NEBRASKA AUDITOR OF PUBLIC ACCOUNTS

Mike Foley
State Auditor

Mike.Foley@nebraska.gov
PO Box 98917
State Capitol, Suite 2303
Lincoln, Nebraska 68509
402-471-2111, FAX 402-471-3301
www.auditors.nebraska.gov

December 10, 2014

Kerry Winterer, Chief Executive Officer
Department of Health and Human Services
301 Centennial Mall
Lincoln, NE 68509

Dear Kerry:

This letter is provided pursuant to AICPA Auditing Standards AU-C Section 265.A17, which permits the early communication of certain audit findings due to their significance and the urgent need for corrective action. The audit work addressed herein was performed as part of the fiscal year 2014 Statewide Single audit. This communication is based on our audit procedures through September 26, 2014. Because we have not completed our audit of the fiscal year 2014 Statewide Single, additional matters may be identified and communicated in our final report.

In planning and performing our A-133 audit, we are considering the State's compliance with the applicable types of compliance requirements, as described in the OMB Circular A-133 Compliance Supplement, for the year ended June 30, 2014. We are also considering the State's internal control over compliance with those requirements that could have a direct and material effect on a major program in order to determine our auditing procedures for the purpose of expressing our opinion on compliance and to test and report on internal control over compliance in accordance with OMB Circular A-133, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the State's internal control over compliance.

Our consideration of internal control was for the limited purpose described in the preceding paragraph and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and, therefore, material weaknesses or significant deficiencies may exist that were not identified.

We noted certain internal control or compliance matters related to the activities of the Nebraska Department of Health and Human Services (DHHS) or other operational matters that are presented below for your consideration. The following comments and recommendations, which have been discussed with the appropriate members of DHHS and its management, is intended to improve internal control or result in other operating efficiencies.

Draft copies of this letter were furnished to DHHS to provide management with an opportunity to review and to respond to the comments and recommendations contained herein. The formal response received has been incorporated into this letter. Such response has been objectively evaluated and recognized, as appropriate, in the letter.

BACKGROUND

In connection with our audit of the Medical Assistance Program for the State fiscal year 2014 Statewide Single Audit, we tested a random sample of 10 personal assistance service (PAS) claims, and 15 nursing facility claims for recipients entering a nursing facility for the first time.

In July 2011, the U.S. Department of Health & Human Services Office of the Inspector General (OIG) performed a review of PAS claims to determine whether claims were made in accordance with Federal and State requirements. Because of the OIG's audit, the Agency repaid $4,482,438 to the Federal government on the March 2014 quarterly report. Our PAS testing found likely questioned costs for the fiscal year ended June 30, 2014, of $7,378,548.

Our prior Single Audit noted that the Agency did not adequately verify the resources of individuals entering nursing home care. Our nursing facility testing for fiscal year 2014 noted likely questioned costs of $1,353,174.

COMMENTS AND RECOMMENDATIONS

1. Program: CFDA 93.778 Medical Assistance Program – Allowability & Eligibility

Grant Number & Year: #051305NE5MAP, FFY 2013; #051405NE5MAP, FFY 2014

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

Criteria: Per Section 1902(a) of the Social Security Act,

> *A State plan for Medical assistance must . . . (27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan . . . .*

Per OMB Circular A-87, to be allowable, costs must be adequately documented.

Title 471 NAC 15-006.06C states that, after receiving a provider's timesheet and billing document, the beneficiary's social service worker or designee must verify that "the hours worked and services provided fall within the parameters of those authorized" by the service needs assessment.

Title 471 NAC Chapter 15 refers to the Form MC-37 "Service Provider Time Sheet" throughout the regulations. However, the form used during the fiscal year was the MC-39, a less descriptive form.

A good internal control plan requires that procedures be in place to ensure Federal and State regulations are followed. All income should be verified and all private insurance investigated.

Condition: During testing of personal assistance service (PAS) claims, we noted the Agency does not obtain adequate supporting documentation to ensure claims are allowable per State and Federal requirements.

Questioned Costs: $4,018 known

Context: The Agency offers PAS (housekeeping, assistance with hygiene, assistance with mobility, etc.) to Medicaid recipients with disabilities and chronic conditions. The services are based on individual needs and criteria that must be determined in a written service needs assessment (SNA). Providers fill out timesheets that are signed by the recipients to indicate services were actually provided. Providers submit these timesheets, along with billing documents, to the Agency for payment.

In July 2011, the U.S. Department of Health & Human Services Office of the Inspector General (OIG) performed a review of PAS claims to determine whether claims were made in accordance with Federal and State requirements. That agency reviewed 100 claims and identified the largest issue as follows: For a portion of each of 87 claims, providers billed for services and time allotments that differed significantly from those laid out in the beneficiaries' SNAs. For these 87 claims, the information varied enough from the nature and extent of PAS authorized in the SNA to question some portion of the claim.

