

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NEBRASKA CLAIMED ALMOST ALL
MEDICAID PAYMENTS FOR TARGETED
CASE MANAGEMENT SERVICES IN
ACCORDANCE WITH FEDERAL
REQUIREMENTS BUT CLAIMED SOME
UNALLOWABLE DUPLICATE PAYMENTS**

*Inquiries about this report may be addressed to the Office of Public Affairs at
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Amy J. Frontz
Deputy Inspector General
for Audit Services

December 2020
A-07-19-03239

Office of Inspector General

<https://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.

Report in Brief

Date: December 2020

Report No. A-07-19-03239

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

Targeted Case Management (TCM) services assist specific State-designated Medicaid groups in gaining access to medical, social, educational, and other types of services. Previous OIG audits found that some States did not always claim Federal Medicaid reimbursement for TCM services in accordance with Federal and State requirements.

Our objective was to determine whether Nebraska claimed Federal Medicaid reimbursement for TCM services during Federal fiscal years (FYs) 2016 through 2018 in accordance with Federal and State requirements.

How OIG Did This Audit

During this period, Nebraska processed claims totaling \$87.7 million (\$45.4 million Federal share) through the Medicaid Management Information System (MMIS), a computerized payment and information reporting system.

We reviewed documentation for a stratified random sample totaling 150 TCM paid claims to determine whether the services provided were allowable, recipients receiving services were eligible, and case managers providing services were qualified to do so. We also compared the rates paid to the payment rates that Nebraska approved for the months in which services were rendered.

Nebraska Claimed Almost All Medicaid Payments for Targeted Case Management Services in Accordance With Federal Requirements but Claimed Some Unallowable Duplicate Payments

What OIG Found

Nebraska claimed almost all Federal Medicaid reimbursement for TCM services during FYs 2016 through 2018 in accordance with Federal and State requirements. The 150 claims we sampled had no errors with respect to services provided, recipient eligibility, or provider qualifications.

However, 6 of the 150 sampled claims were not allowable because the claims had duplicate monthly payments. In these instances, a provider received two or more monthly payments on behalf of a single recipient in a single month, which resulted in a total payment amount that exceeded the approved monthly rate. Nebraska made 164 duplicate monthly payments during our audit period, which resulted in overpayments of \$22,484 (Federal share). Nebraska made these duplicate payments because its system edits did not always prevent it from paying total monthly amounts that exceeded the approved monthly rates to providers on behalf of these recipients.

What OIG Recommends and Nebraska Comments

We recommend that Nebraska refund \$22,484 (Federal share) in overpayments to the Federal Government and implement the necessary MMIS edits to prevent and detect duplicate payments.

Nebraska agreed with both of our recommendations and said that it would refund the \$22,484 in overpayments to the Federal Government. Additionally, Nebraska described corrective actions that it had taken or planned to take to avoid future overpayments associated with duplicate payments. Specifically, Nebraska described the results of its analysis of the causes of the errors we identified. Nebraska also said that it had begun to implement necessary edits to prevent and detect duplicate payments in the future.

TABLE OF CONTENTS

INTRODUCTION 1

 Why We Did This Audit 1

 Objective 1

 Background 1

 Medicaid Program 1

 Medicaid Coverage of Targeted Case Management Services 2

 Nebraska Medicaid Program and Targeted Case Management 2

 How We Conducted This Audit 3

FINDING 3

 Federal Requirements 4

 The State Agency Made Duplicate Monthly Payments..... 4

RECOMMENDATIONS..... 5

STATE AGENCY COMMENTS..... 5

APPENDICES

 A: Audit Scope and Methodology 6

 B: Previously Issued Office of Inspector General Reports..... 8

 C: Statistical Sampling Methodology 9

 D: Sample Results 11

 E: Federal Requirements 12

 F: State Agency Comments..... 13

INTRODUCTION

WHY WE DID THIS AUDIT

Case management services assist Medicaid beneficiaries in gaining access to medical, social, educational, and other types of services. When these services are furnished to one or more specific populations within a State, they are known as Targeted Case Management (TCM) services. During Federal fiscal years (FYs) 2016 through 2018, the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care (State agency), claimed \$87.7 million (\$45.4 million Federal share) for TCM services. Previous Office of Inspector General audits (Appendix B) found that some States did not always claim Federal Medicaid reimbursement for TCM services in accordance with Federal and State requirements.

