Committee Report, Vol. 12, No. 1

The Nebraska Medicaid Program's Collection of Improper Payments

May 2005

Performance Audit Section

Legislative Research Division
Nebraska Legislature

Legislative Performance Auditing

Legislative performance audits are designed to provide legislative oversight of state agency programs and to improve program efficiency and effectiveness. They are conducted under the supervision of the Legislative Performance Audit Committee (Committee), a special committee of the Nebraska Legislature.

Membership on the Committee includes the Speaker of the Legislature, chairpersons of the Executive Board and the Appropriations Committee, and four other members of the Legislature, chosen by the Executive Board. The Committee's responsibilities include selecting audit topics; defining the scopes of audits; adopting recommendations based on reports prepared by the Performance Audit Section (Section); holding public hearings and sponsoring legislation, as necessary, in conjunction with audits; and monitoring agency compliance with Committee recommendations.

The Section, staffed by four professional analysts, is housed within the Legislative Research Division (LRD) and supervised by the Director of Research. In conducting audits, analysts are subject to the Nebraska statutes and provisions of the Government Auditing Standards published by the Comptroller General of the United States, General Accounting Office. Statutes governing the performance audit process in Nebraska are found in Chapter 50, article 12, of the Nebraska Revised Statutes.

Copies of completed reports can be obtained from LRD (402-471-2221). Other inquiries regarding performance auditing can be addressed to the Director of Research, Cynthia Johnson.

Performance Audit Committee

Senator Chris Beutler, Chairperson
Senator Marian Price, Vice Chairperson
Speaker Kermit Brashear
Senator Pat Engel
Senator Phil Erdman
Senator Vickie McDonald
Senator Don Pederson

Performance Audit Section

Cynthia Johnson, Director
Martha Carter, Audit Manager
André Mick, Analyst
Angela McClelland, Analyst
Dan Augustyn, Legal Counsel
Sandy Harman, Committee Clerk

printed on recycled paper

Committee Report, Vol. 12, No. 1

The Nebraska Medicaid Program's Collection of Improper Payments

May 2005

Prepared by
Martha Carter

Editing
André Mick
Cynthia Johnson

PERFORMANCE AUDIT SECTION
Legislative Research Division • Nebraska Legislature
State Capitol • Box 94945 • Lincoln, NE 68509-4945 • (402) 471-2221

Table of Contents

Part I

Key Findings

Key Findings & Recommendations

Performance Audit Section Report

The Nebraska Medicaid Program's Collection of Improper Payments

In light of increasing Medicaid costs, the Legislative Performance Audit Committee (Committee) asked the Legislative Performance Audit Section (Section) to determine whether the Medicaid program is maximizing its resources by preventing improper payments to service providers; identifying improper payments that do occur; recouping improper payments and prosecuting fraud and abuse cases; and collecting post-payment reimbursements.

Findings

- In general, the Section found that **the Medicaid program has in place all the components we believe are necessary to an effective collection system**. However, the program should increase its efforts to identify and recoup improper payments caused by provider or recipient fraud. The Section identified several weaknesses in the program's provider- and recipient-fraud efforts and believes that these weaknesses exist, at least in part, because **no one is responsible for overseeing and enhancing the Medicaid program's overall approach to provider- and recipient-fraud cases**.

- Medicaid program staff members report that **many health insurance companies are uncooperative** with the program's efforts to determine whether an insurance company or the Medicaid program is liable for a Medicaid recipient's services.

Recommendations

In order to resolve the issues identified above, the Section recommended that:

- The Medicaid program **designate a person or unit to oversee and enhance the program's efforts to identify and recover improper payments caused by fraud**. Although the program does not directly administer all of the entities involved in these efforts, it could exert more leadership in this area than it has to date; and

- The Committee **monitor the level of cooperation between private health insurance companies and the Medicaid program and, if necessary, introduce legislation** in the 2005 legislative session to establish penalties for noncompliance.

