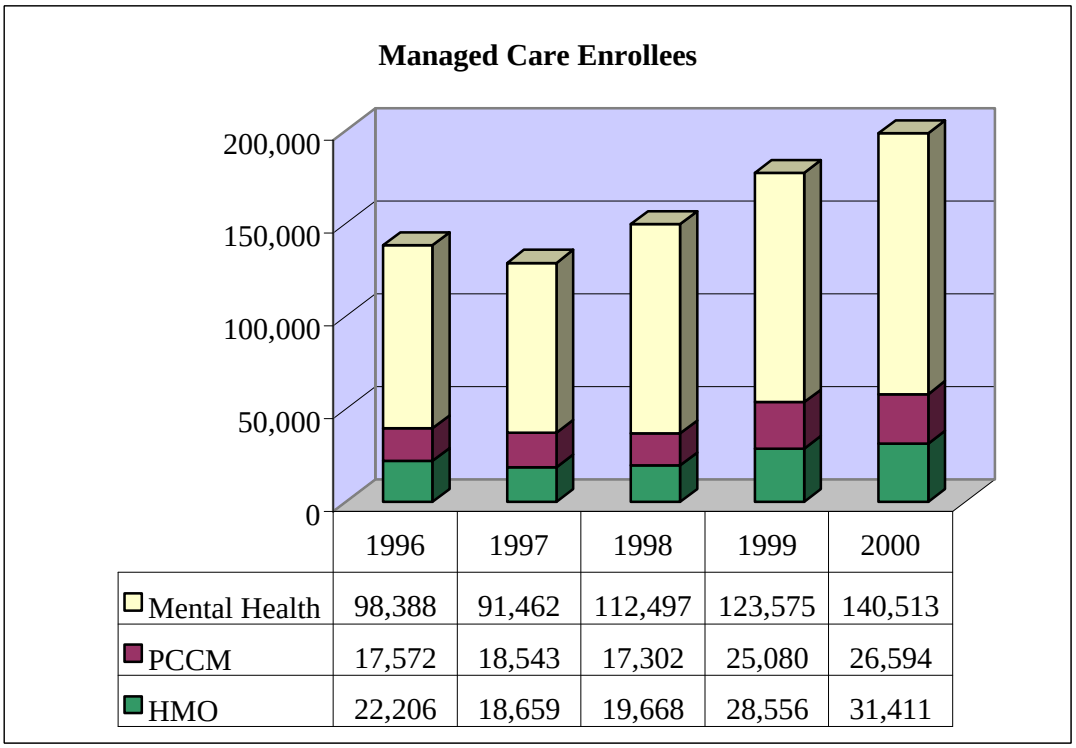
Note: Per the contract, profits in excess of the agreement shall be reinvested into local community based mental health and substance abuse programs. Determination of the programs targeted for reinvestment will be mutually agreed upon between the contractor and the Department. If no If no agreement can be reached by the end of the contract, the funds in the reinvestment account shall be forfeited to the Department.

