



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

November 1, 2011

Report Number: A-07-11-02759

Ms. Vivianne M. Chaumont
Director
Division of Medicaid & Long-Term Care
Department of Health & Human Services
P. O. Box 95026
Lincoln, NE 68509

Dear Ms. Chaumont:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in Nebraska*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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If you have any questions or comments about this report, please do not hesitate to call me at (816) 426-3591, or contact James Korn, Audit Manager, at (303) 844-7153 or through email at James.Korn@oig.hhs.gov. Please refer to report number A-07-11-02759 in all correspondence.

Sincerely,

/Patrick J. Cogley/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
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Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF THE
QUARTERLY MEDICAID STATEMENT
OF EXPENDITURES FOR THE
MEDICAL ASSISTANCE PROGRAM
IN NEBRASKA**



Daniel R. Levinson
Inspector General

November 2011
A-07-11-02759

Office of Inspector General

<http://oig.hhs.gov>

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The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In Nebraska, the Department of Health & Human Services (the State agency) administers the Medicaid program.

Pursuant to section 1905(b) of the Act, the Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income. Additionally, States receive a higher, or enhanced, Federal share for some Medicaid services, such as those related to family planning.

The standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report), summarizes, by category of service, actual Medicaid expenditures for each quarter and is used by CMS to reimburse States for the Federal share of Medicaid expenditures. The amounts reported on the CMS-64 report and its attachments must be actual expenditures with supporting documentation.

State Medicaid programs must provide certain medical services, including inpatient and outpatient hospital, physician, and family planning services. States also may offer certain optional services, such as Nebraska's Medicaid managed care program, as long as the services are included in their approved State plans.

OBJECTIVE

Our objective was to determine whether the State agency's claim for Federal reimbursement of Medicaid expenditures was adequately supported by actual recorded expenditures.

SUMMARY OF FINDINGS

For the quarter ended March 31, 2009, the majority of the Medicaid costs that the State agency claimed which totaled approximately \$413 million (approximately \$273 million Federal share) was adequately supported by actual recorded expenditures. However, the State agency allocated inpatient hospital services as family planning services, which received a 90-percent enhanced rate (enhanced rate) of Federal reimbursement, through an allocation methodology which State agency officials could not explain and for which State agency officials could provide neither supporting documentation nor evidence that CMS had approved that methodology. For the quarter ended March 31, 2009, the State agency received \$43,948 in Federal reimbursement for

family planning services at the enhanced rate, and we were unable to determine what portion of this amount was allowable.

We also identified several weaknesses in the procedures used by the State agency to calculate and claim Medicaid costs. Specifically, the State agency:

- used prison inmates to perform data entry of claims information that included personally identifiable information such as Social Security numbers and
- reported some expenses on the CMS-64 report for the quarter before the quarter in which the expenses were actually paid to providers.

Although the State agency's internal controls were adequate to ensure that the majority of the Medicaid costs that the State agency claimed and that we reviewed for this quarter were claimed correctly, some policies and procedures, as well as some internal controls, could be strengthened. Internal control weaknesses could result in the State agency's reporting incorrect expenditures for Federal reimbursement.

RECOMMENDATIONS

We recommend that the State agency:

- work with CMS to determine what portion of the \$43,948 (Federal share) in enhanced family planning funds that it received was allowable, and submit documentation to CMS supporting the reasonableness of the methodology used to allocate expenses for inpatient hospital services at the enhanced rate;
- discontinue the use of inmates to enter manual claims data that contain personal information;
- report expenditures only during the quarters in which the payments actually occurred; and
- strengthen internal controls to ensure that Medicaid expenditures are correctly calculated, assigned, and claimed in accordance with the approved State plan.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency generally agreed with our recommendations and provided additional information as to corrective actions and improvements that it had implemented or is undertaking. With respect to our third recommendation, the State agency said that it reported expenditures on the CMS-64 report for the same quarter in which those payments were made. The State agency also said that the timeframes in which it processes payments to providers, and records those payments in its accounting system, are such that the State agency sometimes claims these payments on the CMS-64 report in a different month than the month in which the payments actually occurred.