Committee Action

The Committee agreed that the Section's recommendations were necessary at the time they were made. In addition, the Committee noted that the previous agency director was dismissive of and uncooperative with the performance audit process, up to and including the Committee's September 2004 public hearing on this audit. However, the agency's new director, Mr. Richard Nelson, subsequently has implemented all of the Section's recommendations. Consequently, the Committee found adoption of those recommendations unnecessary. The

Committee greatly appreciates Mr. Nelson's efforts and his cooperative approach to working with the Committee.

In addition, during the 2005 legislative session, and at the request of the Health and Human Services Finance and Support Agency, the Legislative Performance Audit Committee introduced LB 589 to establish penalties for insurers who do not cooperate with the Medicaid program in determining whether the program or the insurer is liable for payment of a recipient's medical bills.

Legislative Performance Audit Committee
Nebraska Legislative Research Division **May 2005**

Part II

Performance Audit Section Report

Performance Audit Section Report

The Nebraska Medicaid Program's Collection of Improper Payments

---

Prepared by
Martha Carter

Editing
André Mick
Cynthia Johnson

PERFORMANCE AUDIT SECTION
Legislative Research Division • Nebraska Legislature
State Capitol • Box 94945 • Lincoln, NE 68509-4945 • (402) 471-2221

CONTENTS

INTRODUCTION

The federally-established Medicaid program, which is jointly funded by the federal and state governments, provides health coverage to eligible members of low-income families and certain disabled individuals. The program contracts with health care providers to deliver services to its clients and reimburses the providers for part of the service cost. As a condition of participation in the program, providers must accept the reimbursement as full payment for the service and are prohibited from attempting to obtain the difference from the Medicaid clients.

In Nebraska, as in many other states, Medicaid program costs are increasing at a rate that may soon be unsustainable. The Legislature has enacted a number of program changes to reduce costs, but those efforts have not significantly slowed the program's rate of growth. The problem of high program costs is compounded by record-low state revenue.

Faced with increasing Medicaid costs and decreasing state revenue, the Legislative Performance Audit Committee asked the Legislative Performance Audit Section to determine whether the Medicaid program is maximizing its resources by preventing improper payments to service providers; identifying improper payments that do occur; recouping improper payments and prosecuting fraud and abuse cases; and collecting post-payment reimbursements.

To address the committee's concerns, we identified the components of a reasonable collection system and assessed whether Nebraska's Medicaid program embraces each of these components. We also assessed whether the program's efforts in each area are sufficient to meet federal and state requirements. Finally, in the areas in which data was readily available, we assessed whether those efforts are cost-effective. When we identified areas that we believed could be improved, we made recommendations for doing so.

In Section I of this report, we describe the Nebraska Medicaid program. In Section II, we describe the components of a reasonable collection system. In Sections III through V, we describe the Nebraska program's efforts to address each component and introduce our findings. In Section VI, we summarize our findings and present our recommendations.

We appreciate the cooperation and assistance provided by staff members in the Medicaid program and related programs.

SECTION I: The Medicaid Program

In 1965, the federal government created the Medicaid program to provide health coverage to eligible members of low-income families and certain disabled individuals. State participation in the program is voluntary, but all states have Medicaid programs.

The federal government requires state Medicaid programs to meet numerous requirements in exchange for significant financial assistance. In some areas, such as the criteria for eligibility and services covered, states may go beyond federal thresholds, and many have done so. Consequently, each state program is unique.

Administration, Funding, and Per-Person Cost

In Nebraska, the Medicaid program is administered by the Health and Human Services System (HHSS), principally via its Finance and Support Agency. However, two other agencies fall under the HHSS umbrella (the Regulation and Licensure Agency and the Health and Human Services Agency), and each of them is responsible for Medicaid-program functions.

In FY2002-03, the total cost of Medicaid services and program administration was more than $1.4 billion, of which the federal government paid almost $909 million (or about 64 percent). The state paid the remaining $505 million, mostly from state general funds.