For example, if the SNA indicated the recipient needed help with the laundry, but the actual service provided per the timesheet was cleaning the kitchen, the OIG disallowed these costs. Because of the OIG's audit, the Agency repaid $4,482,438 to the Federal government on the March 2014 quarterly report.

In September 2011, the Agency sent a Provider Bulletin to all PAS providers to inform them that the form they use to document PAS work performed was changing from the MC-37 form to the MC-39 form. The new form was less descriptive – instead of listing all activities performed, it showed times in and out only. The new form is not adequate for Federal and State requirements, and the Agency did not change its regulations to refer to the new form.

We tested 10 personal assistance claims and noted the new, less descriptive form was used in all 10 instances. For all claims tested, the Agency did not have adequate documentation on file to support that services paid were in accordance with the service needs assessment. However, the provider did maintain its own internal support for 3 of the 10 claims. This additional detail supported a portion of the claims tested, which explains why we did not question 100% of the population.

Federal payment errors noted were $1,737. The total Federal sample tested was $2,236, and the total Federal share of PAS claims during the fiscal year was $9,498,646. Based on the sample tested, the case error rate was 100% (10/10). The dollar error rate for the sample was 77.68% ($1,737/$2,236), which estimates the potential dollars at risk for fiscal year 2014 to be $7,378,548 (dollar error rate multiplied by population).

For one of the payments tested, we also noted that the budget included a $160 medical disregard for five months after the policy expired, including the specific month tested. The Agency discovered the error after the fact but did not recalculate any budgets or assess any overpayments. Without the medical disregard, the recipient was over income limits for Medicaid. Medicaid payments, excluding PAS claims, totaled $2,281 for the fiscal year and are questioned costs.

We also noted one of the recipients tested had private insurance coverage. The Agency did not check to see if the private insurance would have paid for the PAS.

Cause: Unknown – the individuals who decided to change forms no longer work for the Agency. However, it appears the Agency was attempting to avoid future audit findings by removing the detail that caused issues from the forms. However, if this detail is removed, the payments do not have adequate documentation.

The Agency does not check for third-party liability for any PAS claims because they are paid out of a different system (NFOCUS) than the system that stores the third-party liability information (MMIS). Most medical claims are paid out of MMIS.

Effect: When insufficient supporting documentation is maintained for PAS payments, this increases the risk the services provided were not in accordance with the recipients' needs and increases the risk of loss or misuse of Federal funds.

Recommendation: We recommend the Agency implement procedures to ensure all applicable Federal and State regulations are followed.

> ***Management Response:*** *The agency agrees with the conditions reported. The Agency will publish a Provider Bulletin informing providers of the Nebraska Medicaid Regulation 471 NAC 15-006.05(11a) provider responsibility to maintain documentation supporting the provision of services to each client served and the documentation aligns with activities described on the service authorization. The Agency will revise the MC-39 form to align with the Personal Assistance Services (PAS) Medicaid Regulations.*
>
> *As the PAS claims are paid out of the NFOCUS system which does not have the system capability to edit against Third Party Liability information contained in the MMIS, the Agency will analyze the feasibility of moving the PAS claims payment function to the current MMIS or include in the scope of the MMIS replacement project.*

2. Program: CFDA 93.778 Medical Assistance Program – Eligibility

Grant Number & Year: #051305NE5MAP, FFY 2013; #051405NE5MAP, FFY 2014

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

Criteria: Per OMB Circular A-87, Attachment A, § C(1)(c), allowable costs must be "authorized or not prohibited under State or local laws or regulations."

Per Title 477 NAC 21-001.01, "If the total equity value of available non-excluded resources exceeds the established maximum, the client is ineligible." Per 477 NAC 21-001.16, the resource limit for individuals eligible only for medical assistance is $4,000 for one and $6,000 for a two-person unit.

Per Title 477 NAC 21-001.09I, Transfer of Ownership:

> *Once it's been determined that the alternate care spouse is otherwise eligible, the case is approved without waiting for completion of the transfer. The client must be advised of the 90-day period. If the couple fails to complete the transfer within 90 days, the case is closed.*

Per Title 477 NAC 21-001.15B12, Motor Vehicles:

> *One motor vehicle [is excluded] regardless of its value as long as it is necessary for the client or a member of his/her household for employment or medical treatment must be disregarded. If the client has more than one motor vehicle, the vehicle with the greatest equity must be excluded. Any other motor vehicles are treated as non-liquid resources and the equity is counted in the resource limit.*

Per Title 477 NAC 21-001.25A, Deprivation of Resources:

> *Any action taken by the individual, or any other person or entity, that reduces or eliminates the individual's or spouse's recorded ownership or control of the asset for less than fair market value (full value) is a deprivation of resources.*

Per Title 477 NAC 21-001.25D1, Look Back Period:

> *To determine if a client or his/her spouse deprived himself/herself of a resource to qualify for medical assistance, the worker must look back 60 months before the month of application.*

A good internal control plan requires procedures to ensure all income, resources, and expenses are updated for changes timely, adequately documented, and verified.

