DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Washington, D.C. 20201

June 28, 2011

TO: Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: /Lori S. Pilcher/
Acting Deputy Inspector General for Audit Services

SUBJECT: Nebraska Medicaid Payments for Personal Care Services (A-07-10-03152)

Attached, for your information, is an advance copy of our final report on personal care services claims in the Nebraska Medicaid program. We will issue this report to the Nebraska Department of Health & Human Services within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov or Patrick J. Cogley, Regional Inspector General for Audit Services, Region VII, at (816) 426-3591 or through email at Patrick.Cogley@oig.hhs.gov. Please refer to report number A-07-10-03152.

Attachment

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

July 5, 2011

Report Number: A-07-10-03152

Ms. Vivianne Chaumont
Director, Division of Medicaid & Long Term Care
Nebraska Department of Health & Human Services
301 Centennial Mall South, 3rd Floor
P.O. Box 95026
Lincoln, NE 68509-5026

Dear Ms. Chaumont:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Nebraska Medicaid Payments for Personal Care Services*. 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Greg Tambke, Audit Manager, at (573) 893-8338, extension 30, or through email at Greg.Tambke@oig.hhs.gov. Please refer to report number A-07-10-03152 in all correspondence.

Sincerely,

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

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

NEBRASKA MEDICAID PAYMENTS FOR PERSONAL CARE SERVICES

Daniel R. Levinson
Inspector General

July 2011
A-07-10-03152

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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 (State agency) is responsible for administering the Medicaid program. Social service workers in local offices authorize personal care services (PCS) requested by beneficiaries. Authorized PCS are detailed in a Service Needs Assessment/Plan (SNA).

The State agency must comply with certain Federal and State requirements in determining and redetermining whether beneficiaries are eligible for PCS. Pursuant to section 1905(a)(24) of the Act and implementing Federal regulation (42 CFR § 440.167), PCS must be (1) authorized for an individual by a physician in a plan of treatment or in accordance with a service plan approved by the individual State; (2) provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and (3) furnished in a home or, at the State's option, in another location.

OBJECTIVE

Our objective was to determine whether the State agency claimed Federal Medicaid reimbursement for PCS from January 1, 2007, through June 30, 2009, in accordance with Federal and State requirements.

SUMMARY OF FINDINGS

The State agency did not always claim Federal Medicaid reimbursement for PCS claims in accordance with Federal and State requirements. Of the 100 paid claims in our random sample, portions of 11 claims were not allowable because of inaccurate or missing documentation, and portions of 87 claims may have been unallowable because providers' billing documentation differed significantly from the beneficiaries' SNAs. Specifically, of the 100 paid claims in our random sample, 5 claims had inaccurate or missing documentation, 81 claims had potentially unallowable costs, and 6 claims had both inaccurate documentation and potentially unallowable costs. We found no errors in 8 of the 100 claims.

In addition to our random sample, our computer data match identified 464 instances in which providers billed for PCS during the beneficiaries' inpatient hospital stays.

Based on the unallowable portions of the claims that we identified in our random sample and the results of our computer data match, we estimated that the State agency improperly claimed a total of $275,485 ($168,652 Federal share) in Medicaid reimbursement. In addition, based on the potentially unallowable portion of the claims that we identified in our random sample, we estimated that the State agency claimed $7,415,003 ($4,482,438 Federal share) for PCS that may not have been allowable in accordance with Federal and State requirements.

These errors and potential errors occurred because of inadequate prepayment and postpayment claim reviews.

RECOMMENDATIONS

We recommend that the State agency:

- refund $168,652 to the Federal Government;

- work with CMS to determine whether payment and service documentation fully complied with Federal and State requirements and, if not, determine what portion of the $4,482,438 (Federal share) in set-aside costs should be refunded to the Federal Government; and

- strengthen controls by developing policies and procedures for more substantive documentation and prepayment and postpayment claim review to ensure that PCS claims are reviewed and paid in accordance with Federal and State requirements.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency described corrective action that it had taken or planned to take. Specifically, the State agency said that it would refund $168,652 to the Federal Government and added, in reference to our second recommendation, that it would work in cooperation with CMS to address any concerns with payment and service documentation. In reference to our third recommendation, the State agency described improved controls that it had implemented or was planning to implement to ensure that Medicaid payments comply with Federal and State requirements. The State agency's comments are included in their entirety as Appendix C.