In FY2002-03, the Medicaid program covered more than 200,000 individuals, or about 12 percent of the state population. Generally speaking, the groups eligible for Medicaid coverage are:

- Low-income Children (Children);
- Adults Related to Certain Low-income Children;
- the blind or disabled; and
- the aged.

An average of monthly eligibility figures for FY2002-03 shows that the Children group was the largest but had the lowest per-person cost. In contrast, the Aged group was the smallest but had the highest per-person cost. These figures and comparable figures for the other groups are shown in Table 1, on page 2.

Table 1. FY2002-03 Average Monthly Medicaid Population By Eligibility Category, Cost Per Category, and Cost Per Person

Eligibility Category	Number	Dollars Spent (in millions)	Per-Person Cost
Children	131,525 (65.3%)	$ 27 (26.9%)	$ 206
Aged	18,401 (9.1%)	$ 29 (29.3%)	$ 1,600
Adults Related to Certain Low-Income Children	24,963 (12.4%)	$ 8 (8.0%)	$ 322
Blind & Disabled	26,644 (13.2%)	$ 36 (35.8%)	$ 1,349
Total	**201,533 (100.0%)**	**$ 100 (100.0%)**	**NA**

Source: The Section calculated the per-person cost based on recipient and cost data made available by the HHSS Finance and Support Agency.

In FY2002-03, the most expensive service covered by Medicaid was nursing home care, which cost the state more than $343 million, or about 28 percent of total Medicaid expenditures that year. For all long-term care services, the program expended more than $481 million, or about 40 percent of the Medicaid program's total outlay that year.

The significance of long-term care costs is discussed in Section V.

SECTION II: Components of an Effective Collection System

In keeping with the scope statement for this audit, we assessed whether the Nebraska Medicaid program has an effective system for: (1) preventing improper payments to service providers; (2) identifying and recouping any improper payments that do occur; and (3) collecting "post-payment reimbursements." In each of these areas, we identified processes or "components" the system should have in place, which we refer to collectively as the *components of an effective collection system*. We also assessed whether the Nebraska system incorporates each component.

Identifying the Components of an Effective Collection System

To identify the components of an effective collection system, we reviewed federal Medicaid collection requirements and reports on Medicaid collection systems in other states. Based on this research, we identified 10 components that we believe together constitute an effective collection system. These components, grouped into the three categories described above, are listed in Figure 1.

Figure 1.
Components of an Effective Medicaid Collection System

Preventing Improper Payments

1) Enforce recipient-eligibility criteria;
2) Enforce provider-enrollment criteria;
3) Determine third-party liability;
4) Review claims prior to payment; and
5) Identify the extent and causes of improper payments.

Recouping Improper Payments

6) Identify and investigate questionable payments;
7) Recoup payments administratively; and
8) Refer fraud cases for prosecution.

Collecting Post-Payment Reimbursements

9) Maximize prescribed drug rebates; and
10) Maximize recovery from estates.

FINDING: The Nebraska Medicaid program's collection system includes all the components determined to be necessary to an effective system.

The Nebraska Medicaid Program and the Components of an Effective Collection System

After identifying the components of an effective collection system, we assessed whether the Medicaid program's collection system incorporates each one. Based on extensive interviews with program staff, we determined that it does. We also found that, although the Medicaid program administers most of the components, some are administered by programs in the other two HHSS agencies. Figure 2, on page 5, lists the agencies and the collection-system components undertaken by each.

The Efficacy of HHSS Efforts in Implementing the Identified Collection-System Components

Having concluded that all necessary components are incorporated in the Medicaid program's collection system, we then assessed how well the system implements them. For each component, we determined whether the program's efforts: (1) meet major federal requirements, state statutory requirements, and common practice standards; and (2) are cost-effective, based on available data.

In the next three sections, we describe each component and report our findings regarding HHSS efforts in each area.