OBJECTIVE

Our objective was to determine whether the State agency claimed Federal Medicaid reimbursement for TCM services during FYs 2016 through 2018 in accordance with Federal and State requirements.

BACKGROUND

Medicaid Program

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.

States use the standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report), to report actual Medicaid expenditures for each quarter. CMS uses the CMS-64 reports to reimburse States for the Federal share of Medicaid expenditures. The amounts that States report on the CMS-64 report and its attachments must be actual expenditures with supporting documentation. The amount that the Federal Government reimburses to State Medicaid agencies, known as Federal financial participation (FFP) or Federal share, is determined by the Federal medical assistance percentage (FMAP), which varies based on a State's relative per capita income. Although FMAPs are adjusted annually for economic changes in the States, Congress may increase or decrease FMAPs at any time. During our audit period, Nebraska's FMAP ranged from 51.16 percent to 52.55 percent.

Medicaid Coverage of Targeted Case Management Services

The Social Security Act (the Act) authorizes State Medicaid agencies to provide case management services to Medicaid beneficiaries (§ 1905(a)(19)). Furthermore, the Act defines case management services as “services which will assist individuals eligible under the [State] plan in gaining access to needed medical, social, educational, and other services” (§ 1915(g)(2)).

Federal regulations (42 CFR § 440.169(b)) refer to case management services as TCM services when they are furnished to specific populations in a State. Federal regulations state that allowable TCM services include assessment of an individual to determine service needs, development of a specific care plan, referral and related activities to help the individual obtain needed services, and monitoring and followup activities (42 CFR § 440.169(d)). However, Federal regulations also state that TCM services do not include the direct delivery of the underlying medical, educational, social, or other services to which the Medicaid-eligible individual has been referred, including services such as providing transportation (42 CFR § 441.18(c)).

The CMS *State Medicaid Manual* states that FFP is not available for the specific services needed by an individual as identified through case management activities unless they are separately reimbursable under Medicaid. Also, FFP is not available for the cost of the administration of the services or programs to which beneficiaries are referred (CMS *State Medicaid Manual* § 4302.2(G)(1)).

Nebraska Medicaid Program and Targeted Case Management

In Nebraska, the State agency administers the provision and payment of Medicaid services. The State agency uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims.

The Nebraska State plan includes a Supplement that addresses the provision of TCM services (TCM State plan supplement) and that designates three target groups to receive TCM services:

- aged, blind, and disabled;
- families with children aged three and younger who have developmental delays, health care needs, or both; and
- persons with developmental disabilities.

For each target group, the TCM State plan supplement contains information about, among other things, allowable TCM services, beneficiary eligibility requirements, and case management provider qualifications.

In general, the State agency receives bills for TCM services from Medicaid providers, reviews and pays those bills, and claims Federal reimbursement for these services on the CMS-64 reports. More specifically, according to both the TCM State plan supplement and State officials, TCM services for all three target groups are billed using a 1-month unit of service, and each target group has its own approved monthly rate.¹ Therefore, providers receive a flat rate each month regardless of how many TCM services they actually provide during the month.

HOW WE CONDUCTED THIS AUDIT

We reviewed a stratified random sample totaling 150 TCM paid claims, which included claims from all three target groups.² We obtained and reviewed documentation of services provided, beneficiary eligibility, and provider qualifications to determine whether the TCM services provided and paid for complied with Federal and State requirements. We also compared the rates paid to the payment rates that the State agency approved for the months in which services were rendered.

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 objectives.

Appendix A contains details of our audit scope and methodology, Appendix C contains our statistical sampling methodology, Appendix D contains our sample results, and Appendix E contains details on the Federal requirements related to TCM.

FINDING

The State agency claimed almost all Federal Medicaid reimbursement for TCM services during FYs 2016 through 2018 in accordance with Federal and State requirements. The 150 claims we sampled had no errors with respect to services provided, beneficiary eligibility, or provider qualifications.

However, 6 of the 150 sampled claims were not allowable because the claims had duplicate monthly payments. In these instances, a provider received two or more monthly payments on behalf of a single beneficiary in a single month, which resulted in a total payment amount that

¹ TCM services for the first two target groups (aged, blind, and disabled; and families with children aged three and younger who have developmental delays, health care needs, or both) are provided by contracted providers, and the monthly rate is approved by the State agency. TCM services for persons with developmental disabilities are provided by State agency service coordinators, and the monthly rate is calculated using actual costs from the preceding State fiscal years.