The State agency's comments are included in their entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that our findings and recommendations remain valid. Regarding our third recommendation, the State agency said that it reported expenditures on the CMS-64 report for the same quarter in which those payments were made. However, some of the State agency's payments were in fact not reported for the quarter in which the payments were made. Although a particular claim might have been fully processed through the State agency's Medicaid Management Information System, the payment did not actually occur until it was processed through the State agency's accounting system. In some cases a new quarter began during that interval, and those are the cases when, contrary to Federal regulations (45 CFR § 95.13(b)), the State agency did not always report expenditures during the quarter in which the payments actually occurred. To conform to these regulations, the State agency must therefore revise its policies and procedures for the processing of payments to ensure that expenditures made in a quarter are reported on that quarter's CMS-64 report.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In Nebraska, the Department of Health & Human Services (the State agency) administers the Medicaid program.

Pursuant to section 1905(b) of the Act, the Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income. Although FMAPs are adjusted annually for economic changes in the States, Congress may increase FMAPs at any time. Certain Medicaid services receive a higher FMAP, including family planning services which receive a 90-percent enhanced rate (enhanced rate) of Federal reimbursement.

As part of the implementation of their Medicaid programs, States may submit waiver requests to CMS; these waivers, when approved, allow exceptions to certain requirements or limitations of the Act. Two such waivers authorized by the Act are home and community-based waivers (section 1915(c)) and demonstration waivers (section 1115).

American Recovery and Reinvestment Act of 2009

The American Recovery and Reinvestment Act of 2009 (Recovery Act), P.L. No. 111-5, enacted February 17, 2009, provides fiscal relief to States to protect and maintain State Medicaid programs in a period of economic downturn. For the recession adjustment period (October 1, 2008, through December 31, 2010), the Recovery Act provided an estimated \$87 billion in additional Medicaid funding based on temporary increases in States' FMAPs.¹ Section 5000 of the Recovery Act provides for these increases to help avert cuts in health care payment rates, benefits, or services and to prevent changes to income eligibility requirements that would reduce the number of individuals eligible for Medicaid. Sections 5001(a), (b), and (c) of the Recovery Act provide that a State's increased FMAP during the recession adjustment period will be no less than its 2008 FMAP increased by 6.2 percentage points and that a State may receive an increase greater than 6.2 percentage points based on increases to its average unemployment rate.

¹ The Education Jobs and Medicaid Assistance Act (P.L. No. 111-226, section 201) extended the recession adjustment period for the increased FMAP through June 30, 2011.

With the Recovery Act funding, Nebraska's FMAP for Medicaid expenditures increased from 59.54 percent to 65.74 percent for the quarter ended March 31, 2009.

Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program

The standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report), summarizes, by category of service, actual Medicaid expenditures for each quarter and is used by CMS to reimburse States for the Federal share of Medicaid expenditures. The amounts reported on the CMS-64 report and its attachments must be actual expenditures with supporting documentation.

Quarterly Medicaid Statement of Expenditures Oversight

On a quarterly basis, CMS Regional office staff members perform a desk review on the amounts reported on the CMS-64 report, a review that is designed to provide CMS with limited assurance that the report complies with applicable Federal laws, regulations, and policy guidance and is filed in compliance with CMS reporting requirements.

Medicaid Management Information System

Section 1903(r)(1)(a) of the Act states that, to receive Federal funding for the use of automated data systems in administration of the Medicaid program, a State must have a mechanized claims processing and information retrieval system. Pursuant to chapter 11, section 11100, of the CMS *State Medicaid Manual*, this mechanized system is the Medicaid Management Information System (MMIS). An MMIS is a system of software and hardware used to process Medicaid claims and manage information about Medicaid beneficiaries and services. This system may be operated by either a State agency or a fiscal agent, which is a private contractor hired by the State.

Use of Nebraska Data Systems to Process Medicaid Payments to Providers

In addition to Nebraska's MMIS, the State agency processed some Medicaid expenditures through one or more of three additional data systems:

- Nebraska Information System (NIS): This application is responsible for processing the financial, human resource, and procurement data business processes for the State of Nebraska. State agency procedures call for all providers of Medicaid services to be paid through the NIS data system. MMIS claim payments interface with NIS, as do other State data system applications. According to State agency officials, NIS is the official accounting system of the State of Nebraska.²

² State agency officials said that for public providers (i.e., the Beatrice State Developmental Center), the State portion of the Federal matching requirement is not portrayed on the NIS system but is State-appropriated through a separate State budget process.