Figure 2. Medicaid Collection Functions In Each of the Health and Human Services System Agencies

Finance and Support Agency

The Medicaid Division administers the Medicaid program. Within this division the:

- Claims Processing Division enrolls most providers; pursues third-party reimbursements; and reviews claims prior to making payment.
- SURS Unit investigates provider fraud and recipient misuse of coverage.
- Pharmacy staff members pursue prescribed-drug rebates.
- Estate recovery staff member pursues the recovery of money from the estates of deceased Medicaid clients.

Health and Human Services Agency

- OEFS staff members in local offices determine applicants' eligibility.

Regulation and Licensure Agency

- SIU investigates recipient fraud.
- PER Unit reviews a portion of HHSS staff members' eligibility determinations.

Abbreviations: SURS—Surveillance and Utilization Review Subsystem; OEFS—Office of Economic and Family Support; SIU—Special Investigations Unit; and PER—Program Evaluation and Review.

SECTION III: Preventing Improper Payments

For most services, the Medicaid program makes a reimbursement payment to the health care provider who delivered the service to a Medicaid recipient.[1] Federal and state regulations restrict these payments in many ways, and we define the term "improper payment" broadly to include a payment that violates any of these statutory or regulatory standards. Preventing improper payments is important because it is more cost-effective than trying to recoup such payments after they have been made.

We identified five components of an effective collection system related to preventing improper payments. To prevent such payments, the program should: (1) enforce recipient-eligibility criteria; (2) enforce provider-enrollment criteria; (3) determine third-party liability; (4) review claims prior to payment; and (5) identify the causes of improper payments that have already occurred. Following is a discussion of each of these components.

Enforcing Recipient-Eligibility Criteria

Federal and state regulations restrict Medicaid coverage to individuals who meet certain eligibility criteria, including having assets and resources valued below set limits. By enforcing these criteria, the program prevents payments for services delivered to individuals that the program was not designed to assist.

Enforcing Medicaid eligibility criteria is one of the collection-system components that is not administered directly by the Medicaid program. Instead, it is the responsibility of the Health and Human Services Agency (HHS Agency). The HHS Agency has local offices across the state, and staff members in those offices determine applicants' eligibility for Medicaid, as well as for other public assistance programs.

In processing Medicaid-eligibility determinations, the HHS Agency staff relies in part on a computer system that compares an individual applicant's information to the Medicaid program's eligibility criteria. If a staff member incorrectly enters the applicant's information into the computer system, it may make an improper determination. As a result, an ineligible recipient may receive Medicaid coverage.[2]

[1] The program pays for the remaining services via a Health Maintenance Organization (HMO). For services delivered by the HMO, the program pays a flat monthly rate for each recipient, which covers any services the recipient needs that month. The program assesses these rates quarterly and adjusts for any improper payments that occurred.

[2] It is also possible for the system to incorrectly determine that an applicant is ineligible.

External Review of Eligibility Determinations

To assess the extent of Medicaid-eligibility determination errors, federal regulations require that an external entity review a sample of the determinations. The Program Evaluation Review Unit (PER Unit), within in the HHSS Regulation and Licensure Agency, conducts these reviews monthly. If it finds an error, the unit reports it to the staff member responsible for the case and his or her supervisor. However, neither the Health and Human Services Agency staff member nor the supervisor is required to report whether the identified error had any impact on the recipient's eligibility. Federal regulations do not require such reporting, but we believe that doing so would increase the overall effectiveness of the external recipient-eligibility reviews by holding workers and supervisors accountable for their responses to identified problems.

FINDING: The PER Unit's external recipient-eligibility reviews could be used more effectively.

Periodic Internal Recipient-Eligibility Reviews

By state statute, HHS Agency staff members must periodically review the circumstances of individuals who already have Medicaid coverage. If a recipient's financial circumstances change, he or she may no longer be eligible for Medicaid.

To assist the HHS Agency staff with this process, the computer system notifies the relevant staff member when a case for which he or she is responsible is eligible for review. The staff member is responsible for reviewing the case and entering the review date in the computer.

FINDING: In the timeframe for this audit, we could not assess whether internal recipient-eligibility reviews are occurring periodically, as required by state statute.