Medical/Surgical Medicaid Recipients
June 30, 1995-2000

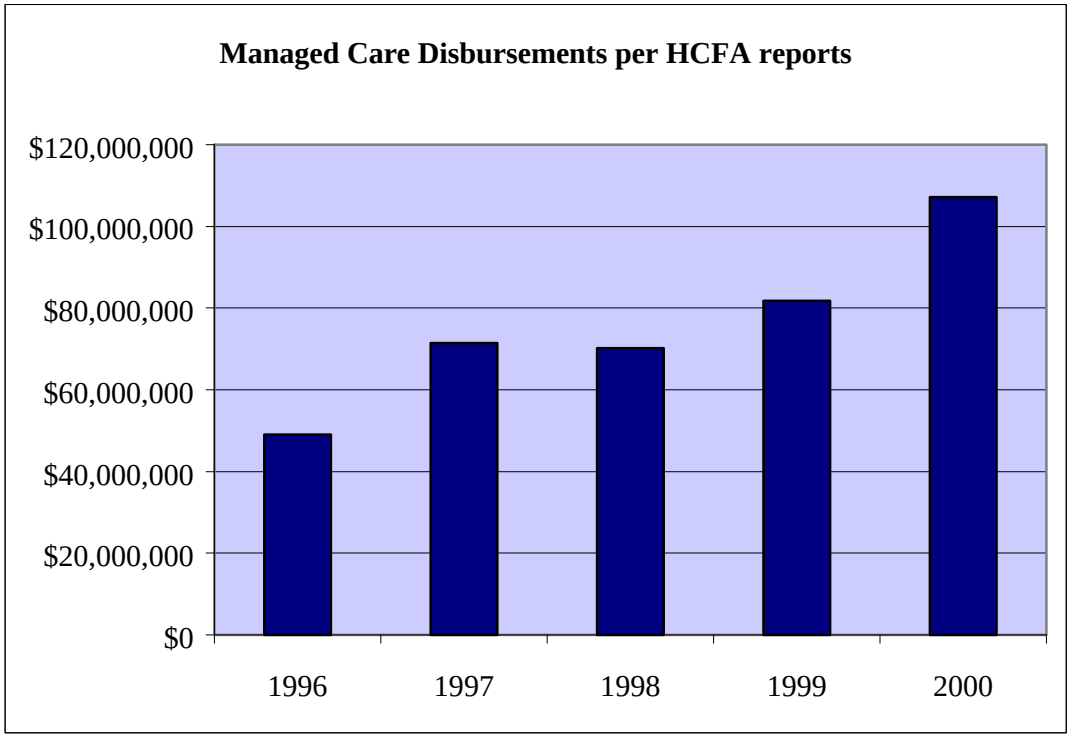


	1995	1996	1997	1998	1999	2000
Non-Managed Care	146,403	110,528	114,215	121,366	125,324	131,631
PCCM		17,572	18,543	17,302	25,080	26,594
HMO		22,206	18,659	19,668	28,556	31,411

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
MEDICAID MANAGED CARE PROGRAM
MANAGED CARE DISBURSEMENTS AND ENROLLEES
Fiscal Years Ended June 30, 1996-2000



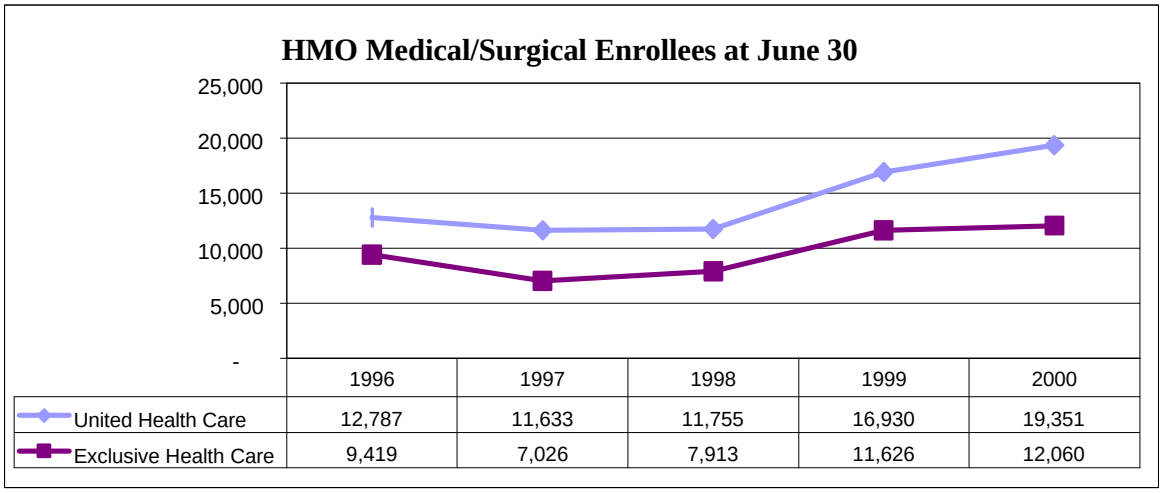
	1996	1997	1998	1999	2000
Mental Health	98,388	91,462	112,497	123,575	140,513
PCCM	17,572	18,543	17,302	25,080	26,594
HMO	22,206	18,659	19,668	28,556	31,411



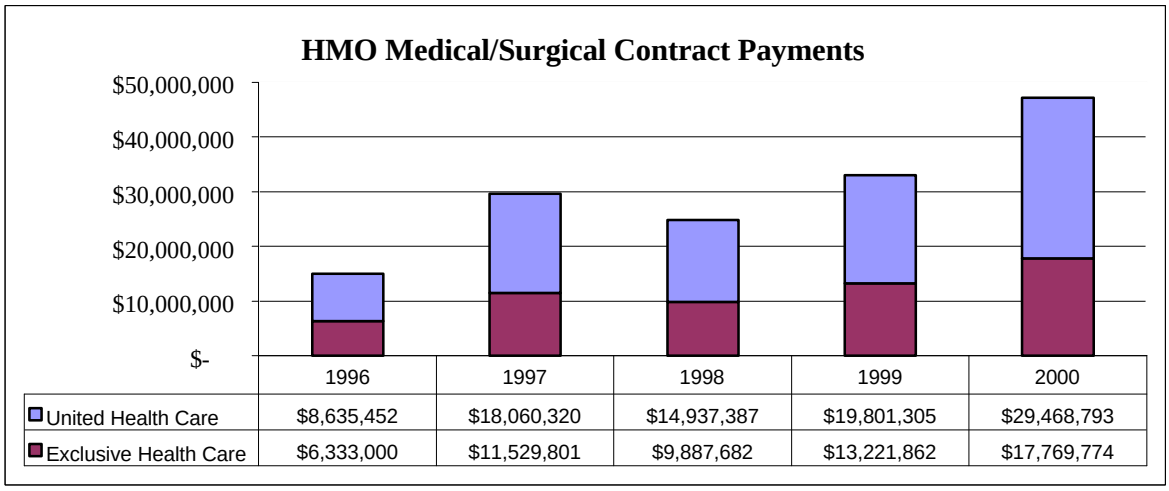
NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
MEDICAID MANAGED CARE PROGRAM