- Nebraska Family Online Client User System (NFOCUS): The NFOCUS application is used to automate benefit/service delivery and case management for over 30 State agency programs. NFOCUS processes include client/case intake, eligibility determination, case management, service authorization, benefit payments, claims processing and payments, provider contract management, interfacing with other State and Federal organizations, and management and government reporting.
- Coordinating Options in Nebraska's Network Through Effective Communication and Technology (CONNECT): Users access the CONNECT application through the State's web portal. Individual user access to the application is controlled by the Access Restriction by Granular User Services (ARGUS) application. State agency programs that use this application include the Early Development Network, the Aged and Disabled Waiver, the Centers for Independent Living, the Area Agencies on Aging, Respite Services, the Medically Handicapped Children's program, and the Disabled Persons and Family Support Services.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency's claim for Federal reimbursement of Medicaid expenditures was adequately supported by actual recorded expenditures.

Scope

The State agency claimed Medicaid costs totaling approximately \$413 million (approximately \$273 million Federal share) for the quarter ended March 31, 2009. Our review period for reviewing internal controls included October 1, 2008, through March 31, 2010, with expenditure testing conducted on our selected quarter of interest (the quarter ended March 31, 2009). Our review covered six judgmentally selected line items as well as judgmentally selected costs relating to section 1915(c) home and community-based services waivers. The six line items and the section 1915(c) waiver amounts totaled approximately \$274 million (approximately \$181 million Federal share), which constituted approximately 66 percent of the State agency's claimed costs for the quarter.³ The six line items were for Inpatient Hospital Services, Nursing Facility Services, Physicians' Services, Outpatient Hospital Services, Prescribed Drugs, and Medicaid Managed Care Organization Services.

We limited our review of supporting documentation to records that the State agency maintained; we did not evaluate claims submitted by providers to determine their validity. Our objectives did not require a review of the overall internal control structure of the State agency. Therefore, we limited our internal control review to the State agency's procedures for aggregating Medicaid

³ We obtained the costs that the State agency claimed and the judgmentally selected costs that we reviewed from the Form 64.9 Base of the CMS-64 report and the section 1915(c) waiver pages; however, these amounts did not include adjustments. Although we reviewed the adjustments for the six selected line items, the net adjustments were immaterial.

expenditures on the CMS-64 report and reconciling those expenditures to detailed supported records.

We conducted fieldwork at the State agency in Lincoln, Nebraska, from April through October 2010.

Methodology

To accomplish our objectives, we:

- reviewed applicable Federal laws, regulations, and guidance, and applicable portions of the Nebraska State Medicaid plan;
- interviewed CMS officials responsible for monitoring the CMS-64 report to gain an understanding of the process used by CMS to review the CMS-64 report;
- interviewed State agency officials to gain an understanding of their policies and procedures for reporting Medicaid expenditures on the CMS-64 report and of the systems used by the State agency for reporting Medicaid costs;
- analyzed the State agency's procedures for aggregating Medicaid expenditures for the CMS-64 report to assess whether those procedures would produce a reasonable and accurate claim for Federal reimbursement;
- reviewed the State agency's process for reconciling expenditures reported on the CMS-64 report to supporting accounting records for the period October 1, 2008, through March 31, 2010;
- gained an understanding of the State agency's Medicaid waiver programs;
- assessed the overall accuracy of amounts claimed on the CMS-64 report by tracing those amounts to supporting reports from the State agency's accounting system;
- judgmentally selected for review the six line items on the CMS-64 report and the costs associated with the waivers, as discussed earlier;
- reviewed the CMS-64 report for the quarter ending March 31, 2009, and compared the amounts claimed for Federal reimbursement to the information in the State agency's MMIS and other data systems and to the State agency's accounting records;
- reviewed the information in the State agency's MMIS to assess whether duplicate payments occurred and to identify any errors in the MMIS data; and
- discussed our results with State agency officials on May 23, 2011.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

For the quarter ended March 31, 2009, the majority of the Medicaid costs that the State agency claimed which totaled approximately \$413 million (approximately \$273 million Federal share) was adequately supported by actual recorded expenditures. However, the State agency allocated inpatient hospital services as family planning services, which received a 90-percent enhanced rate (enhanced rate) of Federal reimbursement, through an allocation methodology which State agency officials could not explain and for which State agency officials could provide neither supporting documentation nor evidence that CMS had approved that methodology. For the quarter ended March 31, 2009, the State agency received \$43,948 in Federal reimbursement for family planning services at the enhanced rate, and we were unable to determine what portion of this amount was allowable.