We had hoped to use this computer data to assess whether these reviews are, in fact, being conducted in accordance with the timeframes established by statute. However, we determined that we could not rely on this data without reviewing the supporting case-file documentation. We were unable to undertake such a review in the timeframe of this audit.

Enforcing Provider-Enrollment Criteria

In addition to preventing payments for services received by ineligible individuals, the program should also prevent payments to ineligible providers. The Medicaid program's Claims Processing Division (division), within the Finance & Support Agency, enrolls most providers.[3] As required by federal regulation, the division determines whether the provider is licensed in Nebraska and is in

[3] The providers of some long-term care service are enrolled through the Office of Aging and Disability Services in the Health and Human Services Agency.

good standing with other federal health care programs, such as Medicare. These determinations are intended to screen out dishonest providers, who are more likely to try to obtain improper payments.

Provider-Enrollment Review

After initially enrolling providers, it is common practice for Medicaid programs to verify that the providers remain in good standing by periodically reenrolling them. However, the Nebraska program does not conduct such reassessments.

FINDING: The Medicaid program is not reenrolling providers as often as it should.

In a recent report, the Medicaid program's federal oversight agency raised this same point. The report found that the Nebraska program had not reenrolled providers since 1995 and recommended that it do so annually. However, according to staff, the program does not have enough personnel to conduct annual reenrollment assessments. Again, we were unable to assess the validity of this claim in the timeframe for this audit.

Determining Third-Party Liability

When a provider submits a reimbursement claim to the Medicaid program, the program's Claims Processing Division staff reviews the claim to determine whether any third party, such as a private health insurance company, is responsible for a portion of the service cost. This review is designed to prevent the program from paying for services for which it is not responsible.

When a division staff member finds that a third party is liable, he or she determines whether the other party has paid its share of the claimed costs. Once the third party has paid its share, the division pays the remainder, up to the program's limit for that service.[4]

FINDING: Some insurance companies are uncooperative with the Medicaid program's efforts to coordinate benefits, which causes an unnecessary expenditure of state funds.

For this process to be effective, insurance companies must cooperate with division staff members. While some insurance companies do cooperate, others do not. This lack of cooperation causes the unnecessary expenditure of state funds in two ways.

First, if division staff members are unaware of a recipient's private insurance coverage or are unable to confirm coverage for a particular service, the program pays for that service unnecessarily.

[4] However, in some instances, the division does not become aware of third-party coverage until after it has paid the claim. In those instances, the division attempts to recoup its costs from the third party.

Second, the time staff members spend haggling with uncooperative companies is another unnecessary expense.[5]

Prior to the 2004 legislative session, the Health and Human Services System considered introducing legislation to require insurance companies to cooperate with the Medicaid program. In response to concerns expressed by the Director of Insurance, who administers the state agency that regulates private insurance companies, HHSS did not introduce such a bill. Instead, the Director of Insurance issued a directive to health insurance companies instructing them to cooperate with the program and informing them that failure to do so could cause a company to be in violation of state statute.[6]

Reviewing Claims Prior to Payment

Once the Claims Processing Division has established that the Medicaid program is liable for a claim, it reviews the claim to ensure that it meets other requirements. First, division staff members ensure that the claim contains all information necessary for processing. If not, it is returned to the provider.

If the claim is complete, the staff member enters the claim information into the Medicaid Management Information System (MMIS) computer system, which assesses the claim for more than 100 possible errors. If a claim contains any of these errors, the claims-processing staff investigates further.

FINDING: The efficiency of the program's computer system for claims processing is questionable.

The MMIS system, which is the backbone of the claims-processing function, was created in the 1970s. We question whether a system that old can process claims efficiently. Most state Medicaid programs have newer systems or contract with a private entity to process claims. We were unable to conduct a cost-benefit analysis of upgrading this system in the timeframe for this audit, but the Finance and Support Agency has initiated a process to hire a consultant to conduct such an assessment.