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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 (State agency) is responsible for administering the Medicaid program. The State agency's Federal medical assistance percentage (FMAP) rate ranged from 57.93 percent to 58.02 percent for claims paid from January 1, 2007, through September 30, 2008.[1] For the period October 1, 2008, through June 30, 2009, the State agency's temporarily increased FMAP under the provisions of the Recovery Act ranged from 65.74 percent to 67.79 percent.

Federal and State Requirements Related to Personal Care Services

The State agency must comply with certain Federal and State requirements in determining and redetermining whether beneficiaries are eligible for personal care services (PCS). Pursuant to section 1905(a)(24) of the Act and implementing Federal regulations (42 CFR § 440.167), PCS must be (1) authorized for an individual by a physician in a plan of treatment or in accordance with a service plan approved by the individual State; (2) provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and (3) furnished in a home or, at the State's option, in another location.[2]

Pursuant to section 1902(a)(27) of the Act, every person or institution providing services under the State plan must keep records necessary to fully disclose the extent of services provided for individuals receiving assistance under the State plan. Additionally, section 1902(a)(37)(B) of the Act requires States to have procedures for prepayment and postpayment claim review, including review of appropriate data about providers, patients, and the nature of the services for which payments are claimed.

[1] Pursuant to the American Recovery and Reinvestment Act of 2009, P.L. No. 111-5 (Recovery Act), as amended by P.L. No. 111-226, States' FMAPs were temporarily increased for the period October 1, 2008, through June 30, 2011.

[2] Federal requirements further clarify these provisions by stating that "[f]or purposes of this section, *family member* means a legally responsible relative [emphasis in original]" (42 CFR § 440.167(b)). A "legally responsible relative" is defined in 471 Nebraska Administrative Code (NAC) 15-003.02 as a spouse or parent of a child under 18 years of age.

In addition to Federal requirements, 471 NAC, chapter 15, details the State requirements for PCS.

Nebraska's Medicaid Personal Care Services Program

The NAC refers to PCS as "personal assistance services" and defines them as tasks that provide a beneficiary's activities of daily living, as well as certain other related activities (471 NAC 15-003.01). Pursuant to 471 NAC 15-003.01, the State agency administers five main categories of PCS: (1) basic personal hygiene; (2) toileting/bowel and bladder care; (3) mobility, transfers, and comfort; (4) nutrition; and (5) medications. When any of these services are essential to enable the beneficiary to remain in the home and community, certain supportive services may also be provided: specifically, housekeeping and accompanying and assisting the beneficiary during physician office visits.[3]

The State agency provides social service workers to oversee the provision of PCS in more than 100 local offices statewide. Social service workers in the local offices are responsible for authorizing PCS to Medicaid-eligible individuals. The workers use a software program called Nebraska Family On-line Client User System (N-FOCUS) for activities such as intake, eligibility determinations, payments, and monitoring ongoing services.

A Medicaid beneficiary initiates PCS by discussing his or her needs with a social service worker. If the social service worker determines that PCS are warranted, he or she develops a State-approved service plan, known as the Service Needs Assessment/Plan (SNA). The SNA authorizes specific services with designated frequencies per week, as well as an estimated amount of time to complete each service. A beneficiary's SNA may authorize the provision of PCS for up to 12 months before recertification is necessary.

Beneficiaries receive PCS after their chosen providers successfully complete the State's provider approval process. Providers record on timesheets arrival and departure times and a description of services provided. Providers may receive payment only for services provided "within the parameters" of the SNA (471 NAC 15-006.6C). Providers record timesheet hours on their billing documents in quarter-hour units (a 40-hour workweek is thus 160 quarter-hour units); the providers also attach the timesheets themselves to the billing documents as supporting documentation.[4] Providers then obtain verifying signatures from the beneficiaries, after which the providers submit billing documents and timesheets to the State agency. In turn, the State agency reviews billing document hours to ensure that providers bill within the parameters for the services and time allotments outlined in each beneficiary's SNA. The State agency then enters the approved billing documents into N-FOCUS for payment.