HMO MEDICAL SURGICAL ENROLLEES AND PAYMENTS

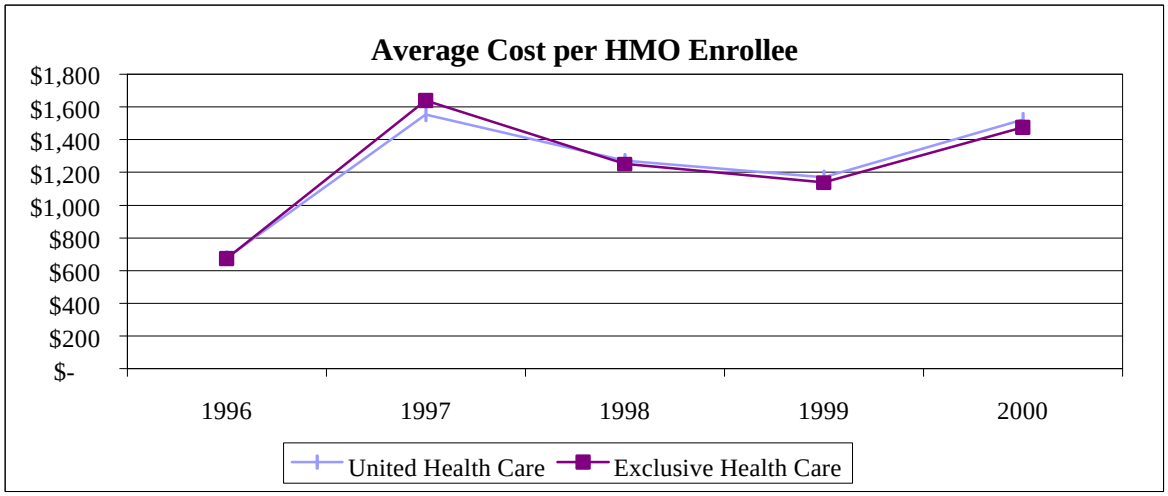
Fiscal Years Ended June 30, 1996-2000



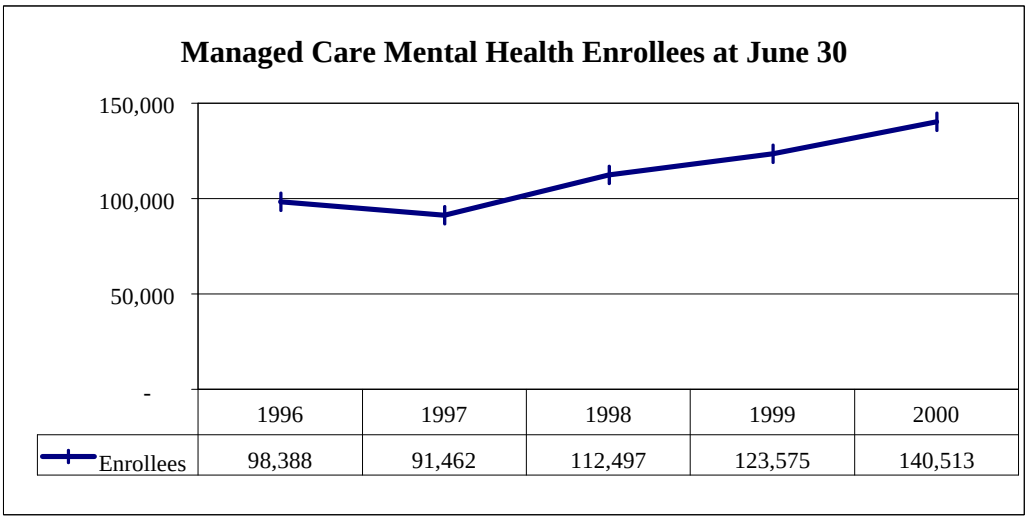
	1996	1997	1998	1999	2000
United Health Care	12,787	11,633	11,755	16,930	19,351
Exclusive Health Care	9,419	7,026	7,913	11,626	12,060



