ATTESTATION REPORT
OF THE
NEBRASKA DEPARTMENT OF
HEALTH AND HUMAN SERVICES
HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

JULY 1, 2010 THROUGH FEBRUARY 5, 2013

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Issued on May 29, 2013

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NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

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NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

BACKGROUND

The Nebraska Department of Health and Human Services (DHHS) – Health Insurance Premium Payment Program (HIPP Program) was created in 1994 under the Nebraska Medicaid Program (Medicaid). Medicaid pays for covered medical services for those persons who are unable to afford to pay for medically necessary services and who meet certain eligibility requirements. Nebraska Medicaid is funded jointly by the State and Federal Government. The funding is established annually pursuant to the Social Security Act and is referred to as the Federal Medical Assistance Percentages (FMAP). For each Federal fiscal year, the percentages used during the period tested follow:

Federal Fiscal Year	Federal Portion	State Portion
2010	60.56%	39.44%
2011	58.44%	41.56%
2012	56.64%	43.36%
2013	55.76%	44.24%

Note 1: The Federal fiscal year is October 1 to September 30 each year.
Note 2: For Federal fiscal years 2010 and 2011, a portion of the Federal funding came from the American Recovery and Reinvestment Act (ARRA) of 2009. DHHS did not record, in EnterpriseOne, the use of ARRA funds to the subsidiary ledger used by the HIPP Program, so these figures were not adjusted in this report.

The HIPP Program was designed to reduce Medicaid costs by reimbursing participants for their cost of private health insurance coverage. The reimbursement of the private health insurance premiums by the Medicaid program is required to be more cost effective than the payment of the medical claims by the Medicaid program. Upon approval, the Medicaid-eligible client's private health insurance premiums are paid for with Medicaid funds. Then, prior to being submitted to Medicaid, claims for the medical services of the client are submitted to the private insurance carrier – thereby, reducing the costs charged to the Medicaid program.

The HIPP Program is administered by DHHS under Title 471 NAC 30, Payment for Health Insurance Premiums. A copy of Title 471 NAC 30 is included as **Attachment A** of this report.

From July 1, 2010, through February 5, 2013, DHHS paid 661 payees a total of $6,520,440 in HIPP Program payments. The APA tested 70 HIPP Program participants, who received $1,812,792 in payments. Following is a summary of the HIPP Program payments by Federal fiscal year from the State's accounting system, EnterpriseOne:

Funding Source	FFY 2010		FFY 2011		FFY 2012		FFY 2013 through February 5, 2013		Total	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
State	$ 247,475	43.49%	$ 973,183	40.48%	$ 1,527,450	43.59%	$ 19,319	44.24%	$ 2,767,427	42.44%
Federal	$ 321,510	56.51%	$ 1,430,842	59.52%	$ 1,976,309	56.41%	$ 24,352	55.76%	$ 3,753,013	57.56%
Total	$ 568,985	100.00%	$ 2,404,025	100.00%	$ 3,503,759	100.00%	$ 43,671	100.00%	$ 6,520,440	100.00%

BACKGROUND
(Continued)

Title 471 NAC 30-006 (See **Attachment A**) states, in relevant part:

> *NMAP [Nebraska Medical Assistance Program] will pay the health insurance premium directly to the insurance carrier. If payment cannot be made directly to the carrier and the method of premium payment is payroll deduction, NMAP will arrange to pay the employer directly in lieu of the payroll deduction. If payment cannot be made directly to the carrier or employer, NMAP will reimburse the policyholder for the payroll deduction made for health insurance.*

This regulation indicates that payments will be made to reimburse the policyholder for the payroll deduction made for health insurance. In many cases, the total cost of the insurance premium is shared by the employee and employer. For example, the State of Nebraska pays 79% of the total cost of the health insurance premium, while the employees are responsible for paying the remaining 21%, which is generally processed as a deduction from pay.

The participants of the HIPP Program are employed by both public and private entities. Of the 70 participants selected for testing, 36 worked for public entities, such as the State, University, State Colleges, other governmental entities, etc. The APA independently verified the premium amounts for those employees. The remaining 34 participants were employed by private entities, and their premium amounts were not verified.

DHHS Payment and Approval Process

The HIPP Payment Reviewer was responsible for the day-to-day activities of the HIPP Program. The HIPP Payment Reviewer reported to a DHHS Administrator.

Applicants typically seek the guidance of their case worker or the HIPP Payment Reviewer to determine if they meet the eligibility requirements of the HIPP Program. If the case worker preliminarily determines the applicant may meet the eligibility requirements, a referral is made to the HIPP Payment Reviewer, who is to calculate the cost effectiveness and determine eligibility. DHHS rules and regulations include the methodology for the cost effectiveness calculation in Title 471 NAC 30.004. See **Attachment A**. Basically, the cost of insurance is required to be less expensive than paying for the medical expenses of the client.

Once the participant's eligibility is approved, the HIPP Payment Reviewer is required to obtain documentation to support the insurance premiums paid by the participant and then sends the participant a Notice of Finding. The Notice of Finding includes information related to the HIPP Program and the participant's eligibility.

Monthly, the HIPP Payment reviewer is to prepare the HIPP Program reimbursement payments, which are sent to DHHS Finance for processing. These payments are required to have supporting documentation in order to verify the reimbursement is accurate and proper.

BACKGROUND
(Continued)

To protect the identity of the individuals tested throughout this report, the APA has referred to the parent/guardian/policyholder as participants, and the Medicaid eligible persons covered have been referred to as clients.

Information Technology Systems

In addition to the State's accounting system, EnterpriseOne, DHHS utilizes the following information technology applications to assist with the HIPP Program:

Nebraska Family Online Client User System (NFOCUS) – The NFOCUS application is used to automate benefit/service delivery and case management for over 30 DHHS programs.

Medicaid Management Information System (MMIS) – This application supports the operation of the Medicaid program, which is Federally regulated, State administered, and provides medical care and services.

OnBase Enterprise Content Management (ECM) System – A system offered to state agencies that provide the ability to electronically capture, store, and retrieve supporting documentation.

EXIT CONFERENCE

An exit conference was held May 6, 2013, with DHHS to discuss the results of our examination. Those in attendance for DHHS were:

NAME	TITLE
Kerry Winterer	DHHS CEO
Vivianne Chaumont	DHHS Director of Medicaid and Long-Term Care
Jeanne Larsen	DHHS Deputy Director
Tim Curtis	DHHS Administrator
Matt Clough	DHHS Chief Operating Officer
Kevin Nelson	DHHS Internal Auditor
Brad Gianakos	DHHS Legal Services Administrator
Willard Bouwens	DHHS Financial Services Administrator

APA EXECUTIVE SUMMARY

As a result of the significant lack of controls and oversight of the HIPP Program, the APA identified numerous payments that were potentially fraudulent, ineligible, or incorrect. The most significant among these issues is the lack of adequate documentation to support the cost effectiveness determination for each client. Because DHHS lacked the proper documentation to support its calculation, the APA questions the cost effectiveness of all payments made during the period, or $6,520,440.

Despite the lack of documentation regarding cost effectiveness, the APA tested 70 participants' payments made by DHHS during the period and found the following specific issues related to the HIPP payments:

Issues Noted	Current Period Overpaid Amounts	Current Period Underpaid Amount	Prior Period Overpaid Amounts	Net Overpaid Amount
Cost Effectiveness	$265,851.63	$0.00	$0.00	$265,851.63
Potential Fraudulent Payments	$87,467.59	$0.00	$26,785.18	$114,252.77
Medicare Eligible Participants	$19,006.93	$0.00	$30,821.15	$49,828.08
Duplicate Payments	$11,967.69	$0.00	$0.00	$11,967.69
Medicaid Ineligible Participants	$5,982.41	$0.00	$933.54	$6,915.95
Premium Holiday Payments	$4,172.56	$0.00	$0.00	$4,172.56
Payments for Excluded Items	$4,549.27	-$101.40	$0.00	$4,447.87
Other Incorrect Payments	$31,404.99	-$8,001.32	$0.00	$23,403.67
Totals	**$430,403.07**	**-$8,102.72**	**$58,539.87**	**$480,840.22**

As a reminder, these payment errors were identified only from the sample of 70 participants selected for testing and not 100 percent of the participants paid under the HIPP Program. Had all of the participants (over 661) receiving payments for insurance premiums been tested, the APA strongly expects that the overpayment amount would significantly increase.

Some participants were reimbursed incorrect amounts for health insurance premiums. If the participant can be shown to have acted intentionally, by fostering a false impression or otherwise, for the express purpose of obtaining reimbursements greater than the amount for which that individual was eligible, such activity may constitute fraud.

While certain clients may have been entitled to premium payments during the period, the APA questions all of the payments made due to the lack of documented cost effectiveness calculations for all participants. Participants and clients are entitled to reimbursements only if they meet the eligibility requirements of Title 471 NAC 30. In addition, they are entitled only to the amounts they actually paid for their health insurance premiums.

APA EXECUTIVE SUMMARY
(Continued)

Based upon the volume of errors, lack of documentation available to support the HIPP payments, and lack of internal control and supervision, the APA recommends DHHS take immediate action to prevent further loss or misuse of State and Federal funds. DHHS should evaluate the current staffing to determine its capabilities of appropriately handling this program. Steps should be immediately taken to ensure that more than one individual is handling the approval and payments made in connection with this program.

DHHS should also assess the potential tax consequences regarding reimbursements made directly to the participants, rather than to the insurance companies or employers.

Further, DHHS should determine whether the overpayments can be recovered and, if so, take whatever action necessary to recover the overpaid amounts. Due to the potentially fraudulent payments that were identified, the APA will refer this report to the Attorney General and other regulatory agencies.

SUMMARY OF COMMENTS

During our examination of the HIPP Program, we noted certain deficiencies and other operational matters that are presented here.

These comments and recommendations are intended to improve the internal control over financial reporting or result in operational efficiencies in the following areas:

1. ***Cost Effectiveness Calculations*:** DHHS failed to adequately document the cost effectiveness calculation for any of the 70 participants tested by the APA. Therefore, the APA questions the cost effectiveness of all the payments made during the period, or $6,520,440.

2. ***Incorrect Payments*:** DHHS incorrectly paid 53 of the 70 participants tested, resulting in net overpayments of $156,449. These errors resulted from a wide variety of issues, including potentially fraudulent payments, ineligible payments, and others. Had all of the participants (over 661) receiving payments for insurance premiums been tested, the APA strongly expects that the overpayment amount would significantly increase.

3. ***Inadequate Internal Controls*:** The overall control environment was severely deficient. One person was in charge of every aspect of the HIPP Program, from eligibility determination to processing of payments, to the collection of refunded payments. Additionally, the majority of payments were made without adequate documentation to support the premium amount paid. This lack of controls has resulted in the numerous issues described in the preceding comment regarding incorrect payments.

4. ***Potential Tax Consequences*:** The potential tax consequences regarding the reimbursements made directly to the participants has not been assessed. In some cases, the participants had insurance premiums deducted from their wages as pre-tax deductions, so the insurance deductions were not included in their income. The insurance payments were reimbursed by the HIPP Program and this was not reported on 1099s, thus it was not included in participant's income for tax purposes, resulting in the potential for significant tax consequences.

5. ***Subsequent Event:*** DHHS improperly recorded $647,185.22 in Federal funds to the incorrect grant year.

More detailed information on the above items is provided hereafter. It should be noted that this report is critical in nature, containing only our comments and recommendations on the areas noted for improvement and does not include our observations on any accounting strengths of DHHS.

Draft copies of this report were furnished to DHHS to provide its management with an opportunity to review and to respond to the comments and recommendations contained herein. The formal responses received have been incorporated into this report. Where no response has been included, DHHS declined to respond. Responses that indicate corrective action has been taken were not verified at this time, but will be verified in the next examination.

COMMENTS AND RECOMMENDATIONS

1. Cost Effectiveness Calculations

The purpose of the HIPP Program is to reduce Medicaid costs, by reimbursing the cost of private health insurance, only if it is ***COST-EFFECTIVE*** to do so. The cost effectiveness calculation is the key component in determining whether a client is eligible for health insurance reimbursements through the HIPP Program, as noted in Title 471 NAC 30-004 (**Attachment A**).

DHHS did not have adequate documentation to support the cost effectiveness calculation for any of the 70 clients tested during the period July 1, 2010, through February 5, 2013. The documentation that was maintained by DHHS did not comply with its regulations and was not current. DHHS staff confirmed that the files lacked adequately documented cost effectiveness calculations.

Per discussions with the HIPP Payment Reviewer, DHHS has not followed the cost effectiveness methodology approved in its regulations for some time, as the wording in Chapter 30, related to the cost effectiveness, is mostly "outdated." The HIPP Payment Reviewer confirmed that DHHS had not been receiving the health plan information, including effective dates of the policy, exclusions to enrollment, covered services, and any riders to the plan, as required. It is unclear, based on discussions with DHHS, when the last time the cost effectiveness calculation was completed using the methodology defined in the regulations.

Additionally, the APA did not recalculate the cost effectiveness, per Title 471 NAC 30-004, for any of the clients tested because the information necessary to make the calculation was not documented in the case files or available to the APA. The HIPP Payment Reviewer indicated that DHHS compared the annual premium costs to the medical cost reports from MMIS. However, that documentation was not maintained in the case files and DHHS did not have any records to show that the comparison was performed.

As such, the APA questions all HIPP Program reimbursement payments, or $6,520,440, during the period based on the lack of adequate documentation to support the cost effectiveness for each participant. The APA also noted other significant issues related to the cost effectiveness, as follows:

Participant 1

One participant's health insurance premium reimbursement is currently $9,617 per month. A total of $265,852 in premiums was paid between July 1, 2010, and February 5, 2013. For this participant, the following monthly premiums were paid during the period:

Months of Coverage	Monthly Premium	Total HIPP Payments Received
August 2010 through September 2010	$6,006.12	$12,012.24
October 2010 through March 2011	$6,907.05	$41,442.30
April 2011 through September 2011	$8,150.30	$48,901.80
October 2011 through February 2013	$9,617.37	$163,495.29
Total from July 1, 2010 to February 5, 2013		**$265,851.63**

COMMENTS AND RECOMMENDATIONS
(Continued)

1. Cost Effectiveness Calculations (Continued)

The APA initially questioned and reviewed the cost effectiveness of this premium due to the fact that no other monthly premiums tested were as substantial as this one. The case file provided did not contain documentation to support DHHS' cost effectiveness determination. After our inquiry, DHHS obtained a report that included the detail of the claims paid by private insurance and the claims paid by Medicaid for all claims submitted to DHHS for the client. Based on this information, the APA performed the following calculation:

Total Premiums and Medicaid Claims Paid Under HIPP Program	**Amounts**
HIPP Premiums Paid by Medicaid (see above)	$265,851.63
Medicaid Claims Paid per DHHS report	$30,906.06
Total Premiums and Medicaid Claims Paid	***$296,757.69***
COMPARED TO:	
Total Medical Claims as Submitted to DHHS	
Private Insurance Claims per DHHS report	$142,700.13
Medicaid Claims Paid (same as above)	$30,906.06
Total Medical Claims as Submitted	***$173,606.19***
Excess of HIPP Program Amounts vs Total Medical Claims Reported to DHHS	**$123,151.50**

Note: It is possible that additional claims were paid by the private insurance carrier but were not submitted to Medicaid; however, DHHS lacked sufficient documentation of these other claims.

The table above indicates that payments to this participant were not cost effective, based on the documentation maintained. According to this calculation, the costs associated with the HIPP Program were $123,152 more than if DHHS had just paid all of the medical claims under the Medicaid Program.

Furthermore, this client's case file included a copy of a letter dated March 4, 2010, from the HIPP Payment Reviewer, indicating that it was no longer cost effective to pay the participant's health insurance premium because of an increase in the premium amount. At the time of the letter, the insurance premium had increased to $5,138. Currently, the participant's insurance premium is reimbursed at over $9,600 per month. A copy of the letter is included below. The APA removed any information that would identify the participant and client.

(Continued on Next Page)

COMMENTS AND RECOMMENDATIONS
(Continued)

1. <u>Cost Effectiveness Calculations</u> (Continued)

DHHS
Nebraska Department of Health and Human Services
Division of Medicaid and Long-Term Care
State of Nebraska
Dave Heineman, Governor

Participant Name and Address Removed

March 4, 2010

Medicaid Number: *Client Name and Medicaid Number Removed*

Dear [redacted],

Participant and Vendor Name Removed

Please see the attached letter from [redacted] regarding an increase in insurance premiums.

Your current premium is $4468.22. With a 15% increase as indicated this would put your monthly premium amount at $5138.45. At this rate it no longer becomes cost effective for the State of Nebraska to pay your health insurance premium.

Please review the attached notice that they have sent regarding "Cost Reduction Options".

We will continue to pay this premium for the next 3 months while you are looking at your options for health insurance.

Please contact me when you have made a decision.

Sincerely,

[redacted]

Name & Phone number was removed.

HIPP payment reviewer

[redacted]

Cc [redacted] York-Local Office
Fairbury-Local Office

Letter was copied to DHHS local offices, and the names were removed.

Helping People Live Better Lives

Payments continued to the participant after this letter was sent, and no further information was maintained to document the reason for the continuation or increase in the payments to over $9,600 per month in 2013.