Identifying the Extent and Causes of Improper Payments

An assessment of the extent and causes of improper payments would enable the program to better target its efforts to control improper payments. These assessments, which require analysis of complex eligibility-determination, medical, and claims-payment information are labor-intensive and, therefore, expensive. His-

[5] Division staff members are unable to quantify the size of this problem but report that it is increasing.
[6] Bulletin No. CB-107, *Response to Nebraska Medicaid Information Requests Required*, L. Tim Wagner, Director of Insurance, 20 January 2004.

torically, few state Medicaid programs have had sufficient incentives to undertake them.

FINDING: We commend the Medicaid program for seeking federal funding that has allowed it to assess its payment error rate. The results should provide valuable information about how the program can prevent improper payments.

A recent federal initiative significantly increased those incentives by offering grant funding to states to assess their Medicaid payment error rates. In 2002, the Nebraska Medicaid program received such a grant, and it subsequently reviewed the appropriateness and processing of more than 1,000 payments. The final report on this assessment is expected to be released in April, 2004.[7]

The federal grant program is the precursor to a pending federal regulation, which, if adopted, will require states to conduct such assessments every few years.[8] This regulation is expected to address errors in the eligibility-determination process, as well as payment errors.

[7] The assessment was conducted by the staff members of the Medicaid program's Surveillance and Utilization Review Subsystem (SURS) unit, which is responsible for cases of provider fraud.

[8] The proposed regulation is expected to be released in June or July of 2004. It will include a requirement that states "regularly" conduct these assessments. However, it is not expected to go into effect until federal fiscal year 2006, at the earliest. (Telephone conversation with Wayne Slaughter, Ph.D., PAM Project Officer, Centers for Medicare and Medicaid Studies, 4 March 2004.)

SECTION IV: Recouping Improper Payments

In Section III, we discussed preventing improper Medicaid payments. In this section, we discuss the importance of identifying and recouping improper payments that have occurred.

Even if the Medicaid program has strong prevention efforts, some improper payments will inevitably occur, due to human error or dishonest behavior that goes undetected prior to payment. To recoup improper payments, the program should: (1) identify and investigate improper payments; (2) refer fraud cases for prosecution; and (3) recoup improper payment amounts administratively if the evidence of wrong-doing is insufficient to support prosecution.

Federal regulations require the Medicaid program to investigate improper payments that appear to have been caused by provider or recipient fraud.[9] If the investigation uncovers sufficient evidence of fraud, the program must refer the case for prosecution. If the investigation does not uncover evidence of fraud, or the evidence is insufficient for prosecution, the program may still attempt to recoup the payments.

In Nebraska, two HHSS units are responsible for recouping improper payments. The Surveillance and Utilization Review Subsystem (SURS) unit in the Medicaid program is responsible for provider fraud. The Special Investigations Unit (SIU) in the Regulation and Licensure Agency is responsible for recipient fraud. Following is a discussion of each unit.

SURS Unit—Surveillance and Utilization Review Subsystem

FINDING: Due to understaffing, the SURS Unit has been unable to conduct data analyses that would identify potential fraud cases.

The SURS Unit is responsible for identifying, investigating, and recouping improper payments caused by provider fraud. Federal regulations require the SURS Unit to investigate cases that come to its attention via referrals, which often come from the Medicaid program staff members who process provider payments. Although not required by federal regulation, the federal Medicaid oversight agency also strongly encourages the SURS Unit to identify potential fraud cases through systematic analysis of payment data.

For several years, the unit has reviewed very few fraud cases identified through data analysis because it has been understaffed. Between FY1999-00 and FY2002-03, the unit never had all of its

[9] We are using the term "fraud" to cover both fraud and abuse cases as defined in federal regulations.

five full-time equivalent positions filled and working full-time on SURS cases. For example, in FY2002-03, all five positions were filled but, due to temporary reassignments of several people to other projects, the unit functioned with the equivalent of only three full-time employees.

Because of this understaffing, staff members have been unable to investigate cases from both referrals and data analysis, as required by federal regulation. Instead, they have prioritized the investigation of referrals, which they believe lead to more significant "finds."

