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November 12, 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 comment and recommendation, which has 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 comment and recommendation 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

The Health Insurance Premium Payment Program (HIPP) was created in 1994 and was designed to reduce Medicaid costs by reimbursing participants for their cost of private health insurance. 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 participant 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 Chapter 30.

Nebraska Medicaid is funded jointly by the State and Federal governments. The funding is established annually pursuant to the Social Security Act and is referred to as the Federal Medical Assistance Percentages (FMAP). The percentages used during the period tested were as follows:

Federal Fiscal Year	Federal Portion	State Portion
2013	55.76%	44.24%
2014	54.74%	45.26%

The Federal fiscal year is October 1 to September 30.

On May 29, 2013, the APA issued an attestation report that examined HIPP Program payments from July 1, 2010, through February 5, 2013. Numerous issues were noted, including missing and insufficient documentation, lack of cost effectiveness calculation, documentation, and incorrect payments.

As a result of this attestation, the HIPP Program was reviewed by DHHS. That review is outlined in a document titled "*Health Insurance Premium Payment Program, Division of Medicaid and Long-Term Care, Department of Health and Human Services, October 15, 2013*." In addition to the review of cases, other program improvements were put in place in order to comply with laws and regulations. This included a redesign of the application, creation of new applicant letters and other internal tracking forms.

From July 1, 2013, through June 30, 2014, DHHS paid 418 payees a total of $1,690,966 in HIPP Program payments. As a follow-up to the previous findings, the Auditor of Public Accounts (APA) tested 20 HIPP Program participants, who received $244,148 in payments. Following is a summary of the HIPP Program payments for State fiscal year 2014 from the State's accounting system, EnterpriseOne:

Federal	State	Total Payments
$940,096	$750,870	$1,690,966

The following is the comment and recommendation for the year ended June 30, 2014, related to the HIPP Program.

COMMENT AND RECOMMENDATION

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

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

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

Criteria: Good internal control requires procedures to ensure payments are proper, adequately supported, and in accordance with State and Federal regulations.

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.*

Title 471 NAC 30-004(1) includes the following methodology for determining the cost effectiveness of health plans:

> *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.*

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

> *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.*

The six-month/twelve-month review reminder notice sent to each participant states, in relevant part, "[D]ental, vision, and other types of insurance are not covered under HIPP."

Condition: Health insurance premium payments (HIPP) were not adequately supported and were not in accordance with regulations.

Questioned Costs: $21,016 known

Context: We selected 20 HIPP payees and noted errors in 16 cases, as follows:

- For two cases tested, the cost effectiveness calculation was not performed or documented, resulting in questioned costs of $6,411. (Federal share)

  A cost effectiveness calculation was not performed for one participant until July 2014. Additionally, plan documentation did not clearly identify the participant as a covered dependent. Also, documentation was received in 2012 indicating the participant was covered under his father's employee and children plan; however, documentation obtained in January 2014 only identified the father as the policyholder and did not identify the covered dependents. Another participant did not have a cost effectiveness calculation; however, per our review of Medicaid claims, medical costs covered by insurance were less than HIPP payments. Consequently, there were no questioned costs.

- For four cases tested, the premium payments included items not covered under the HIPP Program, including dental insurance. The Federal share of questioned costs totaled $1,796. For three of the cases, a breakdown of premiums by coverage level was not obtained, even though the insurance card provided indicated the plan included medical and dental insurance coverage.

- For one case, the HIPP Program reimbursed the total premium amount. The participant should have been reimbursed for only the employee's share of the premium. Providing reimbursement for both the employee and employer shares resulted in overpayments. (Federal share $7,042)

- In one case, payments through February 2014 were based on a September 2010 pay stub. No current information was on file to support the premium amount paid. Also, a copy of the health insurance card obtained in February 2009 identified the participant as a covered dependent; however, the next insurance card received in May 2011 was from a different insurance company, with a different employer. There was insufficient documentation to determine the correct premium amount during this time and whether the participant was a covered dependent. All premium payments during this time period are questioned costs. (Federal share $4,686)

- In six cases tested, the payment did not agree to supporting documentation, resulting in a Federal share of questioned costs of $1,081. Errors included not deducting an employee premium credit, calculating deductions for 26 pay periods instead of 24 periods, and not properly accounting for premium decreases.

- The health insurance card provided for four participants noted only the policyholder of the plan and did not identify the participant as a covered dependent. For three of these participants, additional documentation was later received that identified them as dependents covered under the plan.

For all cases tested, the premium payments were made by the HIPP Program directly to the policyholders, rather than to the insurance companies or employers. It is likely that many of the issues identified may have been prevented or minimized had DHHS complied with regulations and made the payments directly to the insurance providers or employers.

The total Federal share of errors noted was $21,016. The total Federal sample tested was $135,633, and the Federal share of expenditures for HIPP for fiscal year 2014 was $940,096. The dollar error rate for the sample was 15.49% ($21,016/$135,633), which estimates the potential dollars at risk for fiscal year 2014 to be $145,621 (dollar error rate multiplied by population).

A similar finding was noted in the prior audit.

Cause: The Agency did not obtain adequate documentation to determine the correct payment amount.

Effect: Without adequate policies and procedures in place to ensure proper processing of the HIPP Program payments, there is an increased risk for loss or misuse of State and Federal funds.

Recommendation: We recommend the Agency implement procedures to properly document the cost effectiveness calculations. The Agency should re-evaluate the cost 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. We also recommend the Agency implement controls to ensure payments are accurate and supported with adequate documentation. We further recommend the Agency implement procedures to make payments to the insurance provider or employer, when possible, rather than reimbursing the employee or policyholder directly. Finally, we recommend the Agency take appropriate action to recover overpayments.

Management Response: *First of all, we appreciate the acknowledgement by your office of program improvements. In addition to the items noted, we've also implemented a six-month review process to verify ongoing medical insurance coverage and premium amounts, secondary reviews on payment requests, and quality assurance reviews by management staff on a monthly and quarterly basis. Since the last audit, we've also researched best practices and trends in other states, sought guidance from CMS, and have made significant progress on redrafting the regulations covered under 471 NAC Chapter 30 (Payment for Health Insurance Premiums).*

We do agree that there were errors made. However, based on a review of the audit findings, we respectfully disagree that the findings were significant and demonstrate an urgent need for corrective action. In fact, based on our review, the overpayment amount is $4,016.17 as opposed to the amount reported.

The following summarizes our review.

- *There were cases where an error was made and for which recovery will be sought. In two cases, recovery has already been satisfied.*
- *While the coverage decisions can be supported, there are cases where documentation was lacking in file and corrective action is being taken.*
- *As noted, NE Medicaid utilizes an online service for verification of other insurance coverage (real-time and historical). This information is then entered into the Third Party Liability section of the MMIS.*
- *Medicaid's payment as secondary payor also demonstrates other primary insurance coverage and the inclusion of dependent coverage.*
- *In one case, the premium arrangement is tied to the client's partnership/retirement with his former company. In another, the employer plan which covers the client and held by the mother was confused with the father's employer plan.*
- *And finally, 471 NAC 30-006 provides NE Medicaid with the option to reimburse clients for premium where payroll-deduction is demonstrated. Additionally, the fore-mentioned online service allows us to verify coverage on an ongoing basis.*

In closing, while the audit does note opportunities for improvement, the overall results demonstrate the significant progress and corrective action since the last audit conducted in May of 2013.

APA Response: We disagree with the Agency on the dollar amount of questioned costs. The finding will be included in the Statewide Single Audit and referred to the Federal grantor for resolution.

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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,

Mike Foley
Auditor of Public Accounts