<u>Participant 58</u>
The cost effectiveness calculation for this participant was not adequately documented or in accordance with DHHS regulations. The following information was taken from the participant's HIPP application and was dated September 17, 2008:

COMMENTS AND RECOMMENDATIONS
(Continued)

1. <u>Cost Effectiveness Calculations</u> (Continued)

Cost Effectiveness Calculation

1. **Show calculation (total cost ÷ by 6 plus $15 administrative allowance = monthly cost).**
   $777.10 + $15.00 = $792.10

   This estimates the Medicaid costs for the participant, not including the private insurance.

2. **Convert premium to monthly amount. Weekly (amount x 52 ÷ by 12); Biweekly (amount x 26 ÷ by 12); Monthly; quarterly (amount ÷ by 3).**
   $1217.64 monthly

   This shows the insurance premium for the participant.

3. **If comparison does not show the policy to be cost-effective, request itemized medical bills for the same 6 month period and show actual cost.**

   There is no response to this question, but it appears the policy would not be cost effective because the premiums are greater than the Medicaid costs.

In addition to the fact that this calculation was performed in 2008, the amounts included in the above calculation were not adequately supported. For example, the estimated Medicaid costs of $777.10 are not referenced or supported by any documentation whatsoever. Furthermore, this calculation is not in accordance with Title 471 NAC 30-004.

The case file contained no other documentation supporting the cost effectiveness of this participant.

<u>Multiple Health Insurance Plan Coverage</u>
Under the HIPP Program, DHHS reimbursed participants for coverage of a client under multiple private health insurance plans. In these situations, both parents (or guardians) covered the client under separate health insurance plans. Per discussions with DHHS, this is an acceptable practice, provided it is cost effective. However, because of the lack of documentation in the case files to support the cost effectiveness determinations, it is unclear how DHHS determined the payment of two premiums was cost effective.

Good internal control requires procedures to ensure compliance with rules and regulations. Because of the lack of documentation to support the cost effectiveness determination of the 70 participants tested, there is an increased risk for loss or misuse of State and Federal funds. Additionally, because the cost effectiveness determinations are not documented, DHHS cannot document its compliance with the regulations governing the HIPP Program.

> We recommend DHHS determine the best method to determine the cost effectiveness of participation in the HIPP Program in compliance with Title 471 NAC 30-004. DHHS should implement procedures to ensure compliance with the established regulations by properly documenting and showing the cost effectiveness calculations for all individuals, whether accepted into the program or not. In addition, DHHS should re-evaluate the cost

COMMENTS AND RECOMMENDATIONS
(Continued)

1. Cost Effectiveness Calculations (Concluded)

effectiveness calculations on a regular basis, at least annually, or at any time there is a significant change in the circumstances that would affect the cost effectiveness for participants. Finally, all calculations should be reviewed and approved by someone other than the individual who performed them.

DHHS' Response: The Department has reviewed the cost effectiveness determination mandated by 471 NAC 30-004, and has developed additional processes and procedures to ensure that cost effectiveness is calculated and documented in accordance with these regulations prior to enrolling any participant in the HIPP program. The Department is currently in the process of reviewing all current participants to verify cost effectiveness and will terminate any participants from the program if participation is not determined to be cost effective.

2. Incorrect Payments

As noted in the background section of this report, there were a total of 661 payees from July 1, 2010, through February 5, 2013. The APA tested 70 participants within the HIPP Program.

The APA found that 53 of the 70 participants tested received incorrect payments, resulting in net overpayments of $156,448.72. The details for these 53 participants were accumulated in **Exhibit A**. The following is a summary of some of the more serious issues noted:

Issues Noted	Overpaid Amount	Underpaid Amount	Net Overpaid Amount
Potential Fraudulent Payments	$87,467.59	$0.00	$87,467.59
Medicare Eligible Participants	$19,006.93	$0.00	$19,006.93
Duplicate Payments	$11,967.69	$0.00	$11,967.69
Medicaid Ineligible Participants	$5,982.41	$0.00	$5,982.41
Premium Holiday Payments	$4,172.56	$0.00	$4,172.56
Payments for Excluded Items	$4,549.27	-$101.40	$4,447.87
Other Incorrect Payments	$31,404.99	-$8,001.32	$23,403.67
Totals	**$164,551.44**	**-$8,102.72**	**$156,448.72**

Note: In addition to these errors noted for the period tested, the APA also identified an additional $58,540 in incorrect payments made prior to the period tested.

Potential Fraud

The APA identified three cases in which the HIPP Program participants could have defrauded DHHS, if the participant can be shown to have acted intentionally. At a minimum, these three participants received significantly more reimbursements from DHHS than they paid for health insurance premiums. The details for the three participants follow:

COMMENTS AND RECOMMENDATIONS
(Continued)

2. <u>Incorrect Payments</u> (Continued)

<u>Participant 3</u>
Since September 2006, DHHS has reimbursed a participant's health insurance premium even though the participant has not paid the health insurance premium, resulting in overpayments of $29,428.65 during the period tested. This participant worked for two different Nebraska governmental entities, and both entities paid the entire share of the health insurance premium. The APA independently verified with both entities that this employee had not paid or did not have any payroll deductions for health insurance coverage since 2006. The following summarizes the payments made to this participant:

Period	Employer 1	Employer 2	Total Overpaid Amount
July 2010 to August 2011	$4,823.70	$0	$4,823.70
September 2011 to January 2013	$0	$24,604.95	$24,604.95
Total Overpaid Amount	**$4,823.70**	**$24,604.95**	**$29,428.65**

Note: From September 2006 through June 2010, the participant also received $15,504.75 in reimbursements for which the employer had paid the entire portion of the health insurance premium.

The case file lacked adequate documentation to support the premium amount paid. In fact, the case file did not have any documentation to support the premium reimbursed prior to September 2011, when the participant began employment at another entity. The APA observed a handwritten note indicating that, on September 15, 2011, the HIPP Payment Reviewer spoke with the participant's spouse, who explained that the increase in the premium amount was due to a new employer. The APA also observed a fax signed by the participant, indicating what is referred to as the "District Paid Insurance" amount. See below for a partial copy of the fax.

THIS IS THE INPUT INFORMATION FOR PAYROLL - PLEASE CHECK THIS OVER AND RETURN

NAME: Participant Name Removed

Information Removed

BASE SALARY ~~51,480~~ 57,045.40

DISTRICT PAID INSURANCE 1447.30 PER MONTH

EMPLOYEE PAID DISABILITY INSURANCE 15.44

ACCOUNT CODE: 01-2-2120-110-1

August 1,

Participant Name Removed

Phone Number Removed

(SIGNATURE)

extended contract

This information indicated that the governmental entity paid the health insurance premium of the employee.

The fax is evidence that the governmental entity, rather than the employee, paid the health insurance. However, the HIPP Payment Reviewer continued to reimburse the participant for health insurance premiums. The APA independently verified the payroll information with both governmental entities and noted the entities paid the entire premium.

COMMENTS AND RECOMMENDATIONS
(Continued)

2. Incorrect Payments (Continued)

Because the participant is not paying the health insurance premium, that individual is clearly ineligible to receive the reimbursement. It appears, however, that the participant knowingly received the health insurance reimbursements without actually paying a premium. If the participant can be shown to have acted intentionally, by fostering a false impression or otherwise, for the express purpose of obtaining reimbursements for which that individual was not eligible, such activity may constitute fraud.

Additionally, it appears this participant was also overpaid prior to our period tested. From September 2006 through June 2010, the total overpayments total $15,504.75.

Participant 4
Since March 2009, DHHS has reimbursed a participant's health insurance premium based on the employer's share of the premium, rather than the employee's share of the premium, resulting in overpayments totaling $20,238.94 for the period tested. This participant's employer pays the majority of the total monthly health insurance premium. The following is a summary of payments made to this participant:

Batch Number	G/L Date	HIPP Payment	Actual Payroll Deduction	Overpaid Amount
2228508	7/7/2010	$992.77	$330.90	$661.87
2259732	8/5/2010	$992.77	$349.77	$643.00
2293313	9/9/2010	$992.77	$349.77	$643.00
2315545	10/1/2010	$992.77	$349.77	$643.00
2343782	11/1/2010	$992.77	$349.77	$643.00
2344654	11/2/2010	$992.77	$349.77	$643.00
2383141	12/15/2010	$1,985.54	$699.54	$1,286.00
2445033	2/23/2011	$992.77	$349.77	$643.00
2456707	3/8/2011	$992.77	$349.77	$643.00
2483490	4/6/2011	$992.77	$349.77	$643.00
2513762	5/9/2011	$992.77	$349.77	$643.00
2525074	5/19/2011	$1,985.54	$699.54	$1,286.00
2555747	6/20/2011	$1,985.54	$699.54	$1,286.00
2663817	10/4/2011	$992.77	$0.00	$992.77
2677846	10/19/2011	$992.77	$349.77	$643.00
2728795	12/14/2011	$992.77	$349.77	$643.00
2750713	1/5/2012	$992.77	$349.77	$643.00
2786546	2/8/2012	$992.77	$349.77	$643.00
2866975	4/24/2012	$992.77	$349.77	$643.00
2889051	5/15/2012	$992.77	$349.77	$643.00
2928828	6/19/2012	$992.77	$349.77	$643.00
2967789	7/24/2012	$992.77	$349.77	$643.00
3008026	8/27/2012	$992.77	$360.22	$632.55
3046849	10/1/2012	$992.77	$360.22	$632.55

COMMENTS AND RECOMMENDATIONS
(Continued)

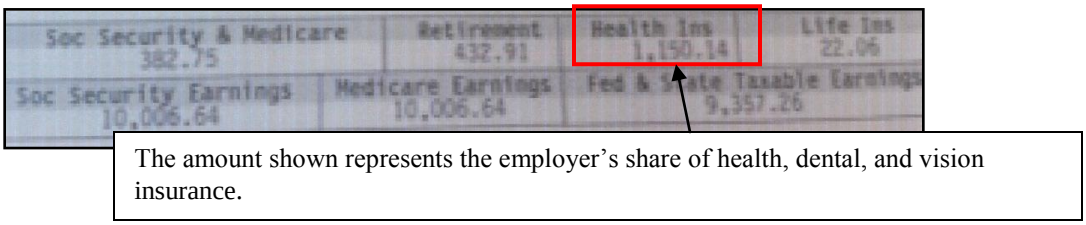
2. <u>Incorrect Payments</u> (Continued)

Batch Number	G/L Date	HIPP Payment	Actual Payroll Deduction	Overpaid Amount
3068903	10/19/2012	$992.77	$360.22	$632.55
3106798	11/27/2012	$992.77	$360.22	$632.55
3137075	1/1/2013	$992.77	$360.22	$632.55
3167122	1/28/2013	$992.77	$360.22	$632.55
TOTALS		**$30,775.87**	**$10,536.93**	**$20,238.94**

Note 1: Prior to the period tested, from March 2009 to June 2010, DHHS overpaid the participant $11,280.43.
Note 2: The highlighted cells shows the HIPP payment made when there was a premium holiday. The premiums are paid a month in advance. This is the November 2011 payment for December 2011 insurance coverage.

The participant's case file included a 2009 paystub that identified the employer share of the premium, $992.77, and the employee share of the premium, $330.92. The HIPP Payment Reviewer has not changed the monthly amount it has reimbursed this participant since 2009, even though the monthly premiums have changed. The APA independently verified the premiums for this participant.

On March 9, 2012, the participant emailed the HIPP Payment Reviewer to inquire about the next payment. At that time, the HIPP Payment Reviewer asked for additional documentation to support the premium amount since the last documentation in the case file was from 2009. As documentation, the participant sent pictures of an undated paystub, included below:



The amount shown represents the employer's share of health, dental, and vision insurance.

The amount shown above is $1,150.14. The APA independently determined this included the following amounts:

Employer's share of health insurance	$1,049.31
Employer's share of dental insurance	$96.99
Employer's share of vision insurance	$3.84
Total	**$1,150.14**

The actual employee share of the health insurance premium at that time was $349.77. This amount was not provided by the participant. Furthermore, after receipt of this documentation from the participant, the HIPP Payment Reviewer continued to reimburse the participant at the 2009 rate of $992.77 each month.

COMMENTS AND RECOMMENDATIONS
(Continued)

2. Incorrect Payments (Continued)

This participant was reimbursed incorrect amounts for health insurance premiums. If the participant can be shown to have acted intentionally, by fostering a false impression or otherwise, for the express purpose of obtaining reimbursements greater than the amount for which that individual was eligible, such activity may constitute fraud.

Participant 2
Since October 2010, DHHS has reimbursed a participant's health insurance premium based on the total premium amount of $2,014. This includes amounts paid by both the employee and the employer, as follows:

Employee Share	$664
Employer Share	$1,350
Total	**$2,014**

The HIPP Payment Reviewer should have reimbursed the participant for only the employee's share of the premium, $664 each month. Instead, providing reimbursements for both the employee's and employer's shares has resulted in overpayments of $1,350 every month since October 2010. The following are the payments made to this participant:

Batch Number	G/L Date	HIPP Payment	Actual Payroll Deduction	Overpaid Amount
2396061	1/3/2011	$8,056.00	$2,656.00	$5,400.00
2426306	2/3/2011	$2,014.00	$664.00	$1,350.00
2457805	3/9/2011	$2,014.00	$664.00	$1,350.00
2485646	4/8/2011	$2,014.00	$664.00	$1,350.00
2513351	5/9/2011	$2,014.00	$664.00	$1,350.00
2541276	6/6/2011	$2,014.00	$664.00	$1,350.00
2578070	7/12/2011	$2,014.00	$664.00	$1,350.00
2611542	8/11/2011	$2,014.00	$664.00	$1,350.00
2636709	9/7/2011	$2,014.00	$664.00	$1,350.00
2663560	10/4/2011	$2,014.00	$664.00	$1,350.00
2705141	11/16/2011	$2,014.00	$664.00	$1,350.00
2718235	12/2/2011	$2,014.00	$664.00	$1,350.00
2745118	1/3/2012	$2,014.00	$664.00	$1,350.00
2797716	2/21/2012	$2,014.00	$664.00	$1,350.00
2830452	3/22/2012	$2,014.00	$664.00	$1,350.00
2864545	4/23/2012	$2,014.00	$664.00	$1,350.00
2893446	5/18/2012	$2,014.00	$664.00	$1,350.00
2928809	6/19/2012	$2,014.00	$664.00	$1,350.00
2968519	7/25/2012	$2,014.00	$664.00	$1,350.00
2992001	8/13/2012	$2,014.00	$664.00	$1,350.00
3034316	9/19/2012	$2,014.00	$664.00	$1,350.00

COMMENTS AND RECOMMENDATIONS
(Continued)

2. Incorrect Payments (Continued)

Batch Number	G/L Date	HIPP Payment	Actual Payroll Deduction	Overpaid Amount
3074714	10/25/2012	$2,014.00	$664.00	$1,350.00
3108526	11/28/2012	$2,014.00	$664.00	$1,350.00
3122503	12/11/2012	$2,014.00	$664.00	$1,350.00
3170122	2/1/2013	$2,014.00	$664.00	$1,350.00
TOTALS		**$56,392.00**	**$18,592.00**	**$37,800.00**

Note: The case file for this participant contained only documentation to support the premium amount for the July 2010 to June 2011 plan year. Because no other documentation was available that indicated the premium changed, the APA continued to use that amount as the employer share of the premium. (See highlighted cells above.)

The monthly HIPP reimbursement amounts have not changed since 2010, which is also questionable. This participant had a private employer, so the amounts included as overpayments are based solely on documentation contained in the DHHS case file and not independently verified by the APA.

This participant was reimbursed incorrect amounts for health insurance premiums. If the participant can be shown to have acted intentionally, by fostering a false impression or otherwise, for the express purpose of obtaining reimbursements greater than the amount for which that individual was eligible, such activity may constitute fraud.

Medicare Eligible Participants

The APA identified two participants who received $19,006.93 in HIPP Program payments during the period tested; however, they were Medicare-eligible clients and, as a result, were not eligible for the HIPP Program. Title 471 NAC 30-002.03, states:

> *If the client is also eligible for Medicare Part B but is not enrolled in Medicare Part B, NMAP does not pay for the premiums or other cost sharing obligations to the health plan.*

The following is a summary of payments made to Participant 6 from July 1, 2010, to February 5, 2013. This participant has been Medicare eligible since 2007; therefore, none of the payments in our period were eligible.

Batch Number	G/L Date	HIPP Payments	Correct Payment Amount	Overpaid Amount
2227481	7/6/2010	$677.07	$0.00	$677.07
2257231	8/3/2010	$677.07	$0.00	$677.07
2284633	8/30/2010	$677.07	$0.00	$677.07
2314634	10/1/2010	$677.07	$0.00	$677.07
2345102	11/2/2010	$677.07	$0.00	$677.07

COMMENTS AND RECOMMENDATIONS
(Continued)

2. Incorrect Payments (Continued)

Batch Number	G/L Date	HIPP Payments	Correct Payment Amount	Overpaid Amount
2382158	12/14/2010	$677.07	$0.00	$677.07
2402833	1/10/2011	$776.22	$0.00	$776.22
2430079	2/8/2011	$776.22	$0.00	$776.22
2462084	3/14/2011	$99.15	$0.00	$99.15
2485869	4/8/2011	$776.22	$0.00	$776.22
2530758	5/25/2011	$776.22	$0.00	$776.22
2582691	7/15/2011	$776.22	$0.00	$776.22
2620376	8/19/2011	$1,552.44	$0.00	$1,552.44
2647019	9/16/2011	$776.22	$0.00	$776.22
Totals		**$10,371.33**	**$0.00**	**$10,371.33**

Note: Participant 6 also received $17,296.09 in overpayments prior to the period tested.