[3] In addition, PCS may be offered to a beneficiary under one of two circumstances: (1) when an attending physician or registered nurse determines that specialized procedures called "health maintenance activities" can be safely performed by a provider in the home and community or (2) when needed to maintain competitive integrated employment or to attend an adult day care program, a beneficiary may be provided PCS outside the home (that is, at his or her worksite, on work-related travel, or when residing in a licensed residential service program).

[4] To calculate the maximum hours billable in a week, each service's frequency is multiplied by its estimated amount of time to complete that service; the results for each authorized service are then summed.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency claimed Federal Medicaid reimbursement for PCS from January 1, 2007, through June 30, 2009, in accordance with Federal and State requirements.

Scope

We reviewed the State agency's PCS claim payments for the period January 1, 2007, through June 30, 2009. Our audit population consisted of 136,975 claims totaling $32,765,957 ($19,917,229 Federal share) that the State agency claimed for Federal reimbursement.

We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed the State agency's internal controls to the extent necessary to accomplish our objective.

We performed our fieldwork from July 2009 through June 2010 at the State agency in Lincoln, Nebraska, and at various local offices throughout Nebraska.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- held discussions with State agency officials to gain an understanding of the PCS program requirements and the State agency's role in overseeing the program;
- requested and received PCS claim data, which totaled 136,975 data records, each equaling 1 PCS claim;
- selected and reviewed a simple random sample of 100 paid claims from our population of 136,975 PCS claims (Appendixes A and B) and, for each sampled claim:
    - converted the time to complete each authorized service, as reflected on a beneficiary's SNA, into quarter-hour increments;[5]
    - calculated provider hours using the beneficiary's SNA and the provider's description of services provided;

[5] We rounded each SNA service in our random sample up to the nearest 15-minute increment. For example, brushing teeth was rounded up from 5 minutes to 15 minutes, or meal preparation was rounded up from 20 minutes to 30 minutes.

- reviewed the beneficiary's case file;
- compared billing documents with attached timesheets to identify errors; and
- determined the amount in error for each of the 100 sampled claims;

- performed a computer data match comparing periods when beneficiaries were hospital inpatients with the service periods for which providers billed for PCS and identified 464 instances (outside of our random sample) in which providers billed for PCS during the beneficiaries' inpatient hospital stays;

- for each instance with matching service periods,[6] reviewed and verified the service periods in which beneficiaries were hospital inpatients and compared the service periods that providers billed to the corresponding beneficiaries' inpatient hospital stays;[7]

- computed the overpayment amount by estimating the unallowable errors at the lower limit of the 90-percent confidence interval and adding the results of the errors identified in the data match; and

- discussed our results with State agency officials on September 16, 2010.

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

The State agency did not always claim Federal Medicaid reimbursement for PCS claims in accordance with Federal and State requirements. Of the 100 paid claims in our random sample, portions of 11 claims were not allowable because of inaccurate or missing documentation, and portions of 87 claims may have been unallowable because providers' billing documentation differed significantly from the beneficiaries' SNAs. Specifically, of the 100 paid claims in our random sample, 5 claims had inaccurate or missing documentation, 81 claims had potentially unallowable costs, and 6 claims had both inaccurate documentation and potentially unallowable costs. We found no errors in 8 of the 100 claims.

In addition to our random sample, our computer data match identified 464 instances in which providers billed for PCS during the beneficiaries' inpatient hospital stays.

[6] The term "service period" refers to the timespan of 1 or more days a provider billed for PCS. For the data match, we identified 1,307 periods when beneficiaries were hospital inpatients. We compared those periods with service periods for which providers might have billed for PCS.

[7] Because a beneficiary could have received PCS on the date of admission and/or date of discharge of an inpatient hospital stay, we excluded those matches from our review.

Based on the unallowable portions of the claims that we identified in our random sample and the results of our computer data match, we estimated that the State agency improperly claimed a total of $275,485 ($168,652 Federal share) in Medicaid reimbursement. In addition, based on the potentially unallowable portion of the claims that we identified in our random sample, we estimated that the State agency claimed $7,415,003 ($4,482,438 Federal share) for PCS that may not have been allowable in accordance with Federal and State requirements.

These errors and potential errors occurred because of inadequate prepayment and postpayment claim reviews.