Referral for Prosecution

If, after investigation, a SURS Unit staff member determines that an improper payment was caused by fraud, he or she must decide whether there is sufficient evidence to refer the case for prosecution. During the course of this audit, the Legislature changed the means by which provider-fraud cases will be prosecuted. In 2004, the Legislature enacted a bill that creates a Medicaid Fraud Control Unit (MFCU) in the Attorney General's office.[10] That unit will prosecute most of the state's provider fraud cases.

Prior to the establishment of the MFCU, the unit referred cases for prosecution to the Health Care Task Force, which is chaired by the regional representative of the U.S. Attorney. The SURS Unit also had a relationship with a national organization of Medicaid Fraud Control Units, which enabled Nebraska to receive a portion of settlement awards generated as a result of national provider fraud cases. In FY2002-03, the program received $563,051 as a result of these settlements.

Administrative Collections

FINDING: The SURS unit is cost-effective because it collects significantly more than the salary costs of its staff members.

In FY2002-03, the SURS Unit investigated 295 cases of suspected provider fraud. The unit pursued collection in 168 of those cases and recouped payments in 149. The unit collected a total of $770,921, or an average of more than $5,000 per case.[11] The largest single collection was $244,779.

To assess the cost-effectiveness of the unit's efforts, we compared the amount collected in FY2002-03 with the state's portion

[10] Nebraska had a MFCU previously, but its history is somewhat unclear. It is clear that, in 1995, when the federal government instituted a requirement that states have such units, Nebraska requested, and received, a waiver of that requirement. Federal regulations permit such waivers if a state shows that a fraud control unit would not be cost-effective because a minimal amount of fraud occurs in the state. The waiver remained in place until the MFCU was created again in 2004.

[11] These figures exclude the amount collected through settlements in national MFCU cases.

of SURS Unit salaries, including benefits. We found that the collections covered these salary costs and returned more than $700,000 to the General Fund.

SIU—Special Investigations Unit

While the emphasis of the SURS Unit is provider fraud, the Special Investigations Unit (SIU) is responsible for cases in which improper payments are caused by recipient fraud. The SIU investigates alleged recipient fraud in many public assistance programs, including Medicaid. The SIU identifies questionable payments exclusively through referrals.

FINDING: The Medicaid program, in conjunction with the Office of Economic and Family Support, could do more to encourage referrals of potential recipient-fraud cases.

The Health and Human Services Agency staff members who determine Medicaid eligibility are a common source of referrals to the SIU. These staff members, who have access to extensive financial information, are in a good position to notice suspicious behavior. However, we are concerned that the program may not be doing everything it can to encourage referrals from these workers. First, we found the regulations describing the circumstances in which these staff members should report cases to the SIU confusing. Second, we found that the workers receive little training in how to identify potentially fraudulent behavior or when to report such behavior to the SIU.

Referral for Prosecution

Like SURS Unit staff members, SIU staff members investigate cases and determine if an improper payment has occurred. If there is sufficient evidence of fraud, the SIU refers the case to the county attorney in the recipient's county of residence for prosecution. If the evidence is insufficient for prosecution, the SIU may attempt to collect the improper payment administratively.

Administrative Collections

FINDING: The SIU is cost-effective because it collects significantly more than the salary costs of its staff members.

Because the SIU deals with recipient fraud in several public assistance programs, it is impossible to assess whether its efforts are cost-effective in terms of its Medicaid caseload alone. In FY2002-03, the unit's five staff members closed 1,489 cases from all the programs it addresses and collected almost $1.2 million. Like SURS Unit staff, the SIU staff's salaries are funded with a combination of state and federal money. Consequently, we conclude that the SIU's efforts are cost-effective because they collect much more than the cost of their own salaries.

SECTION V: Collecting Post-Payment Reimbursements

In the previous sections, we discussed the importance of preventing and recouping improper payments made to service providers. In this section, we address a means by which the program can recoup money from third parties liable to reimburse it for payments already made to providers. We refer to these as post-payment reimbursements.