The following is a summary of payments made to Participant 7 from July 1, 2010, to February 5, 2013. This participant has been Medicare eligible since 1994; therefore, none of the payments in our period were eligible.

Batch Number	G/L Date	HIPP Payments	Correct Payment Amount	Overpaid Amount
2243894	7/21/2010	$431.78	$0.00	$431.78
2266905	8/12/2010	$431.78	$0.00	$431.78
2306371	9/22/2010	$431.78	$0.00	$431.78
2332626	10/20/2010	$431.78	$0.00	$431.78
2353684	11/10/2010	$431.78	$0.00	$431.78
2387076	12/20/2010	$431.78	$0.00	$431.78
2413922	1/21/2011	$431.78	$0.00	$431.78
2441515	2/18/2011	$431.78	$0.00	$431.78
2469356	3/22/2011	$431.78	$0.00	$431.78
2494456	4/18/2011	$431.78	$0.00	$431.78
2526104	5/20/2011	$431.78	$0.00	$431.78
2561646	6/23/2011	$431.78	$0.00	$431.78
2589676	7/22/2011	$431.78	$0.00	$431.78
2624363	8/24/2011	$431.78	$0.00	$431.78
2653118	9/22/2011	$431.78	$0.00	$431.78
2682332	10/24/2011	$431.78	$0.00	$431.78
2708564	11/21/2011	$431.78	$0.00	$431.78
2726078	12/12/2011	$431.78	$0.00	$431.78
2769076	1/24/2012	$431.78	$0.00	$431.78
2810080	3/2/2012	$431.78	$0.00	$431.78
Totals		**$8,635.60**	**$0.00**	**$8,635.60**

Note: Participant 7 also received $13,525.06 in overpayments prior to the period tested.

Based on the documentation maintained in NFOCUS, these participants were not eligible for participation in the HIPP Program because they are both eligible for Medicare.

COMMENTS AND RECOMMENDATIONS
(Continued)

2. Incorrect Payments (Continued)

Furthermore, because they had been eligible for Medicare since 2007 and 1994, respectively, they also received overpayments prior to our period tested. Participant 6 received $17,296.09 since October 2007. Participant 7 received $13,525.06 since April 1994.

Duplicated Payments
The APA found seven participants who either received duplicate payments or had their monthly premium reimbursements incorrectly doubled. See below for details:

Participant	Batch Number	G/L Date	HIPP Payment	Correct Payment Amount	Overpaid Amount	Explanation
Participant 8	2506857	5/2/2011	$5,595.46	$2,301.97	$3,293.49	The May 2011 premium was paid at double the incorrect premium rate of $2,797.73.
Participant 12	2434000	2/11/2011	$1,195.44	$0.00	$1,195.44	This was a duplicate payment for February 2011 made to the participant.
Participant 12	2620559	8/19/2011	$1,315.80	$60.18	$1,255.62	The insurance company billed $60.18 for September 2011. The actual monthly premium was $1,255.62; however, there was a previous overpayment to the insurance company of $1,195.44, resulting in a balance of only $60.18 owed. The HIPP Payment Reviewer paid $1,255.62 plus $60.18 for September 2011, increasing the overpayment, instead of offsetting it.
Participant 17	2928632	6/19/2012	$1,822.20	$0.00	$1,822.20	This was a duplicate payment for June 2012 which was previously paid in March 2012.
Participant 10	2830515	3/22/2012	$2,785.72	$1,392.86	$1,392.86	April 2012 premium was doubled.
Participant 14	2977855	8/1/2012	$549.37	$268.08	$281.29	Premium appears to have been doubled or almost doubled each month.
Participant 14	3011753	8/29/2012	$509.70	$268.08	$241.62	
Participant 14	3046891	10/1/2012	$536.16	$268.08	$268.08	
Participant 14	3069813	10/22/2012	$536.16	$268.08	$268.08	
Participant 14	3167108	1/28/2013	$536.16	$268.08	$268.08	
Participant 21	2834644	3/27/2012	$2,412.46	$1,206.23	$1,206.23	March 2012 premium was doubled.
Participant 23	2942311	7/2/2012	$949.40	$474.70	$474.70	June 2012 premium was doubled.
Duplicated Payment Totals			**$18,744.03**	**$6,776.34**	**$11,967.69**	

As described in Comment Number 3, below, the APA also found a lack of consistency for the timing of the monthly HIPP Program payments by DHHS. Some participants did not receive payments for certain months, while other participants may have received multiple payments in the same month. This lack of consistency increases the risk that DHHS will make duplicate payments.

COMMENTS AND RECOMMENDATIONS
(Continued)

2. Incorrect Payments (Continued)

As noted in the table above, Participant 12 received payment for a month that had already been paid, and the participant never cashed the duplicate payment. After one year, State warrants expire, at which time the funds revert to the State's general fund. Because the HIPP Program payments are made with both State and Federal funds, the portion of the payment made from Federal funds was transferred to the State when the warrant expired. Additionally, the payee can still make a claim on the incorrect payment that expired through the State's Risk Management office.

Medicaid Ineligible Participants
Three clients were not Medicaid eligible during periods in which premium payments were made; therefore, they were ineligible for the HIPP Program. DHHS made payments to these individuals, resulting in net overpayments of $5,982. Additional overpayments from the period prior to our engagement were also found, totaling $933.54. The following summarizes the overpayments to these three participants:

Participant	Net Overpaid Amount	Reason for Overpayment
Participant 9	$4,731.49	The client was Medicaid eligible under the medically needy program and had a spenddown obligation. According to DHHS rules and regulations, these clients are not eligible for the HIPP Program. This client was also ineligible prior to the period tested, resulting in additional overpayments of $933.54.
Participant 24	$777.40	The client was not eligible for Medicaid in August and September 2012 and, therefore, not eligible for the HIPP Program.
Participant 30	$473.52	The client was not eligible for Medicaid in March 2012, and therefore, not eligible for the HIPP Program.
Total Overpaid	**$5,982.41**	

Title 471 NAC 30-001 states, in relevant part:

> *The Nebraska Medical Assistance Program [NMAP] covers payment for health insurance premiums for individuals who are otherwise eligible for Medicaid when determined to be cost effective.*

Furthermore, Title 471 NAC 30-004.02 states:

> *NMAP has determined that payment of premiums for a health plan is not cost effective when the premium is used to meet a spenddown obligation under the medically needy program.*

Premium Holiday
DHHS reimbursed six State employees and two State College employees for health insurance premiums for months in which the employees did not pay the health insurance premium. The APA verified that no health insurance deduction was withheld from the employees' pay for those months.

COMMENTS AND RECOMMENDATIONS
(Continued)

2. Incorrect Payments (Continued)

During November and December of 2012, the State of Nebraska gave all employees covered under the State's health insurance plan a "premium holiday." Similarly, State College employees also had a "premium holiday" during December 2011. A "premium holiday" is a period in which the insurance premiums are not required to be paid. The following is a summary of payments made during the premium holidays:

Batch Number	G/L Date	HIPP Participant	HIPP
2663817	10/4/2011	Participant 4	See Participant 4 Above.
2724485	12/9/2011	Participant 36	$148.84
3107018	11/27/2012	Participant 14	$536.16
3137151	1/1/2013	Participant 14	$536.16
Subtotal for Participant 14			$1,072.32
3102701	11/20/2012	Participant 22	$463.30
3126795	12/14/2012	Participant 22	$463.30
Subtotal for Participant 22			$926.60
3106834	11/27/2012	Participant 23	$372.16
3120047	12/10/2012	Participant 26	$744.32
3102717	11/20/2012	Participant 29	$268.08
3126732	12/14/2012	Participant 29	$268.08
Subtotal for Participant 29			$536.16
3107190	11/27/2012	Participant 32	$372.16
Total			**$4,172.56**

As a State employee, the HIPP Payment Reviewer also received a premium holiday for November and December 2012 and did not have the insurance premium withheld from her pay. The APA also observed an email from the HIPP Payment Reviewer, in which she asks a participant about the premium holiday. Furthermore, the APA found that the HIPP Payment Reviewer had made adjustments to subsequent HIPP Program payments for individuals who had received payment for those months. From these instances, it is evident that the HIPP Payment Reviewer had knowledge of the premium holiday for State employees. However, the participants noted above incorrectly received payments during the premium holiday and had no subsequent payment adjustments.

Payments for Excluded Items

DHHS incorrectly paid four participants whose premiums included additional items not covered under the HIPP Program.

Title 471 NAC 30-006 states, in relevant part:

> *If payment cannot be made directly to the carrier or employer, NMAP will reimburse the policyholder for the payroll deduction made for health insurance.*

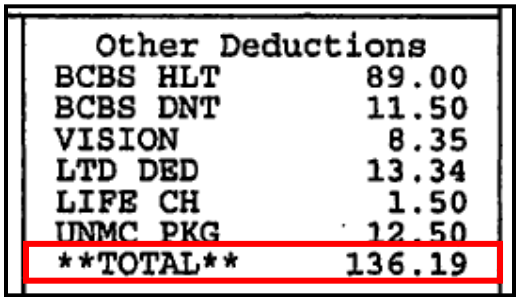
COMMENTS AND RECOMMENDATIONS
(Continued)

2. Incorrect Payments (Continued)

Additionally, the Notice of Finding sent to each participant states:

> *Please note that the premium amount that we are paying does not include dental, vision, etc., coverage, you will be responsible for paying that portion of your premium if you elect to include dental, vision, etc., coverage in your plan.*

One of the individuals received reimbursement for other payroll deductions that were not health insurance, including dental insurance, vision insurance, long-term disability insurance, dependent life insurance, and parking. The employee's paystub clearly identified each deduction amount and was included in the case file, as noted below.



Other Deductions	
BCBS HLT	89.00
BCBS DNT	11.50
VISION	8.35
LTD DED	13.34
LIFE CH	1.50
UNMC PKG	12.50
TOTAL	136.19

The following is a summary of the improper payments noted:

Participant	Batch Number	G/L Date	HIPP Payment	Correct Premium Amount	Overpaid Amount	Explanation
Participant 11	2445059	2/23/2011	$3,918.74	$3,676.08	$242.66	Dental insurance in the amount of $121.33 was paid in addition to the health insurance premium every month. The overpaid amount on 5/22/2012 reflects only the overpayment for the dental insurance. An additional $703.94 is included in Exhibit A as "Other Incorrect Payments."
Participant 11	2462231	3/14/2011	$1,959.37	$1,838.04	$121.33	
Participant 11	2482427	4/5/2011	$1,838.04	$1,838.04	$0.00	
Participant 11	2490390	4/13/2011	$121.33	$0.00	$121.33	
Participant 11	2508553	5/3/2011	$1,838.04	$1,838.04	$0.00	
Participant 11	2530660	5/25/2011	$1,838.04	$1,838.04	$0.00	
Participant 11	2543749	6/8/2011	$242.66	$0.00	$242.66	
Participant 11	2582428	7/15/2011	$1,959.37	$1,838.04	$121.33	
Participant 11	2611305	8/11/2011	$1,959.37	$1,838.04	$121.33	
Participant 11	2645736	9/15/2011	$1,959.37	$1,838.04	$121.33	
Participant 11	2662464	10/3/2011	$1,959.37	$1,838.04	$121.33	
Participant 11	2677657	10/19/2011	$1,959.37	$1,838.04	$121.33	
Participant 11	2718268	12/2/2011	$3,918.74	$1,838.04	$2,080.70	
Participant 11	2760377	1/13/2012	$1,959.37	$1,838.04	$121.33	
Participant 11	2798784	2/22/2012	$1,959.37	$1,838.04	$121.33	
Participant 11	2830231	3/22/2012	$1,959.37	$1,838.04	$121.33	
Participant 11	2860930	4/18/2012	$1,959.37	$1,838.04	$121.33	
Participant 11	2897570	5/22/2012	$2,663.31	$1,838.04	$121.33	
Participant 11	2927605	6/18/2012	$1,959.37	$1,838.04	$121.33	
Participant 11	2969112	7/25/2012	-$1,959.37	$0.00	-$1,959.37	
Participant 11 Totals			**$35,972.60**	**$33,084.72**	**$2,183.94**	

COMMENTS AND RECOMMENDATIONS
(Continued)

2. **Incorrect Payments** (Continued)

Participant	Batch Number	G/L Date	HIPP Payment	Correct Premium Amount	Overpaid Amount	Explanation
Participant 20	2845194	4/5/2012	$4,269.00	$3,796.32	$472.68	Dental insurance was paid in addition to the health insurance premium every month. From April 2012 to August 2012, the dental insurance premium was $118.17 per month. After that time, it increased to $121.70. There is a difference between these amounts and the amounts to the left because the HIPP Payment Reviewer did not increase the HIPP payments when the premiums increased.
Participant 20	2880278	5/8/2012	$1,067.11	$949.08	$118.03	
Participant 20	2929075	6/19/2012	$1,067.11	$949.08	$118.03	
Participant 20	2968293	7/25/2012	$1,067.11	$949.08	$118.03	
Participant 20	3009648	8/28/2012	$1,067.11	$949.08	$118.03	
Participant 20	3046822	10/1/2012	$1,067.11	$974.24	$92.87	
Participant 20	3068951	10/19/2012	$1,067.11	$974.24	$92.87	
Participant 20	3107190	11/27/2012	$1,067.11	$974.24	$92.87	
Participant 20	3128942	12/18/2012	$1,067.11	$974.24	$92.87	
Participant 20	3166994	1/28/2013	$1,067.11	$974.24	$92.87	
Participant 20 Totals			**$13,872.99**	**$12,463.84**	**$1,409.15**	
Participant 19	2396468	1/3/2011	$792.60	$272.00	-$7.80	Payment included dental of $37 and vision of $18.20 in addition to the health insurance premium each month. The payment also included an employer-provided credit of $63 which is why there was actually an underpayment of $7.80 each month. The underpaid amounts on 1/3/2011 and 1/24/2012 reflect only the underpayment described above. An additional $528.40 and $2 in overpayments are included in Exhibit A as "Other Incorrect Payments."
Participant 19	2440353	2/17/2011	$264.20	$272.00	-$7.80	
Participant 19	2469200	3/22/2011	$264.20	$272.00	-$7.80	
Participant 19	2490390	4/13/2011	$264.20	$272.00	-$7.80	
Participant 19	2525500	5/19/2011	$264.20	$272.00	-$7.80	
Participant 19	2561058	6/23/2011	$264.20	$272.00	-$7.80	
Participant 19	2589618	7/22/2011	$264.20	$272.00	-$7.80	
Participant 19	2624348	8/24/2011	$264.20	$272.00	-$7.80	
Participant 19	2651299	9/21/2011	$264.20	$272.00	-$7.80	
Participant 19	2677580	10/19/2011	$264.20	$272.00	-$7.80	
Participant 19	2708977	11/21/2011	$264.20	$272.00	-$7.80	
Participant 19	2725759	12/12/2011	$264.20	$272.00	-$7.80	
Participant 19	2768885	1/24/2012	$264.20	$270.00	-$7.80	
Participant 19	2808855	3/1/2012	$272.38	$178.00	$94.38	Payment includes dental of $23.00, vision of $16.70, long term disability insurance of $26.68, dependent life insurance of $3.00, and a parking fee of $25 in addition to the health insurance premium for an overpayment of $94.38 each month.
Participant 19	2830933	3/22/2012	$272.38	$178.00	$94.38	
Participant 19	2869408	4/26/2012	$272.38	$178.00	$94.38	
Participant 19	2889416	5/15/2012	$272.38	$178.00	$94.38	
Participant 19	2942218	7/2/2012	$272.38	$178.00	$94.38	
Participant 19	2977855	8/1/2012	$272.38	$178.00	$94.38	
Participant 19	3009594	8/28/2012	$272.38	$178.00	$94.38	
Participant 19 Totals			**$5,869.66**	**$4,780.00**	**$559.26**	
Participant 35	2991985	8/13/2012	$804.74	$1,745.07	-$940.33	Payment included dental of $18.90 and vision of $18.04 in addition to the health insurance premium each month.
Participant 35	3037082	9/21/2012	$1,669.78	$581.69	$1,088.09	
Participant 35	3069610	10/22/2012	$618.63	$581.69	$36.94	
Participant 35	3106804	11/27/2012	$618.63	$581.69	$36.94	
Participant 35	3137125	1/1/2013	$618.63	$581.69	$36.94	
Participant 35	3167122	1/28/2013	$618.63	$581.69	$36.94	
Participant 35 Totals			**$4,949.04**	**$4,653.52**	**$295.52**	
Grand Totals			**$60,664.29**	**$54,982.08**	**$4,447.87**	

Based on the regulations outlined above, the HIPP amounts should not include any deductions other than the health insurance deduction. The APA considers these payments to be overpayments.

COMMENTS AND RECOMMENDATIONS
(Continued)

2. Incorrect Payments (Concluded)

Good internal control requires procedures to ensure compliance with rules and regulations. Good internal control also requires procedures to ensure adequate documentation exists to support eligibility determinations and payments made, as well as to ensure the proper processing of the HIPP Program payments. Without these control procedures, there is an increased risk for loss or misuse of State and Federal funds, as evidenced by the findings noted in this comment.

We recommend DHHS:

- Obtain adequate documentation to support the employee health insurance premium amounts paid by participants.
- Ensure participants receiving payments are actually eligible for participation in the HIPP Program.
- Implement controls to ensure monthly payments are made accurately and consistently.
- Obtain documentation to ensure the participant has actually paid the health insurance premium.
- Implement procedures to ensure warrants are cancelled before they expire so that the Federal funds are not moved to the State's general fund.
- Implement controls to ensure only health insurance premiums are paid and not other insurance premiums.
- Implement procedures to first make payments to the insurance provider or employer, when possible, rather than reimbursing the employee directly.