UNALLOWABLE AND POTENTIALLY UNALLOWABLE COSTS

Unallowable Costs

Federal and State Requirements

Section 1902(a)(27) of the Act states that every person or institution providing services under the State Medicaid plan must keep records necessary to fully disclose the extent of services provided to individuals receiving assistance under the State plan.

Section 1902(a)(37)(B) of the Act requires States to have procedures for prepayment and postpayment claims review, including review of appropriate data about providers, patients, and the nature of the services for which payments are claimed.

State requirements (471 NAC 15-006.06C) state 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 SNA.

State requirements (471 NAC 15-006.06) state that to receive payment after PCS are provided, the provider must complete a billing document for each client receiving services for the same time period as that reflected on the timesheet for that client.

Inaccurate or Missing Documentation

Our review of the 100 paid claims in our random sample showed that portions of 11 claims totaling $941 ($552 Federal share) were not allowable because of inaccurate or missing documentation. Based on our random sample, we estimated that the State agency claimed $229,636 ($141,088 Federal share) for PCS that were not allowable in accordance with Federal and State requirements.

Inaccurate Provider Billing

For eight claims totaling $175 ($108 Federal share), entries on providers' billing documents as to time spent providing PCS did not agree with the corresponding entries on the providers' weekly timesheets. The following examples illustrate the incorrect entries:

- Provider A documented 2 days of service on the timesheet at 5 hours per day, for a total of 10 hours. However, the provider billed 16 hours on the billing document. Because the provider's timesheet indicated that 10 hours were provided, 6 hours were unallowable.

- Provider B documented 3 hours of service on the timesheet. However, the provider billed 4 hours on the billing document. Because the provider's timesheet indicated that 3 hours were provided, 1 hour was unallowable.

Duplicated Provider Billing

For one claim totaling $355 ($206 Federal share), the provider used the same timesheet to bill for more than one service period. Specifically, Provider C used the timesheet from a single service period (September 8 through September 14, 2008) as supporting documentation for at least three billing documents. Only the claims for the period September 8 through September 14, 2008, were allowable.

Missing Documentation

For two claims totaling $410 ($238 Federal share), the State agency did not provide any documentation to support the PCS claimed for Federal reimbursement. Consequently, both claims in their entirety were unallowable.

Potentially Unallowable Costs

Federal and State Requirements

Section 1902(a)(27) of the Act states that every person or institution providing services under the State Medicaid plan must keep records necessary to fully disclose the extent of services provided to individuals receiving assistance under the State plan. In addition, section 1902(a)(30)(A) of the Act requires State Medicaid plans to provide methods and procedures "… to assure that payments are consistent with efficiency, economy, and quality of care …."

State requirements (471 NAC 15-006.06) state that to receive payment for PCS, providers must complete a form that documents arrival and departure times and contains a description of services provided each day.

State requirements (471 NAC 15-003.02) state that PCS do not include services not documented in the SNA and do not include companion services, which provide for a person to be present without completing specific tasks.

Inconsistent Description of Services Provided

Our review of the 100 paid claims in our random sample showed that, 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 PCS authorized in the SNA for us to question some portion of the claim.

For example, a beneficiary's SNA approved 18 hours per week of PCS, and the provider billed for 18 hours of PCS. We compared the services documented on the provider's timesheet with the services authorized on the beneficiary's SNA. On one day, the provider billed 3 hours for washing dishes, cleaning the kitchen, mopping the floor, and cleaning the stove. Only one service (washing dishes) was authorized on the SNA. The time allotted on the SNA for washing dishes was 20 minutes, which we rounded up to 30 minutes. Although the other billed services did not match services specified on the SNA, we classified them as "cleaning other living areas," for which the SNA allotted 30 minutes. The discrepancy between the services and time allotments laid out on the SNA (1 hour) and on the timesheet and billing document (3 hours) was significant enough to call the 2-hour difference into question.

The description of the services provided did not support the services authorized on the SNA for portions of 87 of the 100 paid claims in our random sample. Without more substantive documentation, we could not determine whether the providers were providing services authorized by the SNA or whether they were providing other services that were not authorized by the SNA. Because the State agency made payments on the basis of billing documents and timesheets that differed significantly from the PCS outlined on the SNA, we are setting aside $7,415,003 ($4,482,438 Federal share) associated with the potentially unallowable portion of these claims for CMS adjudication.