Condition: The Agency did not adequately verify the income and resources of individuals to ensure limits were not exceeded and the individuals were eligible.

Questioned Costs: $18,979 known

Context: During testing of 15 nursing facility residents, we noted:

- For one case, the resource total of cash and life insurance was $109. The recipient's vehicle was excluded from the resource limit for medical purposes. However, because the recipient was residing in a nursing facility, and medical transportation is covered, this resource was not allowable for exclusion. The recipient valued the vehicle at $3,200. We reviewed the Department of Motor Vehicles (DMV) website and noted the recipient had title to two additional vehicles, including a Winnebago motor home. These vehicles were not declared by the recipient, so they were not considered in the determination of her eligibility. Also, the recipient indicated on her application that she had not "sold, traded or given away any item of substantial value within the past 5 years." However, per our review of the county assessor website, the recipient sold a home for $50,000 within that timeframe. If the home was sold for less than fair market value, this would be

a deprivation of resources necessitating a financial penalty. The home did appear to be sold for fair market value. Because the Agency does not perform its own independent search of undeclared resources, the Agency was unaware that the recipient was not truthful on her application.

The Agency did not have adequate documentation the recipient was under the resource limit. This resulted in questioned costs for the specific payment tested of $1,784 and an additional $10,219 outside of our sample.

- For one case, the recipient's share of cost was understated by $30 ($16 Federal share – questioned costs) because the Agency did not timely update the budget for annual increases in social security payment amounts.

  Additionally for this case, the recipient's spouse was still living at home, so a Designation of Resources was completed to allocate resources between the community spouse and the nursing facility spouse. One requirement is that, within 90 days, all assets designated to the community spouse must be transferred to the community spouse's name only, or else the case is closed. We did not see any documentation that the Agency verified $14,109 in accounts in both spouses' names was appropriately transferred to the community spouse. The case should have closed, resulting in questioned costs outside of our sample of $6,949.

- For one case, a disregard for house insurance was valued at $40 on the budget, but the verified amount was only $20, resulting in questioned costs of $11.

A similar finding was noted in the prior audit.

Federal payment errors noted were $1,811. The total Federal sample tested was $39,905, and the total claims paid to nursing facilities for recipients who entered the facility for the first time during the fiscal year were $29,805,588. Based on the sample tested, the case error rate was 20% (3/15). The dollar error rate for the sample was 4.54% ($1,811/$39,905), which estimates the potential dollars at risk for fiscal year 2014 to be $1,353,174 (dollar error rate multiplied by population).

Cause: Worker error and inadequate review.

Effect: If income, resources, and expenses are not adequately verified, there is an increased risk recipients will be inappropriately determined eligible for Medicaid or determined eligible with an incorrect share of cost.

Recommendation: We recommend the Agency implement procedures to ensure all income, resources, and expenses are updated for changes timely, adequately documented, and verified.

Management Response: *The agency agrees with the conditions reported. For the first case cited, the agency notes the information obtained by the Auditor of Public Accounts (APA) was not known or reported to the agency and a referral will be made to the Special Investigations Unit (SIU). Of the additional two cases sited, one has been closed since July, 2014; the other case remains eligible and the share of cost (SOC) was previously corrected.*

As of October 2013, the Agency has assigned all nursing home cases to specialized staff to ensure these complex cases are handled accurately and timely. The Agency has Program Accuracy Specialists (PAS) and MLTC Eligibility Supervisors that complete second level case reviews on a random sample of cases to ensure eligibility is determined accurately. Department staff utilize a state Department of Motor Vehicles interface and Kelly Blue Book to verify vehicle ownership and valuation and require clients to provide verification of property or land and any values associated. Based on the APA's 2012/2013 findings a review of Department processes for verifying resources was completed. A Resource Verification Guide was created and provided to all MLTC Eligibility staff on 5-7-2014. The PAS unit is planning a targeted review on resource verifications.

We believe with the assignment of complex cases and the creation of the verification guide we have reduced the potential for errors.

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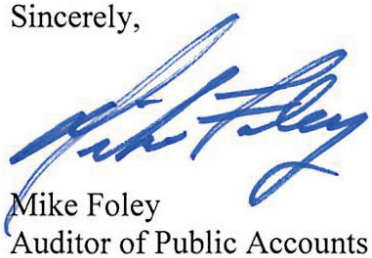
Our audit procedures are designed primarily on a test basis and, therefore, may not bring to light all weaknesses in policies or procedures that may exist. Our objective is, however, to use our knowledge of the Agency and its interaction with other State agencies and administrative departments gained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

This interim communication is intended solely for the information and use of DHHS, its management, the Governor and the State Legislature, and others within these State agencies. It is not intended to be, and should not be, used by anyone other than the specified parties. However, this letter is a matter of public record, and its distribution is not limited.

If you have any questions regarding the above information, please contact my office.

Sincerely,



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Auditor of Public Accounts