We also identified several weaknesses in the procedures used by the State agency to calculate and claim Medicaid costs. Specifically, the State agency:

- used prison inmates to perform data entry of claims information that included personally identifiable information (PII) such as Social Security numbers and
- reported some expenses on the CMS-64 report for the quarter before the quarter in which the expenses were actually paid to providers.

Although the State agency's internal controls were adequate to ensure that the majority of the Medicaid costs that the State agency claimed and that we reviewed for this quarter were claimed correctly, some policies and procedures, as well as some internal controls, could be strengthened. Internal control weaknesses could result in the State agency's reporting incorrect expenditures for Federal reimbursement.

FEDERAL REQUIREMENTS

Federal regulations (42 CFR § 433.32(a)) require that the State agency “[m]aintain an accounting system and supporting fiscal records to assure that claims [reported on the CMS-64 report] for Federal funds are in accord with applicable Federal requirements....” Federal regulations (45 CFR § 92.20(a)) require States to expend and account for grant funds in accordance with relevant State laws and procedures for expending and accounting for their own funds. This regulation also states: “Fiscal control and accounting procedures of the State, as well as its sub-grantees ... must be sufficient to permit preparation of required reports and to permit the tracing of funds to a level of expenditures adequate to establish that such funds [Medicaid] have not been used in violation of the restrictions and prohibitions of applicable statutes.”

In addition, 2 CFR pt. 225 (formerly Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*), Attachment A, section A.2.a.(2), states: “Governmental units assume responsibility for administering Federal funds in a manner consistent with underlying agreements, program objectives, and the terms and conditions of the Federal award [i.e., the Medicaid program].”

UNSUPPORTED AND UNAPPROVED METHODOLOGY TO ALLOCATE INPATIENT HOSPITAL SERVICES AT THE ENHANCED RATE

CMS’s *Financial Management Review Guide Number 20* (Review Guide) states that when multiple procedures are performed during a single hospital stay and one of them is related to family planning, a State claim for Federal reimbursement must distinguish between those costs attributable to family planning services and those costs attributable to other covered services.

The State agency identified inpatient hospital claims whose primary procedures were not family planning services but which had at least one family planning code; for our audit period the costs associated with these procedures totaled \$724,624. The State agency then manually reassigned 25 percent of these costs, or \$181,156, to the category of family planning services, for which the State agency could claim Federal reimbursement at the enhanced rate. A State agency official told us that the 25-percent figure was the product of an analysis that had been conducted over 15 years before our audit period.

The State agency could not document how it had arrived at the 25-percent allocation rate; nor could the State agency provide supporting documentation or evidence that CMS had approved this allocation method. As a result, we were unable to determine the allowable portion of the \$43,948 that the State agency received for the inpatient hospital expenditures that it had reassigned as family planning services and for which it had claimed Federal reimbursement at the enhanced rate.⁴

PROCEDURAL WEAKNESSES

Use of Inmates for Data Entry of Personally Identifiable Information

The Social Security Protection Act of 2010, P.L. No. 111-318, has an effective date of December 18, 2011, and prohibits prison inmates from having access to other individuals’ Social Security numbers. The National Institute of Standards and Technology (NIST) Special Publication 800-12, *An Introduction to Computer Security: The NIST Handbook*, section 10.1.3, states: “Background screening helps determine whether a particular individual is suitable for a given position.... [T]he screening process will attempt to ascertain the person’s trustworthiness and appropriateness for a particular position.”

During the audit period, the State of Nebraska employed Nebraska Correctional Facility inmates to perform data entry of CMS 1500 forms, a procedure that gives inmates access to PII such as Social Security numbers. These inmates were incarcerated for crimes including drug use, theft,

⁴ The \$43,948 represented the difference between the amount claimed at the enhanced rate and the amount claimed at the FMAP rate (65.74 percent).

and fraud. Additionally, the State determined whether a particular inmate was suitable for this activity based upon the inmate's criminal background check. According to a State agency official, inmates who are held to be at high risk of committing fraud, bad checks, forgery, and related offenses, are excluded from participation in this activity. The amount of claims that the inmates entered for the quarter ended March 31, 2009, was approximately \$5.7 million.