UNALLOWABLE BILLING FOR PERSONAL CARE SERVICES DURING INPATIENT HOSPITAL STAYS

Section 1905(a)(24) of the Act authorizes payment for PCS "… furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease …."

State requirements (471 NAC 15-004.01) state that to be eligible for PCS, a beneficiary must meet several criteria, one of which is that he or she live in a residence that is not a hospital, nursing facility, intermediate care facility, prison, or other institution.

Our computer data match identified 464 instances in which providers billed for PCS during the beneficiaries' inpatient hospital stays. The State agency improperly claimed $45,849 ($27,564 Federal share) for these 464 instances.[8]

For example, a beneficiary suffered a stroke and was a hospital inpatient from April 20 through April 24, 2008. The provider billed $491 ($285 Federal share) for services rendered to the beneficiary for the period April 16 through April 22, 2008. On April 21 and April 22, 2008—days on which the beneficiary was an inpatient—the provider billed for the following services: made breakfast, administered medications, bathed, dressed, pinned hair, changed bedding, washed laundry, made lunch, cleaned, made dinner, and dressed for bed. There was an overlap of services (both inpatient hospital services and PCS) on these 2 days, resulting in an improper payment of $181 ($105 Federal share).

[8] In computing these unallowable costs, we did not use the dates of admission and/or dates of discharge of inpatient stays.

INADEQUATE CONTROLS

These errors may continue to occur unless prepayment and postpayment claim review is strengthened. According to State agency officials, providers are not subject to regular oversight visits by the State agency. Oversight of providers is generally performed by beneficiaries themselves, who confirm the accuracy of their providers' billing documentation; the State agency verifies that the hours worked fell within the parameters authorized by the SNA and then processes the documentation for payment based on the beneficiaries' confirmation. State agency staff members conduct varying levels of review as part of this payment process. In addition, we were not able to identify any policies and procedures that governed State agency review of billing documentation, particularly with respect to services provided.

UNALLOWABLE MEDICAID REIMBURSEMENT

Based on the unallowable portion of the claims that we identified in our random sample and the results of our computer data match, we estimated that the State agency improperly claimed a total of $275,485 ($168,652 Federal share) in Medicaid reimbursement. In addition, based on the potentially unallowable portion of the claims that we identified in our random sample, we estimated that the State agency claimed $7,415,003 ($4,482,438 Federal share) for PCS that may not have been allowable in accordance with Federal and State requirements.

RECOMMENDATIONS

We recommend that the State agency:

- refund $168,652 to the Federal Government;

- work with CMS to determine whether payment and service documentation fully complied with Federal and State requirements and, if not, determine what portion of the $4,482,438 (Federal share) in set-aside costs should be refunded to the Federal Government; and

- strengthen controls by developing policies and procedures for more substantive documentation and prepayment and postpayment claim review to ensure that PCS claims are reviewed and paid in accordance with Federal and State requirements.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency described corrective action that it had taken or planned to take. Specifically, the State agency said that it would refund $168,652 to the Federal Government and added, in reference to our second recommendation, that it would work in cooperation with CMS to address any concerns with payment and service documentation. In reference to our third recommendation, the State agency described improved controls that it had implemented or was planning to implement to ensure that Medicaid payments comply with Federal and State requirements. The State agency's comments are included in their entirety as Appendix C.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of paid claims representing personal care services (PCS) provided by a beneficiary's chosen provider and paid by the Nebraska Department of Health & Human Services (State agency) for the period January 1, 2007, through June 30, 2009.

SAMPLING FRAME

The sampling frame was a database of 136,975 lines of paid claims totaling $32,765,957 ($19,917,229 Federal share) representing PCS provided by a beneficiary's chosen provider and paid by the State agency for the period January 1, 2007, through June 30, 2009.

A paid claim is an individual line from the provider billing document that indicates when the service was provided, the payment amount, the claim identification, the line number, the service period, the recipient (beneficiary), and the provider involved. For example, a provider's billing document had five lines of data. Each line represented a service period. Every service period represented one line in our database (a paid claim).

SAMPLE UNIT

A sample unit was one line of a provider billing document (for PCS during a given time period) paid by the State agency.