We also recommend DHHS refer these cases to the appropriate parties to determine whether fraud has occurred. Finally, DHHS should take appropriate action to recover overpayments.

DHHS' Response: The Department has reviewed the processes and procedures related to the HIPP program to ensure that all case files contain adequate documentation of eligibility for participation in the program, coverage under the primary insurance policy, and that payments are accurate. Where appropriate, the Department will pursue collection of overpayments and refer specific cases to outside agencies for further investigation.

3. Inadequate Internal Controls

The overall control environment for the HIPP Program was severely deficient, as revealed by the numerous issues found, including a lack of segregation of duties and oversight, missing and insufficient documentation, untimely payments, miscoded transactions, noncompliance with DHHS regulations, and other questionable or inconsistent policies and procedures. This lack of controls, along with the issues described in the preceding comment, appear to be directly related to the weak control environment. Additional details of these issues are as follows.

COMMENTS AND RECOMMENDATIONS
(Continued)

3. Inadequate Internal Controls (Continued)

Lack of Segregation of Duties
DHHS lacked adequate controls to ensure no one individual had complete oversight and control of the HIPP Program. One person was responsible for determining eligibility of the applicants, authorizing payments, receiving any refunds, and monitoring the HIPP Program on an ongoing basis. There was no separate review and approval by management, or any other DHHS staff, to ensure eligibility determinations were appropriate or to confirm the amounts paid to participants agreed to adequate supporting documentation. Furthermore, there was no process in place to ensure all refunds received were properly deposited with the State of Nebraska, as no log, receipts, or adequate accounting of these refunds was prepared by the HIPP Payment Reviewer, who received the refunds.

A good internal control plan requires policies and procedures are in place to ensure no one individual has complete control over all phases of the HIPP Program.

Missing and Insufficient Documentation
DHHS failed to maintain adequate documentation to support the premium amount paid to the participants. Many participant case files lacked documentation to support the premium amounts or contained inadequate documentation to support the amounts.

Title 471 NAC 30-004(1) states:

> *Obtain information on the health plan available to the client. This information must include the effective date of the policy, exclusions to enrollment, the covered services under the policy, riders and exclusions of covered services, and premiums paid by the policy owners.* (Emphasis added.)

DHHS had an informal policy of obtaining either a paystub documenting the health insurance deduction or a health insurance premium billing from the insurance company prior to making the first payment. However, the APA noted numerous instances in which payments were based on participant emails, notes from phone conversations, listings of renewal rates and options, or even no documentation at all. Some examples follow:

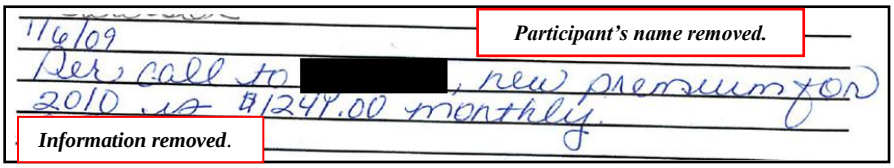
- For Participant 44, the case file lacked documentation to support the premium amount paid. DHHS first paid this participant under the Program in May 2007 at a monthly rate of $204.30. The same amount was paid each month until July 2012. The case file lacked documentation to support the initial premium payment of $204.30. The APA independently verified that the participant's actual premium in 2007 was $188.58. See the table below for the period's actual deduction amounts.

COMMENTS AND RECOMMENDATIONS
(Continued)

3. <u>Inadequate Internal Controls</u> (Continued)

Batch Number	G/L Date	HIPP Participant	HIPP	Deduction Amount	Amount Over/ Under Paid
2246407	7/22/2010	Participant 44	$204.30	$274.00	-$69.70
2270256	8/16/2010	Participant 44	$204.30	$274.00	-$69.70
2307837	9/22/2010	Participant 44	$204.30	$274.00	-$69.70
2335569	10/22/2010	Participant 44	$204.30	$274.00	-$69.70
2359505	11/17/2010	Participant 44	$204.30	$274.00	-$69.70
2390192	12/22/2010	Participant 44	$204.30	$274.00	-$69.70
2416889	1/25/2011	Participant 44	$204.30	$274.00	-$69.70
2444842	2/23/2011	Participant 44	$204.30	$274.00	-$69.70
2474724	3/28/2011	Participant 44	$204.30	$274.00	-$69.70
2496326	4/19/2011	Participant 44	$204.30	$274.00	-$69.70
2529724	5/24/2011	Participant 44	$204.30	$274.00	-$69.70
2560327	6/22/2011	Participant 44	$204.30	$274.00	-$69.70
2591350	7/25/2011	Participant 44	$204.30	$274.68	-$70.38
2626117	9/1/2011	Participant 44	$204.30	$274.68	-$70.38
2655733	9/26/2011	Participant 44	$204.30	$274.68	-$70.38
2680660	10/21/2011	Participant 44	$204.30	$274.68	-$70.38
2709241	11/21/2011	Participant 44	$204.30	$274.68	-$70.38
2727841	12/13/2011	Participant 44	$204.30	$274.68	-$70.38
2768798	1/24/2012	Participant 44	$204.30	$274.68	-$70.38
2805790	3/1/2012	Participant 44	$204.30	$274.68	-$70.38
2830926	3/22/2012	Participant 44	$204.30	$274.68	-$70.38
2865044	4/23/2012	Participant 44	$204.30	$274.68	-$70.38
2893467	5/18/2012	Participant 44	$204.30	$274.68	-$70.38
2942238	7/2/2012	Participant 44	$204.30	$274.68	-$70.38
2968207	7/25/2012	Participant 44	$204.30	$215.34	-$11.04
TOTALS			**$5,107.50**	**$6,799.50**	**-$1,692.00**

- Since 2010, DHHS has paid Participant 55 the same monthly amount of $1,241. That amount was based on a handwritten note by the HIPP Payment Reviewer describing a phone call from the participant, as follows:



- DHHS paid Participant 8 monthly payments of $2,797.73 for May 2011 through January 2013, including a duplicate payment for the same amount in May 2011. The only documentation maintained by DHHS to support this monthly rate was an email (shown below) and a list of rate options with various rates circled (also shown below).

COMMENTS AND RECOMMENDATIONS
(Continued)

3. **Inadequate Internal Controls** (Continued)

From: [redacted]
Sent: Monday, March 21, 2011 4:14 PM
To: [redacted]
Subject: RE: [redacted]
Attachments: [redacted] rates effective Dec. 1, 2010.pdf

Hi [redacted]
I finally got a copy of our monthly rates starting December 1, 2010. Hopefully, this will give you the information you need. I can also send you a copy of our next bill. Thank you for your patience as we made it through this process. [redacted]
-[redacted] wrote:
> [redacted]
>
> I have processed the amount due on the policy. Please send me a copy of the billing statement when you get a chance. Thanks so much.
>
>
>
> HIPP Payment Reviewer
> DHHS
> PO Box 95026
> Lincoln, NE 68509-5026
>
>
>
>
> -----Original Message-----
> From: [redacted]
> Sent: Wednesday, February 09, 2011 2:41 PM
> To: [redacted]
> Subject: [redacted]
>
>
> Here is a copy of our current [redacted] bill. The last one I sent had a incorrect amount I think. Our monthly premimum is notw $2797.73 per month. I was paying the amount they billed us for in January and now I owe an extra $1189.71. Call me if you need clarification.
Thanks, [redacted]

Information removed.

Personally identifiable information has been removed. APA added highlighting.

This is the only documentation to support the monthly premium amount.

Monthly Rates

Option 2
Renewal Rates

Age Band	Male	Female w/o Maternity	Female w/Maternity
Under 24	$335.82	$533.61	$796.43
25-29	$364.15	$635.46	$1,024.93
30-34	$439.51	$781.65	$1,056.28
35-39	$523.92	$839.24	$964.64
40-44	$602.90	$957.07	$1,007.45
45-49	$783.77	$1,109.60	$1,132.25
50-54	$1,145.51	$1,290.81	$1,290.81
55-59	$1,507.25	$1,604.32	$1,604.32
60-64	$1,989.57	$1,899.14	$1,899.14
65 +	$1,122.60	$1,223.29	$1,223.29
Child	$452.18		
Percentage Change	21.54%		

x 2 for family rate
= 2,797.63 per month

Each item circled on this list equals the premium amount of $2,797.73, including two of the rates listed as child rates.

This appears to be a renewal option worksheet from the insurance provider. Someone circled the rates on the worksheet, which agree to the premium amount paid. However, there is no documentation to indicate that the participant actually selected and paid for this level of insurance.

Participant's name removed.

The case file for this participant included an actual premium bill for January 2011 that identified a premium rate of $2,301.97. Therefore, without further adequate documentation, it would appear that this was the premium for the plan year December 2010 through November 2011.

COMMENTS AND RECOMMENDATIONS
(Continued)

3. **Inadequate Internal Controls** (Continued)

In addition to the lack of documentation to support the initial payment to participants, DHHS also relied on the participant for notification of any changes in the premium amounts. The APA found that in some instances DHHS had gone years without contacting the participant to verify the premium amount paid or to determine whether the participant was still employed. DHHS paid 27 of 70 participants tested amounts based on prior year premium information. A few examples are included below:

Participant	Batch Number	G/L Date	HIPP Payment	Correct Premium Amount (Plan 1)	Correct Premium Amount (Plan 2)	Overpaid Amount	Explanation
Participant 18	2587629	7/21/2011	$330.92	$0.00	n/a	$330.92	The participant terminated employment in July 2011, resulting in the termination of his health insurance coverage. The participant continued to receive payments through November 2011.
Participant 18	2623225	8/23/2011	$330.92	$0.00	n/a	$330.92	
Participant 18	2651165	9/21/2011	$330.92	$0.00	n/a	$330.92	
Participant 18	2672752	10/14/2011	$330.92	$0.00	n/a	$330.92	
Participant 18	2708381	11/21/2011	$330.92	$0.00	n/a	$330.92	
Participant 18 Totals			**$1,654.60**	**$0.00**	**$0.00**	**$1,654.60**	
Participant 45	2237027	7/14/2010	$302.63	$312.16	n/a	-$9.53	DHHS paid this participant the same premium amount since starting the HIPP Program in August 2007. The APA independently verified the premiums changed each year.
Participant 45	2263258	8/9/2010	$302.63	$312.16	n/a	-$9.53	
Participant 45	2301402	9/16/2010	$302.63	$312.16	n/a	-$9.53	
Participant 45	2319612	10/6/2010	$302.63	$312.16	n/a	-$9.53	
Participant 45	2350704	11/8/2010	$302.63	$312.16	n/a	-$9.53	
Participant 45	2385342	12/16/2010	$302.63	$312.16	n/a	-$9.53	
Participant 45	2407840	1/14/2011	$302.63	$312.16	n/a	-$9.53	
Participant 45	2433081	2/10/2011	$302.63	$312.16	n/a	-$9.53	
Participant 45	2465293	3/16/2011	$302.63	$312.16	n/a	-$9.53	
Participant 45	2492195	4/14/2011	$302.63	$312.16	n/a	-$9.53	
Participant 45	2522552	5/17/2011	$302.63	$312.16	n/a	-$9.53	
Participant 45	2558658	6/22/2011	$302.63	$312.16	n/a	-$9.53	
Participant 45	2586479	7/20/2011	$302.63	$372.16	n/a	-$69.53	
Participant 45	2622722	8/23/2011	$302.63	$372.16	n/a	-$69.53	
Participant 45	2649827	9/20/2011	$302.63	$372.16	n/a	-$69.53	
Participant 45	2670144	10/12/2011	$302.63	$372.16	n/a	-$69.53	
Participant 45	2707686	11/18/2011	$302.63	$372.16	n/a	-$69.53	
Participant 45	2723721	12/8/2011	$302.63	$372.16	n/a	-$69.53	
Participant 45	2764188	1/19/2012	$302.63	$372.16	n/a	-$69.53	
Participant 45	2805958	3/1/2012	$302.63	$372.16	n/a	-$69.53	
Participant 45	2830542	3/22/2012	$302.63	$372.16	n/a	-$69.53	
Participant 45	2865653	4/23/2012	$302.63	$372.16	n/a	-$69.53	
Participant 45	2880284	5/8/2012	$302.63	$372.16	n/a	-$69.53	
Participant 45	2929110	6/19/2012	$302.63	$372.16	n/a	-$69.53	
Participant 45	2967715	7/24/2012	$302.63	$307.54	n/a	-$4.91	
Participant 45	3010773	8/28/2012	$302.63	$307.54	n/a	-$4.91	
Participant 45	3046858	10/1/2012	$302.63	$307.54	n/a	-$4.91	
Participant 45	3069104	10/19/2012	$302.63	$307.54	n/a	-$4.91	
Participant 45 Totals			**$8,473.64**	**$9,442.00**	**$0.00**	**-$968.36**	

COMMENTS AND RECOMMENDATIONS
(Continued)

3. **Inadequate Internal Controls** (Continued)

Participant	Batch Number	G/L Date	HIPP Payment	Correct Premium Amount (Plan 1)	Correct Premium Amount (Plan 2)	Overpaid Amount	Explanation
Participant 34	2622722	8/23/2011	$745.68	$368.08	$339.76	$37.84	DHHS paid the prior plan year's premium amounts for Plan 1 at the rate of $202.96 from July 2011 to October 2012, or for 16 months. The APA independently verified that the health insurance premiums decreased, resulting in overpayments to the participant. Only after an inquiry from the participant did the HIPP Payment Reviewer request updated premium information. See email below. DHHS had documentation to support the private employer premium amounts shown as Plan 2 for June 2011. The APA was unable to verify whether the premium amounts had changed since that time.
Participant 34	2640804	9/12/2011	$372.84	$184.04	$169.88	$18.92	
Participant 34	2682225	10/24/2011	$372.84	$184.04	$169.88	$18.92	
Participant 34	2709904	11/22/2011	$372.84	$184.04	$169.88	$18.92	
Participant 34	2729410	12/14/2011	$372.84	$184.04	$169.88	$18.92	
Participant 34	2769458	1/24/2012	$372.84	$184.04	$169.88	$18.92	
Participant 34	2810078	3/2/2012	$372.84	$184.04	$169.88	$18.92	
Participant 34	2834667	3/27/2012	$372.84	$184.04	$169.88	$18.92	
Participant 34	2865094	4/23/2012	$372.84	$184.04	$169.88	$18.92	
Participant 34	2907734	6/1/2012	$372.84	$184.04	$169.88	$18.92	
Participant 34	2942233	7/2/2012	$372.84	$184.04	$169.88	$18.92	
Participant 34	2968245	7/25/2012	$372.84	$177.96	$169.88	$25.00	
Participant 34	3009157	8/27/2012	$372.84	$177.96	$169.88	$25.00	
Participant 34	3046820	10/1/2012	$372.84	$177.96	$169.88	$25.00	
Participant 34	3069136	10/19/2012	$372.84	$177.96	$169.88	$25.00	
Participant 34 Totals			**$5,965.44**	**$2,920.32**	**$2,718.08**	**$327.04**	

From: [redacted]
Sent: Friday, November 09, 2012 1:33 PM
To: [redacted]
Subject: HIPP information

Personally identifiable information has been removed. APA added highlighting.

Hi [redacted]

After receiving your email I reviewed your file. Could you please send me updated insurance information on your plan including a recent paystub [redacted]? I will also need updated information on your [redacted] policy as well if her information has changed. [redacted] Other than that the answer to your question is yes you will still receive reimbursement for [redacted] policy.

Thank you – [redacted]

NE Department of Health and Human Services
[redacted]
PO Box 95026
Lincoln, NE 68509
[redacted]

This is an example of a November 2012 email from the HIPP Payment Reviewer, asking for documentation of the new premium, ONLY after the participant contacted her with questions. The last pay stub showing the payroll deduction was for June 2011.

In addition to lacking documentation to support the premium amounts paid by participants, DHHS case files also lacked sufficient health insurance policy information – such as the effective dates of coverage and which dependents were covered under the plan – to ensure the eligibility of the applicants. In general, DHHS case files contained only a copy of the insurance card as evidence of the health plan. In many instances, the insurance cards failed to identify the dependents covered under the plan or the effective dates of coverage. A few examples are included below:

COMMENTS AND RECOMMENDATIONS
(Continued)

3. <u>Inadequate Internal Controls</u> (Continued)

- DHHS reimbursed Participant 5 for two separate health insurance plans (one for each parent); however, documentation in the case file clearly indicated that the Medicaid-eligible clients were only covered by one of the health insurance plans. Therefore, DHHS should have reimbursed the participant only for the health insurance plan used to cover the Medicaid-eligible clients.

- DHHS reimbursed Participant 19 for health insurance premiums in November and December 2010 – times in which the Medicaid-eligible client was not covered by the health insurance plan. The case file contained an email from the participant to the HIPP Payment Reviewer indicating that January 1, 2011, was the effective date of coverage for the client. Even after receipt of this email, the HIPP Payment Reviewer failed to make corrections or adjustments for the ineligible reimbursements. A copy of that email is included below:

Sent: Friday, January 28, 2011 1:21 PM
To: [redacted]
Subject: Re: [redacted] HIPP

Makes total sense. His effective date was 1-1-11. Thanks for cking on this!