Because the inmates had been convicted and incarcerated, they did not meet NIST's requirement that a person should be both trustworthy and appropriate for a particular position that involves access to PII.

State agency officials informed us that the State of Nebraska is in the process of discontinuing any practices which give prison inmates access to Social Security numbers and plans to be in compliance with the Social Security Protection Act of 2010 when it goes into effect on December 9, 2011.

Expenditures Reported Before Being Paid

45 CFR § 95.13(b) considers a State agency's expenditure for services under Medicaid to have been made in the quarter in which any State agency made a payment to the service provider. Additionally, CMS's *State Medicaid Manual*, section 2500(D)(2), states that expenditures occur when a cash payment is made to a provider.

Contrary to these Federal requirements, the State agency reported expenditures on the CMS-64 report for the quarter ended March 31, 2009, but did not make payments to providers until the following quarter. Specifically, the State agency made payments of \$27,630,069 on April 4, 2009, but reported those payments on the CMS-64 report for the quarter ended March 31, 2009. Because FMAP rates generally change on an annual basis,⁵ and because the increased FMAP rates provided by the Recovery Act were due to end on June 30, 2011, this procedural weakness created a risk that the State agency would report incorrect and inaccurate data to CMS, particularly if the State agency were to report expenditures on the CMS-64 report for the last quarter of one fiscal year but not make payments to providers until the first quarter of the following fiscal year.

INADEQUATE INTERNAL CONTROLS

Although the State agency's internal controls were adequate to ensure that the majority of the Medicaid costs that the State agency claimed and that we reviewed for this quarter were claimed correctly, some policies and procedures, as well as some internal controls, could be strengthened. Internal control weaknesses could result in the State agency's reporting incorrect expenditures for Federal reimbursement.

In particular, we identified deficiencies related to the State agency's financial and accounting policies and procedures in the following areas: reconciliations, written policies and procedures, segregation of duties, support for calculations of percentages used for expenditure reporting, and

⁵ Pursuant to section 1101(a)(8)(B) of the Act, the Secretary of Health and Human Services is required to calculate and publish yearly in the Federal Register the FMAPs for the 50 States and the District of Columbia.

information technology-related controls for the CONNECT system. In addition, we identified other vulnerabilities that can occur through the use of multiple data processing systems with multiple provider numbers for the same provider as well as the use of manual spreadsheets and manual review of transactions.

Specifically, we identified the following inadequacies in the State agency's internal controls:

- For the quarter ended March 30, 2009, the State agency did not reconcile expenditures, to ensure that they were accurately reported, until August 2010. Appendix A provides further detail on reconciliation for the period October 1, 2008, through March 31, 2010, including the dates of CMS-64 report submission to CMS, the dates of reconciliation, the number of months between CMS-64 report submission and reconciliation, and the variances in claimed expenditures. State agency officials have told us that since our fieldwork the State agency has taken steps to improve its reconciliation procedures. If the State agency does not reconcile amounts reported on the CMS-64 report to its accounting records in a timely manner, it increases the risk that the reported amounts may not be accurate.
- In addition, the State agency had no formal policies and procedures for reconciliation or for the reporting of Recovery Act-related expenditures. Policies and procedures allow employees to understand their roles and responsibilities and help them make timely and well-advised decisions, which in turn can reduce errors in employee performance of duties.
- The State agency did not segregate the duties between the preparation of the CMS-64 report and its reconciliation. This control weakness can prevent mistakes from being identified and can permit incorrect amounts to be reported on the CMS-64 report.
- Because the State agency allocated inpatient hospital services as family planning services through a methodology that State agency officials could not explain and for which State agency officials could provide neither supporting documentation nor evidence of CMS approval, the State agency was not updating the percentage adjustments used in the preparation of the CMS-64 reports in a timely manner. This control weakness can also permit incorrect amounts to be reported on the CMS-64 report.
- The State agency also used manual spreadsheet calculations in its preparation of the CMS-64 reports for each quarter. Manual calculations increase the likelihood of errors in both payments and reporting.
- The State agency did not directly pay the State portion of the Federal matching requirement to public providers;⁶ instead, the State agency calculated the total expense by dividing the Federal share paid to the public providers by the FMAP rate and reported that number to CMS on the CMS-64 report. State agency officials said that the State portion of the Federal matching requirement for public providers was paid through the Nebraska budget process; however, that payment was not recorded through the NIS data

⁶ See footnote 2.

system (payment of record for Medicaid expenditures). This internal control weakness provides another possibility that inaccurate reporting may occur.