² A claim encompasses all TCM services provided by a TCM provider to a single Medicaid beneficiary for a single month. A claim may therefore include multiple TCM activities and case managers.

exceeded the approved monthly rate. The State agency made 164 duplicate monthly payments during our audit period, which resulted in overpayments of \$43,330 (\$22,484 Federal share). Overpayments associated with these duplicate payments represented less than .05 percent of the TCM costs for which the State agency claimed Federal reimbursement during our audit period.

The State agency made these duplicate payments because its MMIS edits did not always prevent it from paying total monthly amounts that exceeded the approved monthly rates to providers on behalf of these beneficiaries.

FEDERAL REQUIREMENTS

If the State agency claims amounts in excess of allowable amounts (overpayments) on a CMS-64 report, it generally must refund the Federal share.³ Overpayments include duplicate monthly payments.

THE STATE AGENCY MADE DUPLICATE MONTHLY PAYMENTS

During our review of the 150 sampled claims, we noted 6 claims for which the State agency had made duplicate monthly payments to providers. In each of these six instances, a provider received two or more monthly payments on behalf of a single beneficiary in a single month, which resulted in a total payment amount that exceeded the approved monthly rate. Instead of estimating these errors, we used the payment data to determine the actual number of duplicate monthly payments that were made during our audit period. We determined that of the \$87.7 million (\$45.4 million Federal share) that the State agency claimed for TCM services rendered to the three target groups during FYs 2016 through 2018, the State agency made 164 duplicate monthly payments, which resulted in overpayments of \$43,330 (\$22,484 Federal share). Overpayments associated with these duplicate payments represented less than .05 percent of the TCM costs for which the State agency claimed Federal reimbursement during our audit period.

The State agency paid an approved monthly rate to each provider for TCM services, regardless of how many TCM services that provider actually rendered during the month. Therefore, a provider should not have received an amount that exceeded the approved monthly rate for a single beneficiary in a single month.

The State agency made these duplicate payments because its MMIS edits did not always prevent it from paying total monthly amounts that exceeded the approved monthly rates to providers on behalf of these beneficiaries. State agency officials agreed that these were duplicate payments that should not have been made. Furthermore, the State agency officials said that they would investigate more deeply the exact cause of the duplicate payments and would take steps to correct this issue. The State agency's comments on our draft report

³ The Act § 1903(d)(2) and 42 CFR § 433.312.

(Appendix F) include details as to what the State agency determined regarding the causes of these duplicate payments.

RECOMMENDATIONS

We recommend that the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care:

- refund \$22,484 (Federal share) in overpayments to the Federal Government and
- implement the necessary MMIS edits to prevent and detect duplicate payments.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with both of our recommendations and said that it would refund the \$22,484 in overpayments to the Federal Government. Additionally, the State agency described corrective actions that it had taken or planned to take to avoid future overpayments associated with duplicate payments for each target group. Specifically, the State agency described the results of its analysis of the causes of the errors we identified. The State agency also said that it had begun to implement necessary edits to prevent and detect duplicate payments in the future.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$87,679,915 (\$45,402,828 Federal share) in Medicaid payments for TCM services provided and paid for in Nebraska during FYs 2016 through 2018 (October 1, 2015, through September 30, 2018).

We reviewed a stratified random sample totaling 150 TCM paid claims, which included claims from all three target groups (footnotes 1 and 2). We obtained and reviewed documentation of services provided, beneficiary eligibility, and provider qualifications to determine whether the claims complied with applicable Federal and State requirements. Specifically, we determined whether the services provided were allowable, beneficiaries receiving services were eligible, and case managers providing services were qualified to do so. We also compared the rates paid to the payment rates that the State agency approved for the months in which services were rendered.

We did not assess the overall internal controls structure of the State agency or the Medicaid program. Rather, we limited our review of the internal controls to those applicable to our audit objective.