Sent from my Verizon Wireless BlackBerry

From: [redacted]
Date: Fri, 28 Jan 2011 13:03:49 -0600
To: [redacted]
Subject: RE: [redacted] HIPP

I started paying your premium in November but I would assume you had him covered prior to that. I looked at the insurance cards that you sent me and noticed that [redacted] wasn't listed. You may want to contact [redacted] and make sure he is on your coverage, then let me know so that I can put the correct date that he became covered. What it sounds like is happening is that we have a date of 10/01/2009 for his effective date and if we receive a claim then we deny it saying that BC/BS is the primary carrier. They may be showing a different effective date, if that is the case we will need to go back and pay on those claims. Please let me know what you find out and I will correct our records. I hope this makes sense and we can figure out what the problem is.

[redacted]
HIPP Payment Reviewer

Personally identifiable information has been removed. APA added highlighting.

- DHHS also reimbursed Participant 20, Participant 21, and Participant 51 when there was no documentation in the case file indicating that the eligible client was covered under the insurance policy.

Untimely Payments

The APA also found numerous instances in which payments to participants were not made timely, resulting in the termination of coverage for the participant or incorrect payments. A few examples are illustrated below:

COMMENTS AND RECOMMENDATIONS
(Continued)

3. <u>Inadequate Internal Controls</u> (Continued)

- DHHS made payments directly to the insurance company for Participant 1. According to the premium billing contained in the case file, premium payments were due on the 1st of each month for that month's coverage. It appears payments were made timely until the HIPP Payment Reviewer failed to pay an insurance premium during October 2012. Late payments were then made during November and December 2012. The insurance company terminated the participant's health insurance coverage when the January 2013 payment had not been received by February 1, 2013. Included below is a copy of termination letter from the insurance provider:

RE: [redacted]
MEDICAL COVERAGE
[redacted]

This is an example of an insurance company terminating coverage due to the lack of payment of the premiums.

DEAR [redacted]

ON BEHALF OF THE INSURANCE CARRIER THAT ISSUED THE POLICY REFERENCED ABOVE, THIS WILL OFFICIALLY NOTIFY YOU THAT COVERAGE HAS BEEN CANCELLED EFFECTIVE 01/01/2013. WE REGRET THIS HAS BECOME NECESSARY, HOWEVER, WE HAVE NOT RECEIVED THE PREMIUM DUE AND MUST ASSUME THAT YOU WISH TO CANCEL. YOUR CERTIFICATE OF CREDITABLE COVERAGE WILL FOLLOW SHORTLY UNDER SEPARATE COVER.

IF YOU WOULD LIKE TO REAPPLY, OR IF WE CAN BE OF ANY ASSISTANCE, PLEASE CALL TOLL FREE AT [redacted] TO SPEAK WITH YOUR ADMINISTRATOR AT [redacted].

Personally identifiable information has been removed. APA added highlighting.

SINCERELY,

[redacted]

HEALTH & LIFE ADMINISTRATOR

The HIPP Payment Reviewer paid the insurance premium for January and February 2013 at the end of January 2013.

- DHHS also made payments directly to the same health insurance company for Participant 25 and Participant 57. Payments were made in June and July 2011 for coverage through September 2011. The HIPP Payment Reviewer made another payment in September 2011, which was later cancelled. No additional payments were made until November 2011 after coverage was terminated by the insurance company effective September 30, 2011. Included below is an email sent from the HIPP Payment Reviewer to the insurance company:

COMMENTS AND RECOMMENDATIONS
(Continued)

3. <u>Inadequate Internal Controls</u> (Continued)

Subject: RE: Premium Payment

I just thought there was so much to explain that I didn't know if email was sufficient. I in error cancelled the payment for [redacted] as there was another payment issued on there in error. Unfortunately I did not get the second payment out timely and now these 3 policies have termed. If I reissue this check for October – December can these 3 policies be reopened?

Thanks so much for your help.

NE Department of Health and Human Services
[redacted]
HIPP Payment Reviewer
PO Box 95026
Lincoln, NE 68509
[redacted]

This is an email in which the HIPP Payment Reviewer is trying to explain why the insurance company terminated insurance for three policies – due to lack of payment.

Personally identifiable information has been removed. APA added highlighting.

Note: The above email indicates three policies terminated; however, one of the policies had actually been paid through December in June 2011 and, therefore, did not actually terminate.

- As an example of the inconsistent payments made, the HIPP Payment Reviewer made two payments in February 2011, no payments in August 2011, December 2011, or February 2012, and three premium payments in March 2012 for Participant 54. The lack of consistent monthly payments increases the risk of coverage termination and the risk of incorrect payments. Payment details for this participant are included below:

Payment Date	Payment Amount
7/8/2010	$1,989.26
8/5/2010	$1,989.26
9/1/2010	$1,989.26
10/5/2010	$1,989.26
11/4/2010	$1,989.26
12/15/2010	$1,989.26
1/11/2011	$1,989.26
2/10/2011	$1,989.26
2/22/2011	$2,598.34
3/16/2011	$2,141.53
4/7/2011	$2,141.53
5/6/2011	$2,141.53
6/9/2011	$2,141.53
7/21/2011	$2,141.53
8/2011	No payment
9/22/2011	$2,141.53
10/11/2011	$2,141.53
11/8/2011	$2,141.53
12/2011	No payment
1/19/2012	$2,141.53
2/2012	No payment
3/15/2012	$3,602.34
3/23/2012	$1,971.35

Two payments in February 2011

Two payments in March 2012

COMMENTS AND RECOMMENDATIONS
(Continued)

3. Inadequate Internal Controls (Continued)

Payment Date	Payment Amount
4/20/2012	$1,971.35
5/24/2012	$1,971.35
6/20/2012	$1,971.35
7/27/2012	$1,971.35
8/17/2012	$1,971.35
9/21/2012	$1,971.35
10/2012	No payment
11/2/2012	$3,942.70
12/2012	No payment
1/29/2013	$3,942.70
Total	**$63,073.38**

Two monthly payments made in November 2012 and January 2013.

Miscoded Transactions
The APA found 13 transactions totaling $7,439 that were not properly coded to the HIPP Program in the accounting system, as documented below. Nine of the transactions were payments, primarily for the month of March 2011. In addition, there was one refund that was miscoded. Without proper procedures to ensure the correct coding of HIPP Program transactions, there is an increased risk that financial information will be inaccurate. All HIPP Program transactions were to be coded to subsidiary ledger – HICOBRA.

G/L Date	Document Number	Subsidiary Ledger	Amount
3/8/2011	20533876	[blank]	$1,241.00
3/8/2011	20533948	[blank]	$361.17
3/8/2011	20533937	[blank]	$692.01
3/8/2011	20533920	[blank]	$1,013.34
3/8/2011	20533863	[blank]	$978.77
3/8/2011	20533965	[blank]	$866.67
3/8/2011	20533904	[blank]	$269.57
3/8/2011	20533927	[blank]	$197.65
3/8/2011	20533883	[blank]	$274.00
3/8/2011	20533894	[blank]	$1,085.30
10/3/2011	21993157	[blank]	$1,095.10
2/15/2012	4572639	[blank]	-$742.35
3/1/2012	23091421	[blank]	$106.87
Grand Total			**$7,439.10**

Payment Recipient
The APA noted that 618 of the 661 payees and payments were made by the HIPP Program directly to the participants, rather than to the insurance companies or employers. According to the HIPP Program regulations, specifically Title 471 NAC 30-006:

COMMENTS AND RECOMMENDATIONS
(Continued)

3. Inadequate Internal Controls (Continued)

NMAP will pay the health insurance premium directly to the insurance carrier. If payment cannot be made directly to the carrier and the method of premium payment is payroll deduction, NMAP will arrange to pay the employer directly in lieu of the payroll deduction. If payment cannot be made directly to the carrier or employer, NMAP will reimburse the policyholder for the payroll deduction made for health insurance.

It is likely that many of the issues identified in this report may have been prevented or minimized had DHHS complied with this regulation and made the payments directly to the insurance providers or employers.

Start and Stop Dates of Payment
DHHS lacked formal policies defining the start date for participants' HIPP Program payments and did not start the benefit payments at the same time for each participant. The HIPP Payment Reviewer indicated that the DHHS informal policy allowed staff to make the initial payment for the month the participant applied to or was referred to the HIPP Program, and was Medicaid eligible. However, payments could also be processed for reimbursements for six months prior to the application or referral, upon request from the participant. The APA found the following situations in which even the informal policy did not appear to have been complied with:

- Participant 64 was referred to the HIPP Program in November 2011 but did not receive any payment until December 2011. This participant did not receive any reimbursement or adjustment for November 2011.

- Participant 43 became Medicaid eligible in July 2010 and had a HIPP Program referral dated September 2010. The first payment was not made until March 2011 and included reimbursement of premiums back to July 2010.

DHHS also lacked sufficient documentation to support the reason for HIPP Program payment termination. The APA found instances in which the HIPP Program payments ended without sufficient documentation to explain why the payments stopped. In many cases, the client continued to be Medicaid eligible, so the reason the payments stopped was unclear. A few examples are included below:

(Continued on Next Page)

COMMENTS AND RECOMMENDATIONS
(Continued)

3. Inadequate Internal Controls (Continued)

Participant Number	Last Month Paid	Last Month Medicaid Eligible	Potential Underpayment	Explanation
Participant 12	November 2012	March 2013	$ (1,216.68)	There was no supporting documentation on file to indicate why the payments ended in November.
Participant 68	January 2012	February 2012	$ (133.72)	The HIPP Payment Reviewer sent a letter to the participant that indicated payments were ending because there was not sufficient documentation to cover the participant's newborn child. The HIPP payments ended after the January 2012 payment. The APA felt the participant was Medicaid eligible for another month, regardless of the status of the newborn child.
Participant 33	October 2011	September 2012	$ (3,547.44)	The HIPP Payment Reviewer sent a letter to the participant that indicated payments were ending because the participant was no longer cost effective. The APA found no documentation identifying a cost effectiveness determination. The HIPP payments ended after the October 2011 payment.
Participant 51	July 2011	Continued to be Medicaid eligible through end of testing period	n/a	The HIPP Payment Reviewer sent a letter to the participant that indicated payments were ending because the participant was no longer cost effective. The APA found no documentation identifying a cost effectiveness determination. The HIPP payments ended after the July 2011 payment. The potential underpayment could not be calculated because the case file lacked sufficient documentation of the premium amount.

Eligibility Determination

The APA found an instance in which the eligibility determination is questionable. The individual was determined not to be eligible for the Medicaid Assistance to the Aged, Blind, and Disabled (AABD) program, due to the income limitations being exceeded. Since the individual was ineligible for AABD, she was placed in the medically needy program and had a spenddown obligation, which made her ineligible for the HIPP Program. The individual was now required to pay her own insurance premiums and, as such, contacted DHHS to recalculate her income level for AABD. Because she paid for her own health insurance, the individual was again determined

COMMENTS AND RECOMMENDATIONS
(Continued)

3. Inadequate Internal Controls (Continued)

to be eligible for the AABD program and eligible for the HIPP Program. It seems the main factor affecting this individual's eligibility into the AABD program was the payment of health insurance premiums; however, once she was determined eligible for AABD, she no longer paid the health insurance premiums.

Per 471 NAC 30-004.02,

> *NMAP has determined that payment of premiums for health plan is not cost effective when the premium is used to meet a spenddown obligation under the medically needy program.*

The HIPP Payment Reviewer ended payments in July 2012, after processing an overpayment for one month. A refund was requested but was never received.

When someone is no longer covered by the HIPP Program, that individual stops receiving reimbursements for his or her health insurance premiums. As a result, such a former participant must begin bearing the actual, unsubsidized costs of paying his or her own monthly health insurance premiums. No longer reimbursed by the State, those actual health insurance costs may now constitute an income deduction for purposes of determining eligibility for other Medicaid programs.

In the present case, due to a change in Medicaid programs, the participant was removed from the HIPP Program. Consequently, that former participant stopped receiving monthly health insurance premium reimbursements. The ensuing premium payment made the former participant eligible to participate in the AABD program. As it so happens, individuals who qualify to participate in the AABD program are – assuming a determination of cost effectiveness – eligible to enroll in the HIPP program. Once accepted for the AABD program, therefore, the participant sought, and was granted, readmission into the HIPP Program.

The appropriateness of this series of events appears questionable, given the fact that the former participant had previously been deemed ineligible for the HIPP program; however, the resulting expulsion paved the way, through later acceptance into the ABBD program, for eventual readmission into the same HIPP Program from which the updated Medicaid program had already mandated removal.

Employer Provided Credits
Some employers, such as the University of Nebraska, provide a credit to their employees to help offset the cost of health insurance and other types of benefits. The NUFlex University of Nebraska Price Tag Summaries state, "Each month you receive $63.00 of NUCredits to spend on your benefit choices."

COMMENTS AND RECOMMENDATIONS
(Continued)

3. <u>Inadequate Internal Controls</u> (Concluded)

University employees can use this credit for a number of different benefits; therefore, the credit may not apply to health insurance in all cases. However, the APA found two individuals, Participant 41 and Participant 42, whose other benefits did not equal $63 per month, so it appears the credit was used to cover part of the health insurance premium. If the employees did not pay the full health insurance premium, they would not be eligible for reimbursement of the full amount. It appears these two participants have been overpaid by $638 and $162, respectively.

Without a strong control environment and proper internal controls over the HIPP Program, there is an increased risk for incorrect payments or fraud.

We recommend DHHS:

- Establish and document policies and procedures to ensure proper segregation of duties over the HIPP Program. DHHS should ensure there is a documented approval of both the cost effectiveness calculation and the monthly payments to participants. The approver should ensure appropriate documentation is on file to support all payments. Additionally, proper controls should be implemented over refunds received.
- Obtain sufficient documentation to ensure the correct premium amounts are paid, and to support the effective dates of the health insurance plans and the members covered. Premium amounts should be updated at least annually, as rates change.
- Implement procedures to ensure that payments are made timely and are properly coded.
- Ensure compliance with regulations and attempt to make payments to the insurance companies or employers before making payments to the participants.
- Establish a formal policy regarding the first month a participant should receive a payment and ensure the policy is followed consistently. DHHS should also ensure there is sufficient documentation on file to support the termination of payments to participants.
- Implement procedures to ensure eligibility determinations are accurate and employer credits are appropriately considered.

DHHS' Response: The Department has begun the process of reviewing all processes and procedures related to the HIPP program. While the Department has already implemented significantly improved internal controls related to this program, the Department will continue to monitor this program and implement additional internal controls as warranted.

COMMENTS AND RECOMMENDATIONS
(Continued)

4. Potential Tax Consequences

In most of the cases tested by the APA, the health insurance premiums were deducted from an employee's wages before any taxes are withheld. As a pretax deduction, the health insurance premium is not subject to Social Security, Medicare, Federal income, and State income taxes – thereby, reducing the employee's total tax liability.

The APA determined, through available documentation, that 41 participants had their health insurance premiums paid by a pre-tax payroll deduction. Those participants then received HIPP Program reimbursements for their health insurance premiums. Because the employees did not pay their premiums, it appears those health insurance reimbursement amounts should have been included as employee income. The APA also found other participants who received more than their share of the premium amounts and who should have considered as income those premium amounts.

The following are the 2013 tax rates:

Tax Type	2013 Tax Rates
Federal Income Tax	10% to 39.6%
NE State Income Tax	2.26% to 6.95%
Social Security	6.20%
Medicare	1.45%

Note: The employer would be required to match the Social Security and Medicare tax rates.

DHHS recorded these premium reimbursements to an account in the State's accounting system, EnterpriseOne, which is not reportable on IRS Form 1099. That IRS form is used for reporting miscellaneous income. These premium reimbursements reduced the participants' tax liability, and none of participants received a Form 1099.

As a result, there is the potential for a significant impact of unreported wages to the Internal Revenue Service, Social Security and Medicare, and the Nebraska Department of Revenue. In order to calculate the true impact to each participant, the individual tax returns would have to be examined.

The APA is required to report this noncompliance to the Social Security Administration, the Nebraska Department of Revenue, and the Internal Revenue Service.

> We recommend DHHS first pay either the insurance carrier or the employer directly, prior to reimbursing the policyholder. If it is not possible to pay employer or carrier, we recommend DHHS ensure payments are coded to a Form 1099 reportable account, such as account number 592200 (an account number used in EnterpriseOne) so that the health insurance premium reimbursements are reported as taxable income.

COMMENTS AND RECOMMENDATIONS
(Continued)

4. <u>Potential Tax Consequences</u> (Continued)

DHHS' Response: The Internal Revenue Service (IRS) has not spoken directly to the issue of whether or not the reimbursement and/or payment of premiums through the HIPP Program should be considered to be gross income for purposes of 26 USC § 61. Payment of premiums through the HIPP Program is a Medicaid benefit payment, and fits the general welfare exclusion to the definition of gross income. (Please see: IRS Publications 525 and 17; Revenue Rulings 2009-19, 2003-12, 1974-153, and 1957-102 (among others); and IRS Information Letter 2010-0243). Further, since the HIPP payments are not considered to be gross income, issuance of 1099s would not be proper. To the extent that the pre-tax payroll deduction should be included in the recipient's gross income, the responsibility to account for that income rests with the employee and in certain circumstances the employer. Finally, at the request of the Department, various States have confirmed that 1099s are not issued in connection with the reimbursement and/or payment of premiums under HIPP. The Department is not aware of any State that does issue 1099s in connection with the HIPP Program.