- The State agency used multiple data systems (NIS, MMIS, NFOCUS, and CONNECT) for costs claimed on the CMS-64 report because of what State agency officials described as system limitations in the MMIS. Overlapping data systems could result in a single claim being paid more than once.
- The State agency did not have procedures to mandate that staff members who want to make changes to their CONNECT systems go through the same approval process as is in effect for changes in other claim and billing systems. This creates a system vulnerability as the CONNECT system is subject to manual manipulation without appropriate oversight.
- The State agency used more than one provider number for the same provider and manually reviewed transactions to determine their allowability. The combination of these two factors could allow a single claim to be paid more than once. Nebraska has edits in place but at times the duplicate payments are kicked out of the system, at which point they are subject only to a manual review.

RECOMMENDATIONS

We recommend that the State agency:

- work with CMS to determine what portion of the \$43,948 (Federal share) in enhanced family planning funds that it received was allowable, and submit documentation to CMS supporting the reasonableness of the methodology used to allocate expenses for inpatient hospital services at the enhanced rate;
- discontinue the use of inmates to enter manual claims data that contain personal information;
- report expenditures only during the quarters in which the payments actually occurred; and
- strengthen internal controls to ensure that Medicaid expenditures are correctly calculated, assigned, and claimed in accordance with the approved State plan.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency generally agreed with our recommendations and provided additional information as to corrective actions and improvements that it had implemented or is undertaking. With respect to our third recommendation, the State agency said that the expenditures it reported on the CMS-64 report were for "... expenses actually paid to providers within the quarter for which they were reported." The State agency also said that its processing of payments to providers "... is impacted by the timing of electronic payments ..." between the MMIS and the NIS accounting system. The State agency added that

the timeframes in which it processes payments to providers, and records those payments in its accounting system, are such that the State agency sometimes claims these payments on the CMS-64 report in a different month than the month in which the payments actually occurred.

The State agency's comments are included in their entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that our findings and recommendations remain valid. Regarding our third recommendation, the State agency said that it reported expenditures on the CMS-64 report for the same quarter in which those payments were made. However, some of the State agency's payments—specifically, some electronic fund transfers (EFT)—were in fact not reported for the quarter in which the payments were made. Although a particular claim might have been fully processed through the MMIS, the payment did not actually occur until it was processed through NIS. The State agency acknowledged that EFTs were not made until the Wednesday after the weekend during which the relevant claims were processed through the MMIS. In some cases a new quarter began during that interval, and those are the cases when, contrary to Federal regulations, the State agency did not always report expenditures during the quarter in which the payments actually occurred.

Federal regulations (45 CFR § 95.13(b)) require a State Medicaid agency to report expenditures on the CMS-64 report in the quarter in which the State agency disbursed or transferred cash to the provider. Thus, in cases when the State agency made EFTs on a Wednesday that fell in Quarter 2, for claims that had been processed through the MMIS on a prior weekend which fell within Quarter 1, the State agency should have reported those payments on the CMS-64 report for Quarter 2. To conform to these Federal regulations, the State agency must therefore revise its policies and procedures for the processing of payments to ensure that expenditures made in a quarter are reported on that quarter's CMS-64 report.