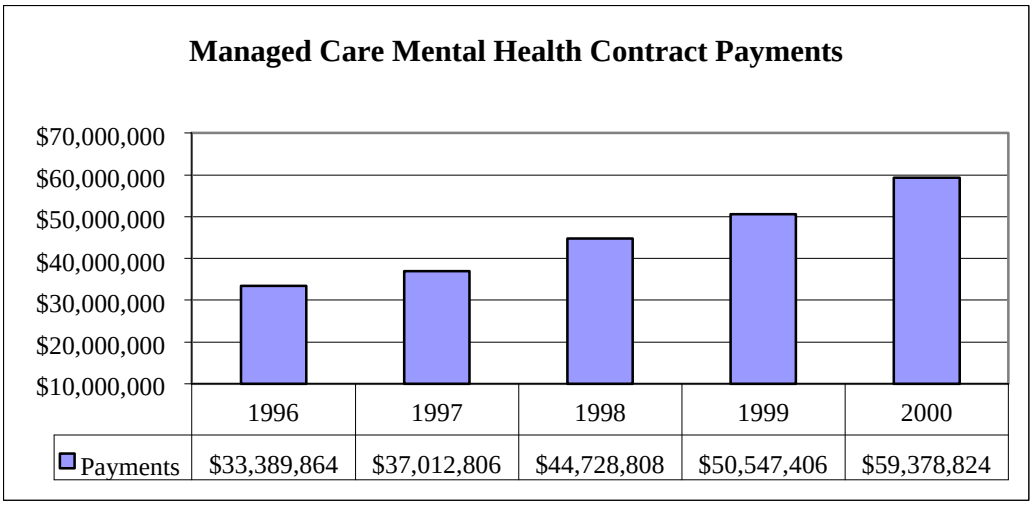
	1996	1997	1998	1999	2000
United Health Care	$8,635,452	$18,060,320	$14,937,387	$19,801,305	$29,468,793
Exclusive Health Care	$6,333,000	$11,529,801	$9,887,682	$13,221,862	$17,769,774



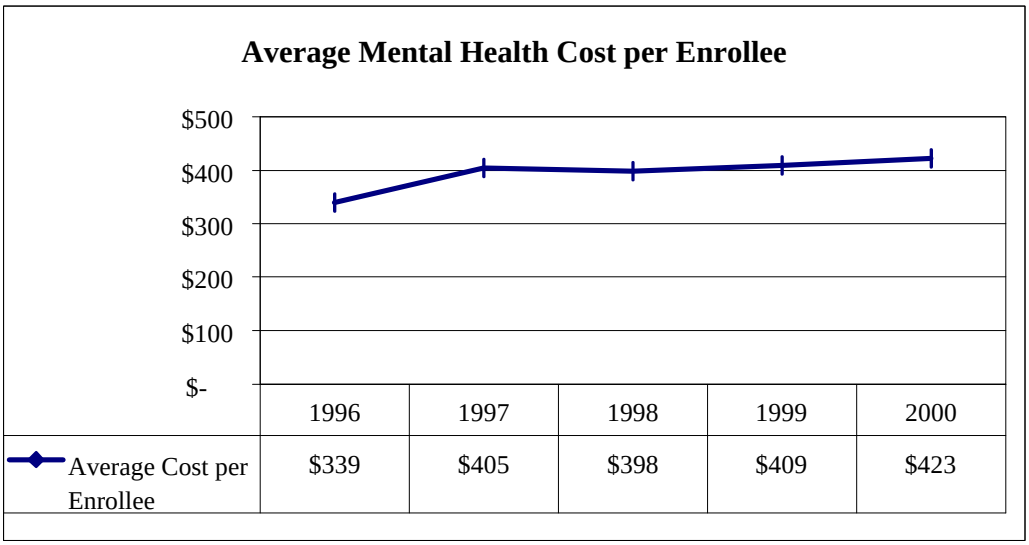
NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
MEDICAID MANAGED CARE PROGRAM
MENTAL HEALTH MANAGED CARE ENROLLEES AND PAYMENTS



	1996	1997	1998	1999	2000
Enrollees	98,388	91,462	112,497	123,575	140,513



	1996	1997	1998	1999	2000
Payments	$33,389,864	$37,012,806	$44,728,808	$50,547,406	$59,378,824



	1996	1997	1998	1999	2000
Average Cost per Enrollee	$339	$405	$398	$409	$423