APA Response: This issue has arisen because, in most cases, DHHS reimburses the employees directly for their health insurance premiums. Had DHHS reimbursed the insurance carrier or the employer instead, there would have been few, if any, resulting tax concerns.

Despite the assertion by DHHS that the IRS has not addressed this particular issue, the APA received explicit guidance from the IRS during the course of the audit. In response to an inquiry by the APA as to whether reimbursements of pre-tax deductions, such as those addressed in this comment, should be taxable, the IRS explained:

> ***The basic answer is that they [the employees] are trying to double dip and it is not allowed. The reimbursement for the employee portion of the health insurance should be taxable.***

The APA forwarded this unambiguous response, along with two supporting rulings also provided by the IRS, to DHHS.

Contrary to what DHHS indicates, this issue does not depend upon the status of Medicaid benefit payments or the general welfare exclusion to the definition of gross income. Rather, as the IRS response makes clear – and, consequently, as DHHS is well aware – an employee cannot benefit from both a pre-tax deduction and the reimbursement without incurring tax consequences.

COMMENTS AND RECOMMENDATIONS
(Continued)

4. Potential Tax Consequences (Concluded)

Below is an example of the tax effect, for one month, of incorrectly reporting the employee share of health insurance reimbursements.

Wages		Employee Paid Insurance (Pre-Tax)	DHHS Reimbursed Insurance (Not Pre-Tax)	Difference/Effect Between reporting Insurance Deduction as Pre-tax when actually insurance was reimbursed and should be taxed.
Gross Wages Monthly Total		$7,083.33	$7,083.33	$0.00
FIT Wages (Taxable Income)	(Gross Wages Less Retirement and Employee Deductions Tax Sheltered)	$6,280.85	$6,653.01	($372.16)
Social Security Wages	(Gross Wages Less Employee Deductions Tax Sheltered)	$6,620.85	$6,993.01	($372.16)
Employee Deductions				
Retirement		$340.00	$340.00	$0.00
Tax Sheltered Deductions				
Family Health Insurance		$372.16	$0.00	$372.16
Dental Insurance		$66.32	$66.32	$0.00
Parking		$24.00	$24.00	$0.00
Employee Taxes				
FIT		$374.00	$429.83	($55.83)
SIT		$288.72	$313.25	($24.53)
Social Security		$410.49	$433.57	($23.08)
Medicare Hospital		$96.00	$101.40	($5.40)
Net Pay Paid		**$5,111.64**	**$5,374.96**	
Employer Share/Contribution				
Social Security Tax		$410.49	$433.57	($23.08)
Medicare Hospital Tax		$96.00	$101.40	($5.40)
Retirement		$530.40	$530.40	$0.00
Family Health Insurance		$1,400.04	$1,400.04	$0.00

The APA reiterates the report recommendation, encouraging DHHS to seek further authoritative guidance, if any is needed, from the IRS regarding this issue.

5. Subsequent Event

On March 18, 2013, DHHS created a journal entry in the State's accounting system, EnterpriseOne, to move $356,885.23 of Federal funds from the Federal fiscal year (FFY) 2012 Medicaid grant to the FFY 2013 Medicaid grant. This entry included transactions posted between October 1, 2012 and December 31, 2012.

The APA observed that from January 1, 2013, through April 17, 2013, an additional $290,299.99 in Federal Funds were charged to the wrong grant year. These funds were not included in the journal entry described above. In response to an APA inquiry regarding these transactions, DHHS responded on April 25, 2013, indicating that these transactions would be moved by May 3, 2013. On May 6, 2013, DHHS created a journal entry in the State's accounting system, EnterpriseOne, to correct and move the $290,299.99.

COMMENTS AND RECOMMENDATIONS
(Continued)

5. Subsequent Event (Concluded)

The following is a summary of the incorrectly coded funds:

Transaction Dates	State Funds	Federal Funds	Totals	Correcting Entry	Explanation
10/1/2012 to 12/31/2012	$284,523.38	$356,885.23	$641,408.61		FFY 2013 transactions posted to FFY 2012 Medicaid Grant
3/18/2013				-$356,885.23	Journal Entry to move only the Federal portion of previous transactions to 2013 Medicaid Grant
1/1/2013 to 4/17/2013	$229,853.58	$290,299.99	$520,153.57		Additional FFY 2013 transactions posted to FFY 2012 Medicaid Grant
5/6/2013				-290,299.99	Journal Entry to move only the Federal portion of previous transactions to 2013 Medicaid Grant
Total	**$514,376.96**	**$647,185.22**	**$1,161,562.18**	**-$647,185.22**	

Not only did DHHS fail to properly move all of the Federal monies from the FFY 2012 grant to the 2013 grant, they also did not record a journal entry to the corresponding State fund for the same period. As noted background section of this report, the State is required to match a portion of the Federal grant. DHHS indicated that they do not plan to correct or adjust the General Funds as it didn't cross the State fiscal years or change the funding source; however, the individual business units used in EnterpriseOne will not reflect the correct amount.

Good internal controls require procedures to ensure all transactions are properly coded. Without proper internal controls, there is an increased risk that funds will be charged to the incorrect grants and improperly reported to the Federal Government.

> We recommend DHHS implement procedures to ensure that all payments are properly coded to the correct fiscal year.

DHHS' Response: The Department moved the $290,299.99 of Federal Funds on May 6, 2013. State Funds do not need to be moved as they are from the same fiscal year appropriation.

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NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

INDEPENDENT ACCOUNTANT'S REPORT

Nebraska Department of Health and Human Services
Lincoln, Nebraska

We have examined the accompanying Schedule of Health Insurance Premium Payments of the Nebraska Department of Health and Human Services (DHHS) for the period July 1, 2010, through February 5, 2013. DHHS' management is responsible for the Schedule of Health Insurance Premium Payments. 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 Health Insurance Premium Payments 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 health insurance premium payments of the Nebraska Department of Health and Human Services for the period July 1, 2010, through February 5, 2013, based on the accounting system and procedures prescribed by the Nebraska Department of Administrative Services, as described in Note 1.

In accordance with *Government Auditing Standards*, we are required to report findings of deficiencies in internal control, violations of provisions of contracts or grant agreements, and abuse that are material to the Schedule of Health Insurance Premium Payments and any fraud and illegal acts that are more than inconsequential that come to our attention during our examination. We are also required to obtain the views of management on those matters. We performed our examination to express an opinion on whether the Schedule of Health Insurance Premium Payments is presented in accordance with the criteria described above and not for the purpose of expressing an opinion on the internal control over the Schedule of Health Insurance

Premium Payments or on compliance and other matters; accordingly, we express no such opinions. Our examination disclosed certain findings that are required to be reported under *Government Auditing Standards*, and those findings, along with the views of management, are described in the Comments Section of the report.

This report is intended solely for the information and use of management, others within DHHS, and the appropriate Federal and regulatory agencies, and is not intended to be and should not be used by anyone other than these specified parties. However, this report is a matter of public record, and its distribution is not limited.

SIGNED ORIGINAL ON FILE

May 20, 2013

Mike Foley
Auditor of Public Accounts

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH INSURANCE PREMIUM PAYMENT PROGRAM
SCHEDULE OF HEALTH INSURANCE PREMIUM PAYMENTS
For the Period July 1, 2010 through February 5, 2013

	Federal Fiscal Year October 1 to September 30		
State Funds			
	2010	$ 247,474.42	
	2011	973,183.50	
	2012	1,527,449.94	
	2013	19,318.79	
		2,767,426.65	Subtotal State Funds Expenditures
Federal Funds			
	2010	321,510.41	
	2011	1,430,841.67	
	2012	1,976,309.00	
	2013	24,352.20	
		3,753,013.28	Subtotal Federal Funds Expenditures
		$ 6,520,439.93	Total Expenditures

The accompanying notes are an integral part of the Schedule.

NOTES TO THE SCHEDULE

For the period July 1, 2010 through February 5, 2013

1. Criteria

The accounting policies of DHHS are on the basis of accounting, as prescribed by the State of Nebraska Department of Administrative Services.

Per Neb. Rev. Stat. § 81-1107(2) (Reissue 2008), the duties of the State of Nebraska's Director of the Department of Administrative Services (DAS) 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[.]*

In accordance with Neb. Rev. Stat. § 81-1111(1) (Reissue 2008), the State Accounting Administrator has prescribed the system of accounts and accounting to be maintained by the State and its departments and agencies and has developed necessary accounting policies and procedures. The prescribed accounting system currently utilizes EnterpriseOne, an accounting resource software, to maintain the general ledger and all detailed accounting records. Policies and procedures are detailed in the Nebraska State Accounting Manual published by DAS State Accounting Division (State Accounting) and are available to the public. The financial information used to prepare the Schedule of Health Insurance Premium Payments was obtained directly from the general ledger maintained on EnterpriseOne. As transactions occur, the agencies record the accounts receivable and accounts payable in the general ledger. 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 expenditures and related accounts payable recorded in the general ledger, as of February 5, 2013, include only those payables posted in the general ledger before February 5, 2013, and not yet paid as of that date. The amount recorded as expenditures, as of February 5, 2013, **does not** include amounts for goods and services received before February 5, 2013, which had not been posted to the general ledger as of February 5, 2013.

The fund types established by the State that are used by the Health Insurance Premium Payment Program are:

> **10000 – General Fund** – accounts for activities funded by general tax dollars and related expenditures and transfers.
>
> **40000 – Federal Funds** – account for the financial activities related to the receipt and disbursement of funds generated from the Federal government as a result of grants and contracts. Expenditures must be made in accordance with applicable Federal requirements.

NOTES TO THE SCHEDULE
(Continued)

1. Criteria (Concluded)

The major expenditure account classification established by State Accounting and used by the Health Insurance Premium Payment Program is:

> **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.

DHHS also used a subsidiary ledger, identified in EnterpriseOne as HICOBRA for recording transactions to the HIPP Program.

2. Reporting Entity

DHHS is a State agency established under and governed by the laws of the State of Nebraska. As such, the Health Insurance Premium Payment Program is exempt from State and Federal income taxes. The schedule includes all funds of the Health Insurance Premium Payment Program, a subsidiary ledger, included in the general ledger as identified in EnterpriseOne.

DHHS is part of the primary government for the State of Nebraska.

3. Subsequent Event

DHHS recorded $647,185.22 of Federal funds to the incorrect fiscal year. A journal entry was recorded on March 18, 2013, to correct part of the incorrectly coded amounts. See Comment Number 5 for further details.

SUPPLEMENTARY INFORMATION

Our examination was conducted for the purpose of forming an opinion on the Schedule of Health Insurance Premium Payments. Supplementary 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 Health Insurance Premium Payments, and, accordingly, we express no opinion on it.

30-000 Payment for Health Insurance Premiums

30-001 Introduction: The Nebraska Medical Assistance Program covers payment for health insurance premiums for individuals who are otherwise eligible for Medicaid when determined to be cost effective. This chapter contains the rules and regulations that apply to this benefit. Conditions of eligibility are addressed in Titles 468, 469, 470, 477, and 479.

30-001.01 Legal Basis: Sections 1905(a) and 1906 of the Social Security Act requires each state Medicaid program to provide this benefit.

30-001.02 Definitions: The following definitions apply to this benefit:

Cost Effectiveness: A determination, made by the Department, that the amount that the Nebraska Medical Assistance Program would pay for premiums, coinsurance, deductibles and other cost sharing obligations under a health plan, plus an amount for administrative costs is likely to be less than the amount paid for an equivalent set of Medicaid services.

Group Health Plan: Any plan of, or contributed to by, an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of employees or former employees. A group health plan must meet S. 5000(b)(1) of the Internal Revenue Code of 1986, and includes continuation coverage pursuant to Title XXII of the Public Health Services Act, S. 4980B of the Internal Revenue Code of 1986, or Title VI of the Employee Retirement Income Security Act of 1974.

Health Plan: Any health insurance plan that, in exchange for premiums paid, pays benefits for medical services. Excluding Medicare Part B premiums (see 471 NAC 1-007).

30-002 Covered Benefits: The Nebraska Medical Assistance Program covers payment of premiums for Medicaid-eligible enrollees in a cost effective health plan. NMAP also covers payment of all deductibles, co-insurance, and other cost sharing obligations under the health plan that are for services covered under NMAP.

30-002.01 Family Members: If a family member who is not eligible for Medicaid must be enrolled in the health plan to obtain coverage for the Medicaid-eligible client, NMAP covers payment only for the premiums; no other cost sharing expenses are covered. The family member may reside in a different household.

30-002.02 Services Covered by NMAP: A client's enrollment in a health plan does not change the client's eligibility for benefits under the Nebraska Medical Assistance Program. If services covered under NMAP are not covered by the health plan, the client may obtain those services from Medicaid-enrolled providers. Payment for those services is made according to the payment methodology currently in effect under NMAP.

If the client's health plan offers more services than covered under NMAP, NMAP does not pay for the deductibles, coinsurance, and other cost sharing obligations for non-covered services.

30-002.03 Medicare Enrollment: If the client is also eligible for Medicare Part B but is not enrolled in Medicare Part B, NMAP does not pay for the premiums or other cost sharing obligations to the health plan.

30-002.04 Cost Sharing Amounts Under NMAP: If the client is required to pay cost sharing amounts under NMAP, payment of the cost sharing amounts are not covered as a benefit under this chapter.

30-002.05 Available Resource: The health plan is considered an available third party resource.

30-003 Enrollment in a Group Health Plan: Group health plans usually limit an individual's enrollment period. If an individual who is already enrolled in a group health plan becomes Medicaid-eligible, NMAP buys into the group health plan as of the effective date of Medicaid eligibility.

30-003.01 Effective Date of Benefit: If a client is not eligible for coverage under a group health plan for a specified waiting period, NMAP buys into the group health plan as of the effective date of eligibility for the group health plan. Until the client is eligible to enroll or entitled to receive services under the group health plan, all Medicaid-covered services are covered and paid under the usual policies and procedures of NMAP.

30-003.02 Delayed Enrollment: If the availability for enrollment in the group health plan and eligibility for Medicaid do not coincide, the client/applicant shall apply for the group health plan (by completing the necessary forms if available). The enrollment application is held until open season and then the form is submitted.

The client/applicant is not eligible for Medicaid if s/he refuses to apply for enrollment in a group health plan. This ineligibility is effective until the next open season for group health plan enrollment.

30-004 Cost Effectiveness Determination: The Nebraska Medical Assistance Program (NMAP) determines the cost effectiveness of health plans using the following methodology:

1. Obtain information on the health plan available to the client. This information must include the effective date of the policy, exclusions to enrollment, the covered services under the policy, riders and exclusions of covered services, and premiums paid by the policy owners.
2. Using the Medicaid Management Information System (MMIS), obtain the total six-month estimated average Medicaid costs of persons like the applicant (age, sex, and category data). Adjust this amount for inflation.
3. Determine the amount of the total six-month Medicaid expenditures that are spent on the services covered by the individual policy, using the following categories: drugs, practitioner services (this includes physician services, durable medical equipment, other practitioners, etc.), inpatient hospital services, outpatient hospital services, and home health services.
4. Estimate the cost of coinsurance and deductibles up to the allowable amounts under the Nebraska Medical Assistance Program.
5. Determine the administrative cost to Medicaid for processing the health plan information by determining the average increase in cost per client for the six-month period.
6. Determine the cost to Medicaid with insurance by adding the following:
   a. The administrative cost determined under item 5;
   b. The coinsurance and deductible cost determined under item 4;
   c. The premium cost (The premium cost is determined by applying a premium factor for the percentage of clients who would receive services compared to those eligible for Medicaid. This accounts for Nebraska's costs being based on "per client" data instead of "per eligible" data.); and
   d. The cost of non-covered services (subtract item 3 from item 2);
7. Compare the cost to Medicaid with insurance (item 6) to the estimated average Medicaid costs (item 2). If the cost to Medicaid with insurance is less than the estimated average Medicaid costs, the health plan is cost effective. If the cost to Medicaid with insurance is equal to or greater than the estimated average Medicaid costs, the health plan is not cost effective.

30-004.01 Exceptional Medical Costs: If the client provides documentation of on-going medical costs that exceed the estimated average Medicaid costs (see item 2 in 471 NAC 30-004), NMAP may determine that the health plan is cost effective.

30-004.02 Spenddown Cases: NMAP has determined that payment of premiums for a health plan is not cost effective when the premium is used to meet a spenddown obligation under the medically needy program.

30-004.03 Non-Covered Benefits: NMAP has determined that payment of premiums for a health plan is not cost effective for the eligibility category of Aged.

NMAP does not pay premiums for health plans that are the court-ordered obligation of an absent parent.

30-005 Balance Billing: Medicaid pays only up to the amount allowed under the Nebraska Medical Assistance Program. For example, if a provider bills $50 for a service and the insurer pays $40, but the Medicaid allowable is $37, Medicaid will not make up the $10 difference between the billed amount and the insurance payment; NOR CAN THE PROVIDER BILL THE CLIENT. If the provider bills $50 and the insurance pays $37 and the Medicaid allowable is $40, Medicaid can pay the difference, up to the Medicaid allowable - in this case, Medicaid pays $3. THE PROVIDER CANNOT BILL THE CLIENT FOR THE DIFFERENCE BETWEEN THE MEDICAID PAYMENT AND THE BILLED AMOUNT.

30-006 Payment for Services: NMAP will pay the health insurance premium directly to the insurance carrier. If payment cannot be made directly to the carrier and the method of premium payment is payroll deduction, NMAP will arrange to pay the employer directly in lieu of the payroll deduction. If payment cannot be made directly to the carrier or employer, NMAP will reimburse the policyholder for the payroll deduction made for health insurance.