SAMPLE DESIGN

We used a simple random sample from the 136,975 claims that the State agency submitted for Federal reimbursement for the period January 1, 2007, through June 30, 2009.

SAMPLE SIZE

We selected 100 sample units (claims) for review.

SOURCE OF THE RANDOM NUMBERS

We generated random numbers using the Office of Inspector General, Office of Audit Services, statistical software RAT-STATS.

ESTIMATION METHODOLOGY

We used the variable appraisal program in RAT-STATS to estimate the unallowable payments for PCS. Because the Federal medical assistance percentage (FMAP) matching rate varied from year to year, we also used the RAT-STATS variable appraisal program to estimate the total FMAP reimbursed to Nebraska for unallowable PCS. We calculated the FMAP amount for each sample item by applying the applicable FMAP rate to the total amount determined to be in error for the sample item.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS

	Frame Size	Value of Frame	Sample Size	Number of Errors	Total Value of Sample	Value of Errors (Federal Share)
Unallowable	136,975	$32,765,957	100	11	$22,302	$552
Potentially unallowable	136,975	32,765,957	100	87	22,302	3,893

ESTIMATES OF UNALLOWABLE AND POTENTIALLY UNALLOWABLE PAYMENTS

(Limits Calculated for the 90-Percent Confidence Interval)

	Unallowable Costs	Potentially Unallowable Costs
Point estimate	$756,141	$5,331,810
Lower limit	141,088	4,482,438
Upper limit	1,371,195	6,181,183

APPENDIX C: STATE AGENCY COMMENTS

Nebraska Department of Health and Human Services

Division of Medicaid and Long-Term Care

State of Nebraska

Dave Heineman, Governor

May 20, 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-07-10-03152

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 *Nebraska Medicaid Payments for Personal Care Services*. DHHS strives to administer Medicaid reimbursement in compliance with current Federal and State law, policies, and procedures and is committed to working to resolve the issues identified in this audit review.

DHHS is also appreciative of the hard work on the part of OIG staff to gather information from staff and providers. 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 recommendations identified in the Draft Audit Report follow.

OIG RECOMMENDATION #1: Refund $168,652 to the Federal Government for unallowable Personal Care Services (PSC) claims.

DHHS RESPONSE: DHHS will refund this amount to the federal government.

OIG RECOMMENDATION #2: Work with CMS to determine whether payment and service documentation fully complied with Federal and State requirements and, if not, determine what portion of the $4,482,438 (Federal share) in set-aside costs should be refunded to the Federal Government.

DHHS RESPONSE: Nebraska Medicaid payment and service documentation is in compliance with Federal and State requirements. DHHS will work in cooperation with CMS to address any concerns with payment and service documentation.

OIG RECOMMENDATION #3: Strengthen controls by developing policies and procedures for more substantive documentation and prepayment and post-payment claim review to ensure that PCS claims are reviewed and paid in accordance with Federal and State requirements.

DHHS RESPONSE: DHHS plans to continue to build on the improvements already implemented to ensure that Medicaid payment complies with Federal and State requirements. As discussed with the OIG auditors, several measures to increase operational efficiency and accuracy were enacted prior to the audit or are currently being developed, including the following:

1) In April 2008, a Memo was sent from the Director of the Division of Medicaid and Long-Term Care to the DHHS Service Areas to clarify that payment for PSC during an inpatient stay in a hospital, nursing or intermediate care facility institution for mental disease is not allowable pursuant to federal or state regulations.
2) In May 2009, DHHS terminated the PSC contract with the Eastern Nebraska Office on Aging. Several of the issues identified by this audit occurred during the time of this contract.
3) DHHS is in the process of systematically moving to Universal caseloads and away from assigned caseloads. This will provide variance in PSC client assessments and billing document review and should address the OIG auditors' concern about caseworker bias or fraud in relation to clients on their caseload.
4) DHHS is reviewing processes and procedures and making recommendations on strategies for increasing statewide uniformity and consistency for services that use individual providers.
5) DHHS is exploring options to identify and deny inappropriate PSC claims, including duplication with inpatient stays.
6) DHHS is exploring options to modify PSC billing processes to improve accuracy and compliance.

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

Sincerely,

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