APPENDIXES

APPENDIX A: Summary of Standard Form CMS-64 Reconciliations

CMS-64 Report ¹ Quarter ended	Date CMS-64 Filed with CMS ²	Date Nebraska Reconciled Quarter	Months Between CMS-64 Submission and Reconciliation	Variance with Claimed CMS-64 Expenditures
12/31/2008	5/15/2009	September 2010	16 months	\$ 983
3/31/2009	6/11/2009	August 2010	14 months	\$ 10,227,619
6/30/2009	8/14/2009	January 2010	6 months	\$ 48,684
9/30/2009	11/17/2009	November 2010	12 months	\$ 1,455,865
12/31/2009	2/19/2010	March 2010	1 month	\$ 3,019,701
3/31/2010	5/3/2010	May 2010	0 months	\$ 3,462,977

¹ Standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program

² Centers for Medicare & Medicaid Services

APPENDIX B: STATE AGENCY COMMENTS



Division of Medicaid and Long-Term Care

State of Nebraska

Dave Heineman, Governor

October 7, 2011

Patrick J. Cogley
 Regional Inspector General for Audit Services
 Office of Inspector General
 Department of Health and Human Services, Region VII
 601 East 12th Street, Room 0429
 Kansas City, Missouri 64106

RE: Report Number A-07-11-02759

Dear Mr. Cogley:

The Nebraska Department of Health and Human Services (DHHS) Division of Medicaid and Long-Term Care is pleased to have the opportunity to respond to the Draft Audit Report entitled *Review of the Quarterly Medicaid Statement of Expenditures for The Medical Assistance Program in Nebraska*. DHHS strives to report Medicaid expenditures in compliance with current Federal and State law, policies, and procedures and is committed to working to resolve issues identified in this audit review.

DHHS is also appreciative of the hard work on the part of the OIG staff to gather information from the DHHS staff. Your observations are important in helping improve policies and procedures already in place and ensure continued compliance. DHHS' specific responses to each of the preliminary findings and recommendation identified in the Draft Audit Report follow:

OIG RECOMMENDATION #1: Work with CMS to determine what portion of the \$43,948 (Federal share) in enhanced family planning funds that it received was allowable, and submit documentation to CMS supporting the reasonableness of the methodology used to allocate expenses for inpatient hospital services at the enhanced rate.

DHHS RESPONSE: DHHS agrees to work with CMS to determine what portion of the \$43,948 (Federal share) in enhanced family planning funds is allowable and obtain approval of a methodology to allocate expenses for inpatient hospital services at the enhanced rate.

OIG RECOMMENDATION #2: Discontinue the Use of Inmates to enter manual claims data that contain personal information.

DHHS RESPONSE: As a result of the passage of the Social Security Number Protection Act of 2010, the Department reviewed its contract with the Department of Corrections Cornhusker State Industries (CSI) for data entry services of some Nebraska Medicaid claims. A notice of termination was sent to CSI on June 29, 2011, and the contract was formally terminated as of August 12, 2011.

All manual claims data for Nebraska Medicaid are now done by a combination of full time and temporary State workers within the Medicaid Claims Unit located in the DHHS Central Office in Lincoln, NE.

OIG RECOMMENDATION #3: Report expenditures on the CMS-64 for the quarter in which the expenses were actually paid to providers.

DHHS RESPONSE: The expenditures reported on the CMS-64 are for expenses actually paid to providers within the quarter for which they were reported. The processing of payments is impacted by the timing of electronic payments between the Medicaid Management Information System (MMIS) and the Nebraska Information System (NIS), the State's accounting system. When a payment is made in MMIS, paper vouchers in NIS show a payment date of the Monday after the weekend of processing. For electronic claims, the NIS payment date is the Wednesday after the weekend of processing. When the Wednesday falls on the 1st or 2nd, the NIS payments will not match MMIS payments for a given month. April 1, 2009, was a Wednesday, so payments in NIS with that payment date were actually included in the March 2009 reports. The payments were processed in MMIS in March 2009, with the appropriate March 2009 match rate.

OIG RECOMMENDATION #4: Strengthen internal controls to ensure that Medicaid expenditures are correctly calculated, assigned, and claimed in accordance with the approved State plan.

DHHS RESPONSE: DHHS plans to continue to build on the improvements already implemented to ensure that Medicaid expenditures are correctly calculated, assigned, and claimed in accordance with the approved State plan. As discussed with the OIG auditors, measures to increase operational accuracy were being worked on during the OIG audit or are in the process of being developed.

Should you have any questions, do not hesitate to contact me.

Sincerely,



Vivianne M. Chaumont, Director
Division of Medicaid and Long-Term Care
Department of Health and Human Services