Some providers that participate in health plans may not be Medicaid participating providers. These providers will be encouraged to participate. Provider participation may be initiated through the submission of a bill for services. If providers refuse to bill Medicaid, NMAP may make payment directly to the client or financially responsible individual for the payment of coinsurance and deductible, up to the Medicaid allowable amount.

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES

EXHIBIT A

HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

CUMULATIVE PAYMENT SUMMARY FOR PARTICIPANTS TESTED BY APA

For the Period July 1, 2010 through February 5, 2013

HIPP Participant	Total HIPP Payments	Overpaid Amount	Underpaid Amount	Net Over (Under) Paid	Explanation	Overpaid Amount Occurring Prior to 7/1/2010
Participant 1	$265,851.63	$265,851.63	$0.00	$265,851.63	Overpaid Amount: DHHS made payments to this participant even though the payments were not cost effective for the entire period tested, resulting in overpayments totaling $265,851.63. On 3/4/2010, DHHS sent a letter to the participant indicating that it was no longer cost effective for DHHS to pay the health insurance premiums; however, DHHS continued to make the premium payments. At the time of the 2010 letter the monthly premiums were $5,138.45. DHHS is currently paying $9,617.37 per month.	$0.00
Participant 58	$20,663.34	$0.00	$0.00	$0.00	The participant was not cost effective according to the calculation documented by DHHS on 9/17/2008. However, per the APA's review of claims submitted to Medicaid for this participant, it is likely that they would have been cost effective under the HIPP Program. See additional information related to this participant below.	$0.00
	$286,514.97	**$265,851.63**	**$0.00**	**$265,851.63**	**Sub-Total of Cost Effectiveness Issues**	**$0.00**
Participant 2	$56,392.00	$37,800.00	$0.00	$37,800.00	Overpaid Amount: For October 2010 to January 2013, DHHS paid both the participant's share of the premium as well as the share of the premium paid by the participant's employer, resulting in overpayments of $1,350 each month, or a total of $37,800. DHHS had documentation in the case file indicating the premium amounts paid included the employer share of premium.	$0.00
Participant 3	$29,428.65	$29,428.65	$0.00	$29,428.65	Overpaid Amount: DHHS paid the participant for insurance payments that the participant never paid, resulting in total overpayments during the period tested of $29,428.65. The APA verified the employment for this participant from July 2010 to August 2011 with Employer 1 and from September 2011 to January 2013 from Employer 2. Both employers verified the health insurance premiums for this participant were paid entirely by the employers, not the participant. In September 2011, DHHS received documentation that indicated the employer paid the participant's entire health insurance premium amount, but DHHS continued to make the payments to the participant. The participant was employed with Employer 1 since September 2006; therefore, all HIPP payments received prior to the period reviewed would also be ineligible. Prior payments were made for September 2006 to June 2010, resulting in additional overpayments totaling $15,504.75.	$15,504.75

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HIPP Participant	Total HIPP Payments	Overpaid Amount	Underpaid Amount	Net Over (Under) Paid	Explanation	Overpaid Amount Occurring Prior to 7/1/2010
Participant 4	$30,775.87	$20,238.94	$0.00	$20,238.94	Overpaid Amount: For July 2010 to October 2011 and December 2011 to January 2013, DHHS paid the employer share of the health insurance premiums, rather than the employee share, resulting in overpayments totaling $19,246.17. DHHS had documentation from 2009 indicating that the amount paid was the employer share of the premium, but they did not have documentation in the case file to support the premium amounts during the period tested. The APA independently verified the correct premium amounts. For November 2011, DHHS also incorrectly paid the premium amount, resulting in an overpayment of $992.77. The APA independently verified that no health insurance premiums were deducted from the employee's pay for that month. For dates prior to the period tested - March 2009 to June 2010 - DHHS also incorrectly paid the employer's share of the health insurance premium, rather than the employee's share, resulting in an additional overpayments totaling $11,280.43.	$11,280.43
	$116,596.52	**$87,467.59**	**$0.00**	**$87,467.59**	**Sub-Total of Potential Fraudulent Payments**	**$26,785.18**
Participant 6	$10,371.33	$10,371.33	$0.00	$10,371.33	Overpaid Amount: For July 2010 to September 2011, DHHS paid the insurance premiums for an ineligible client, resulting in overpayments totaling $10,371.33. DHHS notified the client in October 2011 that the client was no longer eligible for the HIPP Program because the client was Medicare eligible. However, the APA verified in NFOCUS that DHHS received documentation on 6/8/2010 indicating that the client was Medicare eligible since October 2007; therefore, all HIPP payments received since that time were ineligible. Additionally, DHHS made payments prior to the period tested, from October 2007 to June 2010, resulting in an additional overpayments totaling $17,296.09.	$17,296.09

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Participant 7	$8,635.60	$8,635.60	$0.00	$8,635.60	Overpaid Amount: For July 2010 to February 2012, DHHS paid premiums to this ineligible participant, resulting in overpayments totaling $8,635.60. DHHS notified the participant in March 2012 that the client was no longer eligible because the client had been eligible for Medicare since 2009. It does not appear DHHS requested a refund of the overpayment. The APA verified in NFOCUS that the client was actually Medicare eligible since 1994; therefore, all HIPP payments received prior to the period reviewed would also be ineligible. Prior payments were made for August 2005 to June 2010, resulting in additional overpayments totaling $13,525.06.	$13,525.06
	$19,006.93	**$19,006.93**	**$0.00**	**$19,006.93**	**Sub-Total of Payments to Medicare Eligible Participants**	**$30,821.15**
Participant 8	$83,993.59	$3,293.49	$0.00	$3,293.49	Overpaid Amount: For May 2011, DHHS paid twice the incorrect premium amount, resulting in an overpayment of $3,293.49. See additional incorrect payment amounts noted below.	$0.00
Participant 12	$31,740.64	$2,451.06	$0.00	$2,451.06	Overpaid Amount: For February 2011, DHHS made a duplicate payment to the participant, resulting in an overpayment of $1,195.44; however, the warrant was not cashed and it has since expired. For September 2011, DHHS made a duplicate payment to the insurance provider, resulting in an overpayment of $1,255.62.	$0.00
Participant 17	$56,901.51	$1,822.20	$0.00	$1,822.20	Overpaid Amount: For June 2012, DHHS paid the premium twice, resulting in an overpayment of $1,822.20. See additional incorrect payment amounts noted below.	$0.00
Participant 10	$28,796.89	$1,392.86	$0.00	$1,392.86	Overpaid Amount: For April 2012, DHHS paid the premium twice, resulting in an overpayment of $1,392.86. See additional incorrect payment amounts noted below.	$0.00
Participant 14	$10,315.87	$1,327.15	$0.00	$1,327.15	Overpaid Amount: For July to October 2012 and January 2013, DHHS paid the premium amounts twice, resulting in overpayments totaling $1,327.15. DHHS had documentation in the case file to support the correct premium amounts. See additional incorrect payment amounts noted below.	$0.00
Participant 21	$38,599.36	$1,206.23	$0.00	$1,206.23	Overpaid Amount: For March 2012, DHHS made a duplicate payment, resulting in an overpayment of $1,206.23.	$0.00
Participant 23	$5,555.86	$474.70	$0.00	$474.70	Overpaid Amount: For June 2012, DHHS paid an incorrect amount by doubling the payment amount, resulting in an overpayment of $474.70. See additional incorrect payment amounts noted below.	$0.00
	$255,903.72	**$11,967.69**	**$0.00**	**$11,967.69**	**Sub-Total of Duplicate Payments**	**$0.00**

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Participant 9	$4,731.49	$4,731.49	$0.00	$4,731.49	Overpaid Amount: For July 2010 to July 2011, DHHS paid the insurance premiums for an ineligible client, resulting in overpayments totaling $4,731.49. The client was only Medicaid eligible under the medically needy program and had a required share of cost or spenddown. HIPP Regulations, specifically 471 NAC 30-004.02, indicate that it is not cost effective to pay premiums for individuals with a spenddown obligation under the medically needy program. Additionally, DHHS made payments prior to the period tested when the client was under the medically needy program, from December 2009 to June 2010, resulting in an additional overpayments totaling $933.54.	$933.54
Participant 24	$5,444.92	$777.40	$0.00	$777.40	Overpaid Amount: For August to September 2012, DHHS incorrectly paid the premiums to an ineligible client, resulting in overpayments totaling $777.40. The APA verified in NFOCUS that Medicaid for this client ended 8/1/2012.	$0.00
Participant 30	$9,943.92	$473.52	$0.00	$473.52	Overpaid Amount: For March 2012, DHHS paid the premium amount when the client was no longer eligible, resulting in an overpayment of $473.52. The APA independently verified the client was no longer Medicaid eligible in March 2012. See additional incorrect payment amounts noted below.	$0.00
	$20,120.33	**$5,982.41**	**$0.00**	**$5,982.41**	**Sub-Total of Medicaid Ineligible Participants**	**$933.54**
Participant 14	See Participant 14 above.	$1,072.32	$0.00	$1,072.32	Overpaid Amount: For November and December 2012, DHHS incorrectly paid the premium amounts, resulting in overpayments totaling $1,072.32. The APA independently verified that no health insurance premiums were deducted from the employee's pay for those months. See additional incorrect payment amounts noted above and below.	$0.00
Participant 4	See Participant 4 above.	See Participant 4 above.	$0.00	See Participant 4 above.	See incorrect payment amounts noted above.	$0.00
Participant 22	$14,621.74	$926.60	$0.00	$926.60	Overpaid Amount: For November and December 2012, DHHS incorrectly paid the premium amounts, resulting in overpayments totaling $926.60. The APA independently verified that no health insurance premiums were deducted from the employee's pay for those months.	$0.00

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HIPP Participant	Total HIPP Payments	Overpaid Amount	Underpaid Amount	Net Over (Under) Paid	Explanation	Overpaid Amount Occurring Prior to 7/1/2010
Participant 26	$8,850.88	$744.32	$0.00	$744.32	Overpaid Amount: For November and December 2012, DHHS incorrectly paid the premium amounts, resulting in overpayments totaling $744.32. The APA independently verified that no health insurance premiums were deducted from the employee's pay for those months. See additional incorrect payment amounts noted below.	$0.00
Participant 29	$8,452.56	$536.16	$0.00	$536.16	Overpaid Amount: For November and December 2012, DHHS incorrectly paid the premium amounts, resulting in overpayments totaling $536.16. The APA independently verified that no health insurance premiums were deducted from the employee's pay for those months. See additional incorrect payment amounts noted below.	$0.00
Participant 32	$13,123.92	$372.16	$0.00	$372.16	Overpaid Amount: For November 2012, DHHS incorrectly paid the premium amount, resulting in an overpayment of $372.16. The APA independently verified that no health insurance premium was deducted from the employee's pay for that month. See additional incorrect payment amounts noted below.	$0.00
Participant 23	See Participant 23 above.	$372.16	$0.00	$372.16	Overpaid Amount: For November 2012, DHHS incorrectly paid the premium amount, resulting in an overpayment of $372.16. The APA independently verified that no health insurance premium was deducted from the employee's pay for that month. See additional incorrect payment amounts noted above.	$0.00
Participant 36	$3,721.00	$148.84	$0.00	$148.84	Overpaid Amount: For November 2011, DHHS incorrectly paid the premium amount, resulting in an overpayment of $148.84. The APA independently verified that no health insurance premiums were deducted from the employee's pay for that month. See additional incorrect payment amounts noted below.	$0.00
	$48,770.10	**$5,165.33**	**$0.00**	**$5,165.33**	**Sub-Total of Premium Holiday Payments**	**$0.00**
Participant 11	$40,810.81	$2,183.94	$0.00	$2,183.94	Overpaid Amount: For February 2011 to July 2012, DHHS paid amounts that included dental coverage, resulting in overpayments totaling $2,183.94. DHHS had documentation in the case file that the insurance amount included dental coverage. See additional incorrect payment amounts noted below.	$0.00

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HIPP Participant	Total HIPP Payments	Overpaid Amount	Underpaid Amount	Net Over (Under) Paid	Explanation	Overpaid Amount Occurring Prior to 7/1/2010
Participant 20	$13,872.99	$1,409.15	$0.00	$1,409.15	Overpaid Amount: For January 2012 to January 2013, DHHS paid amounts that included dental coverage, resulting in overpayments totaling $1,409.15. DHHS had documentation in the case file that the amount deducted from participant's paycheck included dental coverage but did not have documentation to support the dental coverage amount. The APA independently confirmed the portion of the payment that was for dental coverage.	$0.00
Participant 19	$6,778.04	$660.66	-$101.40	$559.26	Overpaid Amount: For February 2012 to August 2012, DHHS incorrectly paid dental, vision, long-term disability insurance, dependent life insurance, and parking fees, which are all not allowed under the HIPP Program, resulting in overpayments totaling $660.66. DHHS had documentation in the case file to support the premium amounts. See additional incorrect payment amounts noted below. Underpaid Amount: For January 2011 to January 2012, DHHS paid the incorrect premium amounts, resulting in underpayments of $7.80 each month, or a total of $101.40. For this time period, the participant's monthly medical insurance was $272. DHHS also paid the monthly dental and vision insurance premiums totaling $55.20, bringing the monthly insurance costs for this participant to $327.20. That total was reduced by $63 for an employer credit and DHHS paid the participant $264.20 per month. The participant receives this credit monthly, but DHHS only applied it to the payment during this period.	$0.00
Participant 35	$4,949.04	$295.52	$0.00	$295.52	Overpaid Amount: For June 2012 to January 2013, DHHS incorrectly paid dental and vision insurance premiums, which are not allowed under the HIPP Program, resulting in overpayments totaling $295.52. DHHS had documentation that indicated the amount paid included dental and vision.	$0.00
	$66,410.88	**$4,549.27**	**-$101.40**	**$4,447.87**	**Sub-Total of Payments for Excluded Items**	**$0.00**

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HIPP Participant	Total HIPP Payments	Overpaid Amount	Underpaid Amount	Net Over (Under) Paid	Explanation	Overpaid Amount Occurring Prior to 7/1/2010
Participant 5	$45,679.12	$10,783.71	-$2,144.20	$8,639.51	Overpaid Amount: For July 2010 to January 2012, DHHS paid two different premium amounts - one for each parent's health insurance plan coverage. However, the Medicaid-eligible clients were not covered under one of those plans, resulting in overpayments totaling $10,297.49. DHHS had documentation in the case file indicating that the clients were not covered under one of the plans being paid. For July 2010 to January 2011, DHHS paid the wrong premium amounts for the clients' plan, resulting in overpayments totaling $486.22. DHHS had documentation in the case file to support the correct premium amount. Underpaid Amount: For February to November 2011, DHHS paid the incorrect premium amounts, resulting in underpayments totaling $2,144.20. DHHS had documentation in the case file to support the correct premium amount.	$0.00
Participant 10	See Participant 10 above.	$3,301.62	$0.00	$3,301.62	Overpaid Amount: For March 2012 and October 2012, DHHS paid the incorrect amounts, resulting in overpayments totaling $517.62. DHHS had documentation in the case file to support the correct premium amounts. For November 2012, DHHS paid the insurance premium when the client was not eligible, resulting in an overpayment of $2,784. DHHS had documentation that indicated the client's insurance coverage ended on 10/22/2012. See additional incorrect payment amounts noted above.	$0.00
Participant 8	See Participant 8 above.	$3,151.39	-$125.50	$3,025.89	Overpaid Amount: For March to April 2011, DHHS paid the incorrect amounts, resulting in overpayments totaling $176.83. DHHS had documentation in the case file to support the correct premium amounts. For June to November 2011, the payments were based on an email that conflicted with the properly supported amount of $2,301.97, resulting in overpayments totaling $2,974.56. See additional incorrect payment amounts noted above. Underpaid Amount: For December 2010, DHHS paid the prior plan year's premium amount, rather than the new premium amount, resulting in an underpayment of $125.50.	$0.00

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Participant 13	$37,456.97	$2,437.84	$0.00	$2,437.84	Overpaid Amount: In January 2012, DHHS made payment when the client was no longer eligible, resulting in an overpayment of $2,437.84. The APA verified in NFOCUS that DHHS had documentation that indicated the client was no longer covered by an insurance policy as of 12/31/2011 and was Medicare eligible as of 1/1/2012.	$0.00
Participant 15	$21,637.32	$2,226.58	-$542.66	$1,683.92	Overpaid Amount: For May 2011 and January to February 2012, DHHS paid the incorrect amounts, resulting in overpayments totaling $1,239.58. DHHS had documentation in the case file to support the correct premium amounts. DHHS notified the participant in May 2012 that client was no longer eligible for the HIPP Program beginning in June 2012; however, DHHS had already made the June payment and DHHS requested a refund. No refund appears to have been received, resulting in an overpayment of $987. Underpaid Amount: For March to April 2012, DHHS paid the incorrect amounts, resulting in underpayments totaling $542.66. DHHS had documentation in the case file to support the correct premium amounts.	$0.00
Participant 16	$12,998.18	$1,961.76	$0.00	$1,961.76	Overpaid Amount: For July 2010 to June 2011, DHHS paid the incorrect premium amounts, resulting in overpayments totaling $48. DHHS had documentation in the case file to support the correct premium amounts. For July 2011 to June 2012, DHHS paid the prior plan year's premium amounts, rather than the current plan year's premium amounts, resulting in overpayments totaling $1,913.76. DHHS did not have documentation in the case file to support the premiums for this plan year. The APA independently verified the correct premium amounts.	$0.00
Participant 11	See Participant 11 above.	$1,788.94	$0.00	$1,788.94	Overpaid Amount: For June 2012, DHHS paid the incorrect premium amount, resulting in an overpayment of $703.94. DHHS had documentation in the case file to support the correct premium amount. For November 2012, DHHS made an additional payment after coverage ended in July 2012, resulting in an overpayment of $1,085. DHHS had documentation in the case file that the coverage ended in July. See additional incorrect payment amounts noted above.	$0.00