We conducted our audit work from August 2019 to October 2020.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, Federal and State regulations, and the State plan and TCM State plan supplement;
- held discussions with State agency officials to gain an understanding of the operation of the TCM program;
- obtained the MMIS claims payment data for TCM services provided and paid for in FYs 2016 through 2018;
- reconciled the MMIS claims payment data for TCM services to the Medicaid payments that the State agency claimed on the CMS-64 reports for FYs 2016 through 2018;
- developed a sampling frame of MMIS claims provided and paid for during FYs 2016 through 2018 and consisting of 333,764 unique TCM paid claims;
- selected a stratified random sample of 150 TCM paid claims and reviewed supporting documentation for each of these to:

- determine whether the TCM service(s) provided were allowable according to the TCM State plan supplement and whether the unit(s) charged were reasonable,
- determine whether the beneficiary was eligible for TCM services,
- determine whether the TCM provider was qualified to provide TCM services, and
- determine whether the payment rate(s) paid were accurate;
- identified all duplicate claims provided and paid for during FYs 2016 through 2018; and
- discussed the results of our audit with State agency officials on September 3, 2020.

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 objectives.

**APPENDIX B: PREVIOUSLY ISSUED
OFFICE OF INSPECTOR GENERAL REPORTS**

Report Title	Report Number	Date Issued
<i>Missouri Claimed Some Unallowable Medicaid Payments for Targeted Case Management Services</i>	<u>A-07-17-03219</u>	3/5/2019
<i>Colorado Claimed Some Unallowable Medicaid Payments for Targeted Case Management Services</i>	<u>A-07-16-03215</u>	4/4/2018
<i>North Dakota Claimed Some Unallowable Medicaid Payments for Targeted Case Management Services</i>	<u>A-07-16-03210</u>	10/27/2016
<i>Connecticut Claimed Unallowable Medicaid Payments for Targeted Case Management Services Provided to Individuals With Chronic Mental Illness</i>	<u>A-01-14-00001</u>	8/7/2015
<i>Missouri Claimed Unallowable Medicaid Payments for Targeted Case Management Services Provided to Individuals With Developmental Disabilities</i>	<u>A-07-13-03193</u>	10/30/2014
<i>Iowa Medicaid Payments for Targeted Case Management for Fiscal Years 2003 and 2004</i>	<u>A-07-06-03078</u>	11/9/2007
<i>Review of Minnesota Medicaid Reimbursement for Targeted Case Management Services for Fiscal Years 2003 and 2004</i>	<u>A-05-05-00059</u>	10/18/2007
<i>Review of Medicaid Targeted Case Management Services Provided by the Maine Bureau of Child and Family Services During Federal Fiscal Years 2002 and 2003</i>	<u>A-01-05-00004</u>	12/7/2007
<i>Review of Targeted Case Management Services Rendered by the Massachusetts Department of Social Services During Federal Fiscal Years 2002 and 2003</i>	<u>A-01-04-00006</u>	5/19/2006

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The target population consisted of unique TCM paid claims with positive Medicaid reimbursements for TCM services that the State agency provided and paid for during FYs 2016 through 2018 (October 1, 2015, through September 30, 2018).

SAMPLING FRAME

The sampling frame consisted of 333,764 unique TCM paid claims that were provided and paid by the State agency during our audit period, with a total reimbursement of \$87,679,915.37 (\$45,402,827.80 Federal share).

SAMPLE UNIT

The sample unit was one TCM paid claim (footnote 2).

SAMPLE DESIGN

We used a stratified random sample consisting of two strata. We divided the strata based on total Federal reimbursement amounts for the audit period, as shown in Table 1 below.

Table 1: Division of Strata for Sample Design

Stratum	Sample Units	Total Paid	Total Federal Share Paid Amount	Low Federal Share Paid Amount	High Federal Share Paid Amount
One	332,992	\$87,324,060	\$45,218,346	\$103.50	\$176.00
Two	772	\$355,855	\$184,482	\$207.00	\$352.00
Totals	333,764	\$87,679,915	\$45,402,828		

SAMPLE SIZE

We selected 150 unique TCM paid claims: 120 from stratum one and 30 from stratum two.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General, Office of Audit Services (OAS), statistical software (RAT-STATS).

METHOD FOR SELECTING SAMPLE ITEMS

For each stratum, we consecutively numbered the sample units. After generating the random numbers for each stratum, we selected the corresponding sample units in each stratum.

APPENDIX D: SAMPLE RESULTS

Table 2: Sample Results

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Unallowable Claims	Value of Unallowable Claims
Stratum 1	332,992	\$87,324,060	120	\$31,583	0	\$0
Stratum 2	772	\$355,855	30	\$13,844	0	\$0
Total	333,764	\$87,679,915	150	\$45,427	0	\$0

Table 3: Federal Share Sample Results

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Unallowable Claims	Value of Unallowable Claims
Stratum 1	332,992	\$45,218,346	120	\$16,393	0	\$0
Stratum 2	772	\$184,482	30	\$7,172	0	\$0
Total	333,764	\$45,402,828	150	\$23,565	0	\$0

APPENDIX E: FEDERAL REQUIREMENTS

The Act § 1903(d)(2) states: “The Secretary [of Health and Human Services] shall . . . pay to the State, in such installments as he may determine, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made”

Federal regulations (42 CFR § 433.312) state that the State agency has 1 year from the date of discovery of an overpayment to a provider to recover or seek to recover the overpayment before the Federal share must be refunded to CMS.

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES



Pete Ricketts, Governor

November 12, 2020

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

RE: OIG audit A-07-19-03239

Mr Cogley

The Nebraska Department of Health and Human Services (DHHS) agrees with the findings related to OIG audit A-07-19-03239 titled "Nebraska claimed almost all Medicaid payments for Targeted Case Management Services in accordance with federal requirements but claimed some unallowable duplicate payments". The Department agrees to refund the federal government \$22,484 and will work with CMS to complete the transaction. DHHS has also begun efforts to implement necessary edits to prevent and detect duplicate payments in the future.

If you have any questions, please contact John Meals at (402) 471-1332 or via email at john.meals@nebraska.gov.

Thank you.

Sincerely,

Jeremy Brunssen
Interim Director, Division of Medicaid and Long Term Care
Nebraska Department of Health & Human Services

cc Michael Michalski, Chief Financial Officer, NDHHS
John Meals, Comptroller, NDHHS

Nebraska Medicaid Payments for Targeted Case Management Services (A-07-19-03239)

13

OIG Finding:

Nebraska claimed almost all Federal Medicaid reimbursement for TCM services during FYs 2016 through 2018 in accordance with Federal and State requirements. The 150 claims we sampled had no errors with respect to services provided, recipient eligibility, or provider qualifications. However, 6 of the 150 sampled claims were not allowable because the claims had duplicate monthly payments. In these instances, a provider received two or more monthly payments on behalf of a single recipient in a single month, which resulted in a total payment amount that exceeded the approved monthly rate. Nebraska made 164 duplicate monthly payments during our audit period, which resulted in overpayments of \$22,484 (Federal share). Nebraska made these duplicate payments because its system edits did not always prevent it from paying total monthly amounts that exceeded the approved monthly rates to providers on behalf of these recipients.

OIG Recommendation:

We recommend that Nebraska refund \$22,484 (Federal share) in overpayments to the Federal government and implement the necessary MMIS edits to prevent and detect duplicate payments.

Nebraska DHHS Response and Corrective Action:

Developmentally Disabled (DD) Population:

The claims for targeted case management (TCM) for the DD population are processed through the NFOCUS system, a component of the state MMIS. DHHS analyzed the duplicate claims and determined these occurred due to the rare occurrence where an individual was associated with more than one master case. DHHS developed a claim edit a claim edit that will be implemented in the software release planned for December 13, 2020.

Aged and Disabled Population:

The Aged and Disabled waiver implemented a different methodology for TCM in September 2017 for the Area Agencies on Ageing and April 2018 for the Independent Living Centers (League of Human Dignity). These offices now bill for actual costs of administering TCM instead of a monthly member rate. Duplicate billing for individuals is not an issue with this methodology.

EDN Population:

TCM claims for clients served by the Early Development Network (EDN) are processed through the CONNECT system, a component of the state MMIS. A series of pre-payment checks are programmed into CONNECT to significantly reduce the likelihood of duplicate billings, including a cross check of Client ID number, billing month, office match, and billing ID number. If duplicate claims are found across these four criteria, the CONNECT system identifies these claims and sends an email to the assigned services coordinator (SC) indicating that there is a duplicate claim that must be deleted. The SC then can manually delete this claim so that it is not submitted for processing. This system was implemented in early 2016. On the rare occasion when duplicate claims occur, DHHS EDN personnel request repayment from the provider and work with the Financial Services department of NE DHHS to refund federal funds to the Medicaid program.