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Participant 18	$5,625.64	$1,654.60	-$207.35	$1,447.25	Overpaid Amount: For July 2011 to November 2011, DHHS incorrectly paid the insurance premiums of a terminated employee, resulting in overpayments totaling $1,654.60. The APA verified the employee terminated employment in July 2011 and had no health insurance deductions after June 2011. DHHS had documentation dated November 2011 which indicated that the health insurance plan terminated; however, no corrections were made. Underpaid Amount: For August 2010 to June 2011, DHHS paid a prior plan year's premium amounts, rather than the current plan year's premium amounts, resulting in underpayments totaling $207.35. DHHS was paying the premium rates from 2008 and did not have documentation in the case files of the current premium rates. The APA independently verified the correct premium amounts.	$0.00
Participant 19	See Participant 19 above.	$802.78	$0.00	$802.78	Overpaid Amount: For November and December 2010, DHHS incorrectly paid the premiums, resulting in overpayments totaling $528.40. The Medicaid-eligible client was not covered under the participant's health insurance plan until January 2011. DHHS had documentation in the case file indicating such. For January 2012, DHHS paid the prior plan year's premium amount, rather than the current plan year's amount, resulting in an overpayment of $2. DHHS had no documentation in the case file to support the premium. The APA independently verified the correct premium amount. For September 2012, DHHS paid the premium of a terminated employee, resulting in an overpayment of $272.38. The APA independently verified the employee terminated in August 2012 and that no health insurance deductions were made for September 2012. See additional incorrect payment amounts noted above.	$0.00

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Participant 25	$34,945.01	$770.24	$0.00	$770.24	Overpaid Amount: For January to June 2011, DHHS paid the prior plan year's premium amounts, rather than the new plan amounts, resulting in underpayments totaling $967.92. In March 2011, DHHS made an inaccurate correcting payment of $985.64, resulting in a net overpayment of $17.72. DHHS had documentation in the case file to support the correct premium amount. For March 2012, DHHS paid the incorrect amount, resulting in an overpayment of $752.52. DHHS had documentation in the case file to support the correct premium amount.	$0.00
Participant 27	$43,868.48	$581.12	$0.00	$581.12	Overpaid Amount: In January 2011, June 2012, and January 2013, it appeared that DHHS incorrectly adjusted the previous December's payments because of a premium increase, resulting in overpayments totaling $581.12. DHHS had documentation that indicated the premium increases were effective in January of each year.	$0.00
Participant 28	$37,315.33	$548.19	$0.00	$548.19	Overpaid Amount: In February 2011, January 2012, and January 2013, DHHS incorrectly adjusted the previous December's premium payments, resulting in overpayments totaling $542.19. DHHS had documentation that indicated the premium increases were effective in January of each year. For March 2012, DHHS paid the incorrect amount, resulting in an overpayment of $6. DHHS had documentation in the case file to support the correct premium amount.	$0.00
Participant 31	$13,651.88	$412.44	$0.00	$412.44	Overpaid Amount: For July 2010 to May 2011, DHHS paid the incorrect premium amounts, resulting in overpayments totaling $1.10. For June 2011 and July to October 2012, DHHS paid the incorrect plan year's premium amounts, rather than the current plan year's premium amounts, resulting in overpayments totaling $411.34. DHHS had documentation in the case file to support the correct premium amounts for all periods noted above.	$0.00
Participant 33	$5,634.40	$350.50	$0.00	$350.50	Overpaid Amount: For January 2011, DHHS incorrectly paid the premium amount, resulting in an overpayment of $350.50. No health insurance deduction was made from the employee's pay for that month. In its case file, DHHS had a copy of the employee's paystub for that month, which verified there was no health insurance deduction.	$0.00

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Participant 34	$8,209.32	$327.04	$0.00	$327.04	Overpaid Amount: For July 2011 to October 2012, DHHS paid the prior plan year's premium amounts, rather than the current year's premium amounts, resulting in overpayments totaling $327.04. For July 2011 to June 2012, DHHS did not have documentation in the case file to support the premium amounts. The APA independently verified the correct premium amounts. For July 2012 to October 2012, DHHS had documentation in the case file to support the premium amounts.	$0.00
Participant 37	$92,323.56	$144.00	$0.00	$144.00	Overpaid Amount: For April to May 2012, DHHS paid the incorrect amounts, resulting in overpayments totaling $144. DHHS had documentation in the case file to support the correct premium amount.	$0.00
Participant 38	$2,226.28	$52.50	$0.00	$52.50	Overpaid Amount: For July to October 2012 and January 2013, DHHS paid the prior plan year's premium amounts, rather than the current plan year's premium amounts, resulting in overpayments totaling $52.50. DHHS did not have documentation in the case file to support these premium amounts. The APA independently verified the correct premium amounts.	$0.00
Participant 39	$16,924.33	$48.38	-$74.82	-$26.44	Overpaid Amount: For February 2012, DHHS paid the incorrect amount, resulting in an overpayment of $48.38. DHHS had documentation in the case file to support the correct premium amount. Underpaid Amount: For December 2011 to January 2012, DHHS paid the incorrect amounts, resulting in underpayments totaling $74.82. DHHS had documentation in the case file to support the correct premium amounts.	$0.00
Participant 40	$8,432.00	$26.00	$0.00	$26.00	Overpaid Amount: For January 2012 to January 2013, DHHS paid the prior plan year's premium amounts, rather than the current plan year's amounts, resulting in overpayments totaling $26. DHHS did not have documentation in the case file to support the premium amounts since 2009. The APA independently verified the correct premium amounts.	$0.00
Participant 41	$8,432.00	$26.00	$0.00	$26.00	Overpaid Amount: For January 2012 to January 2013, DHHS paid the prior plan year's premium amounts, rather than the current plan year's amounts, resulting in overpayments totaling $26. DHHS did not have documentation in the case file to support the premium amounts since 2010. The APA independently verified the correct premium amounts.	$0.00

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Participant 42	$8,410.00	$4.00	$0.00	$4.00	Overpaid Amount: For January and February 2012, DHHS paid the prior year's premium amounts, rather than the current plan year's amounts, resulting in overpayments totaling $4. DHHS had documentation in the case file to support the correct premium amount.	$0.00
Participant 43	$2,394.00	$4.00	$0.00	$4.00	Overpaid Amount: For January to February 2012, DHHS paid the prior plan year's premium amounts, rather than the current plan year's amounts, resulting in overpayment totaling $4. DHHS had documentation in the case file to support the correct premium amount.	$0.00
Participant 26	See Participant 26 above.	$1.36	$0.00	$1.36	Overpaid Amount: For May to June 2011, DHHS paid the incorrect premium amounts, resulting in overpayments totaling $1.36. DHHS had documentation in the case file to support the correct premium amounts. See additional incorrect payment amounts noted above.	$0.00
Participant 44	$5,979.90	$0.00	-$1,680.96	-$1,680.96	Underpaid Amount: For July 2010 to June 2012, DHHS paid the incorrect amounts, resulting in underpayments totaling $1,680.96. During these months, DHHS paid the same monthly premium amounts that had been paid since 2007. DHHS did not have adequate documentation in the case file to support the premiums paid. The APA independently verified the correct premium amounts.	$0.00
Participant 45	$8,776.27	$0.00	-$968.36	-$968.36	Underpaid Amount: For July 2010 to October 2012, DHHS paid the incorrect amounts, resulting in underpayments totaling $968.36. For each month tested, DHHS paid the same monthly premium amounts, which agreed to the 2007 health insurance premium rates. DHHS did not have adequate documentation in the case file to support the premiums paid. The APA independently verified the correct premium amounts.	$0.00
Participant 46	$47,873.61	$0.00	-$792.36	-$792.36	Underpaid Amount: For July to December 2012, DHHS paid the prior plan year's premium amounts, rather than the new plan amounts, resulting in underpayments totaling $792.36. DHHS had documentation in the case file to support the correct premium amounts.	$0.00

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NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES **EXHIBIT A**

HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

CUMULATIVE PAYMENT SUMMARY FOR PARTICIPANTS TESTED BY APA

For the Period July 1, 2010 through February 5, 2013

HIPP Participant	Total HIPP Payments	Overpaid Amount	Underpaid Amount	Net Over (Under) Paid	Explanation	Overpaid Amount Occurring Prior to 7/1/2010
Participant 47	$10,236.24	$0.00	-$299.60	-$299.60	Underpaid Amount: For July 2011 to August 2012, DHHS paid the prior plan year's premium amounts, rather than the current year's premium amounts, resulting in underpayments totaling $299.60. DHHS did not have documentation in the case file to support the premium amounts from July 2011 to June 2012. However, for July 2012 and August 2012, DHHS had documentation in the case file to support the premium amounts. The APA independently verified the correct premium amounts.	$0.00
Participant 48	$9,239.90	$0.00	-$255.24	-$255.24	Underpaid Amount: For July and August 2012, DHHS paid the prior plan year's premium amounts, rather than the current plan year's amounts, resulting in underpayments totaling $255.24. DHHS had documentation in the case file to support the correct premium amount.	$0.00
Participant 49	$63,865.63	$0.00	-$246.95	-$246.95	Underpaid Amount: For February 2012, DHHS paid the prior plan year's premium amount, rather than the new plan amount, resulting in an underpayment of $246.95.	$0.00
Participant 50	$8,184.00	$0.00	-$222.00	-$222.00	Underpaid Amount: For July 2010 to January 2013, DHHS paid a prior plan year's premium amounts, rather than the current plan year's amounts, resulting in underpayments totaling $222. DHHS did not have documentation in the case file to support the premium amounts since 2008. The APA independently verified the correct premium amounts.	$0.00
Participant 51	$18,633.75	$0.00	-$178.50	-$178.50	Underpaid Amount: For July 2010 to January 2011, DHHS paid the prior plan year's premium amounts, rather than the new premium amounts, resulting in underpayments totaling $178.50.	$0.00
Participant 32	See Participant 32 above.	$0.00	-$115.52	-$115.52	Underpaid Amount: For July 2011 to June 2012, DHHS paid the prior plan year's premium amounts, rather than the current year's premium amounts, resulting in underpayments totaling $14.16. DHHS did not have documentation in the case file to support the premiums for this plan year. The APA independently verified the correct premium amounts. For August 2012, DHHS paid the incorrect premium amount, resulting in an underpayment of $101.36. DHHS had documentation in the case file to support the correct premium amount. See additional incorrect payment amounts noted above.	$0.00
Participant 17	See Participant 17 above.	$0.00	-$78.58	-$78.58	Underpaid Amount: For October to December 2012, DHHS paid the incorrect amounts, resulting in underpayments totaling $78.58. DHHS had documentation in the case file to support the correct premium amounts. See additional incorrect payment amounts noted above.	$0.00

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For the Period July 1, 2010 through February 5, 2013

HIPP Participant	Total HIPP Payments	Overpaid Amount	Underpaid Amount	Net Over (Under) Paid	Explanation	Overpaid Amount Occurring Prior to 7/1/2010
Participant 36	See Participant 36 above.	$0.00	-$26.76	-$26.76	Underpaid Amount: For August 2012 to January 2013, DHHS paid the prior plan year's premium amounts, rather than the current plan year's premium amounts, resulting in underpayments totaling $26.76. DHHS did not have documentation in the case file to support the premium amounts. The APA independently verified the correct premium amounts. See additional incorrect payment amounts noted above.	$0.00
Participant 52	$9,910.64	$0.00	-$14.16	-$14.16	Underpaid Amount: For July 2011 to June 2012, DHHS paid the prior plan year's premium amounts, rather than the current plan year's premium amounts, resulting in underpayments totaling $14.16. DHHS did not have documentation in the case file to support the premiums for this period. The APA independently verified the correct premium amounts.	$0.00
Participant 30	See Participant 30 above.	$0.00	-$9.44	-$9.44	Underpaid Amount: For July 2011 to February 2012, DHHS paid the prior plan year's premium amounts, rather than the current plan year's premium amounts, resulting in underpayments totaling $9.44. DHHS did not have documentation in the case file to support the premiums for this period. The APA independently verified the correct premium amounts. See additional incorrect payment amounts noted above.	$0.00
Participant 14	See Participant 14 above.	$0.00	-$8.16	-$8.16	Underpaid Amount: For July 2011 to June 2012, DHHS incorrectly paid the prior plan year's premiums, rather than the current year's premiums, resulting in underpayments totaling $8.16. DHHS had documentation in the case file to support the correct premium amounts. See additional incorrect payment amounts noted above.	$0.00
Participant 29	See Participant 29 above.	$0.00	-$8.16	-$8.16	Underpaid Amount: For July 2011 to June 2012, DHHS paid the prior year's premium amounts, rather than the current year's premium amounts, resulting in underpayments totaling $8.16. DHHS did not have documentation in the case file to support the premium amounts for this plan year. The APA independently verified the correct premium amounts. See additional incorrect payment amounts noted above.	$0.00
Participant 53	$3,562.00	$0.00	-$2.04	-$2.04	Underpaid Amount: For July to September 2011, DHHS paid the prior year's premium amounts, rather than the current year's premium amounts, resulting in underpayments totaling $2.04. DHHS did not have documentation in the case file to support the premium amounts. The APA independently verified the correct premium amounts.	$0.00
	$592,425.76	**$31,404.99**	**-$8,001.32**	**$23,403.67**	**Sub-Total of Other Incorrect Payments**	**$0.00**

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HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

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For the Period July 1, 2010 through February 5, 2013

HIPP Participant	Total HIPP Payments	Overpaid Amount	Underpaid Amount	Net Over (Under) Paid	Explanation	Overpaid Amount Occurring Prior to 7/1/2010
Participant 54	$63,073.38	$0.00	$0.00	$0.00	This participant did not have sufficient supporting documentation in the case file to verify that the correct health insurance premium amounts were paid.	$0.00
Participant 55	$37,230.00	$0.00	$0.00	$0.00	This participant did not have sufficient supporting documentation in the case file to verify that the correct health insurance premium amounts were paid.	$0.00
Participant 56	$36,627.52	$0.00	$0.00	$0.00	This participant did not have sufficient supporting documentation in the case file to verify that the correct health insurance premium amounts were paid.	$0.00
Participant 57	$37,722.75	$0.00	$0.00	$0.00	This participant did not have sufficient supporting documentation in the case file to verify that the correct health insurance premium amounts were paid.	$0.00
Participant 58	See Participant 58 above.	$0.00	$0.00	$0.00	This participant did not have sufficient supporting documentation in the case file to verify that the correct health insurance premium amounts were paid. See additional incorrect payment amounts above.	$0.00
Participant 59	$41,547.18	$0.00	$0.00	$0.00	This participant did not have sufficient supporting documentation in the case file to verify that the correct health insurance premium amounts were paid.	$0.00
Participant 60	$8,534.92	$0.00	$0.00	$0.00	This participant did not have sufficient supporting documentation in the case file to verify that the correct health insurance premium amounts were paid.	$0.00
Participant 61	$10,535.84	$0.00	$0.00	$0.00	This participant did not have sufficient supporting documentation in the case file to verify that the correct health insurance premium amounts were paid.	$0.00
Participant 62	$12,345.88	$0.00	$0.00	$0.00	This participant did not have sufficient supporting documentation in the case file to verify that the correct health insurance premium amounts were paid.	$0.00
Participant 63	$8,902.51	$0.00	$0.00	$0.00	This participant did not have sufficient supporting documentation in the case file to verify that the correct health insurance premium amounts were paid.	$0.00
Participant 64	$3,782.00	$0.00	$0.00	$0.00	This participant did not have sufficient supporting documentation in the case file to verify that the correct health insurance premium amounts were paid.	$0.00
	$260,301.98	**$0.00**	**$0.00**	**$0.00**	**Sub-Total of Unsupported Payments.**	**$0.00**

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NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES

EXHIBIT A

HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

CUMULATIVE PAYMENT SUMMARY FOR PARTICIPANTS TESTED BY APA

For the Period July 1, 2010 through February 5, 2013

HIPP Participant	Total HIPP Payments	Overpaid Amount	Underpaid Amount	Net Over (Under) Paid	Explanation	Overpaid Amount Occurring Prior to 7/1/2010
Participant 65	$13,239.44	$0.00	$0.00	$0.00	No incorrect payments noted.	$0.00
Participant 66	$2,901.45	$0.00	$0.00	$0.00	No incorrect payments noted.	$0.00
Participant 67	$1,116.56	$0.00	$0.00	$0.00	No incorrect payments noted.	$0.00
Participant 68	$401.16	$0.00	$0.00	$0.00	No incorrect payments noted.	$0.00
Participant 69	$98,126.30	$0.00	$0.00	$0.00	No incorrect payments noted.	$0.00
Participant 70	$30,956.00	$0.00	$0.00	$0.00	No incorrect payments noted.	$0.00
	$146,740.91	**$0.00**	**$0.00**	**$0.00**	**Sub-Total of Participants tested with no issues noted.**	**$0.00**
	$1,812,792.10	**$430,403.07**	**-$8,102.72**	**$422,300.35**	**Totals All**	**$58,539.87**

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