In these cases, the Medicaid program's payments were proper at the time they were made. However, if reimbursement for those payments was available, and the program failed to pursue it, the payments would be considered improper.

We identified two types of post-payment reimbursement that are components of an effective collection system: prescribed-drug rebates and estate recovery, each of which is discussed below. Following that, we briefly describe the relationship between estate recovery and long-term-care costs.

Prescribed-Drug Rebates

Following nursing home care, prescribed drugs are the highest-cost service provided by the Medicaid program. However, payments made in conjunction with the prescribed-drug program are eligible for partial rebates from pharmaceutical companies.

FINDING: Prescribed-drug rebates bring in the most revenue of all the collection efforts.

One staff member in the Finance and Support Agency's Financial Services Division pursues these rebates. In FY2002-03, the rebates returned more than $15 million to the General Fund. This amount is the largest reported as a result of any of the program's collection efforts.

Estate Recovery

Federal regulations require the Medicaid program to recoup the costs of Medicaid services from the estates of certain deceased recipients who were elderly or institutionalized at the time of death. Commonly, a recipient's home is sold after his or her death, and the sale proceeds can be used to repay the program.

One staff member in the Medicaid program is responsible for pursuing estate recoveries. The staff member identifies deceased recipients and files claims against their estates. If a relative challenges the program's claim, the case is referred to the Finance and Support Agency Legal Division. For the vast majority of the challenged claims, the estate is insufficient to cover all the claims

against it. Consequently, the Legal Division negotiates with the estate's representative to ensure that the Medicaid program receives as much as possible after higher-priority claims on the estate have been satisfied. In FY2002-03, the Legal Division negotiated eight such settlements.

FINDING: The estate recovery process is cost-effective because it collects significantly more than the salary costs of the staff member who make the recoveries.

In FY2002-03, the program collected payments from 120 estates, thereby returning $1.2 million to the General Fund. This amount is well over the cost of the estate-recovery staff member's salary and the relevant portion of a Legal Division staff member's salary. Consequently, we conclude that these efforts are cost effective.

Long-Term Care

Estate recovery is one tool the Medicaid program uses to reduce program costs for long-term care services. As described in Section 1, the costs of these services are significant. In addition, they are predicted to increase as the state population ages.

If the state continues funding long-term care services as it has been, and if costs continue to rise, there is no effective way to significantly reduce the state's expenditures in this area. While estate recovery is one tool that can help, its impact is minimal, given the overall costs of the program.

FINDING: Meaningful reduction in Medicaid expenditures will require finding a way to reduce the costs of long-term care. Payment-recovery efforts are not enough.

In 2003, the Legislature's Health and Human Services (HHS) Committee contracted for a study of the state's long-term care expenditures. The resulting report[12] suggested a number of ways to reduce costs for these services, although many would involve significant policy changes, and some would not be possible without changes in federal regulations. The HHS Committee Chairman has said he intends to follow up on these recommendations and may pursue legislation in some areas.

[12] *The Heartland Model for Long-Term Care Reform: A Case Study in Nebraska*, Center for Long-Term Care Financing, December 2003.

Part III

Committee Findings and Recommendations and Fiscal Analyst's Opinion

Performance Audit Committee Recommendations

On 25 February 2005, in accordance with Neb. Rev. Stat. sec. 50-1211(1) of the Legislative Performance Audit Act, the Legislative Performance Audit Committee (Committee) convened to consider the findings and recommendations contained in the Performance Audit Section's (Section's) draft report entitled *The Nebraska Medicaid Program's Collection of Improper Payments.*

The Committee reviewed the Section's recommendations and agreed that the recommendations were necessary and appropriate at the time they were drafted. However, subsequent to the development of those recommendations, a new agency director was appointed. The new director indicated support for all of the Section's recommendations, except one that would conflict with federal law. The Committee is gratified by this support and believes that, since the recommendations are already being implemented, it is unnecessary to adopt them. The Committee will review the agency's progress in implementing the recommendations when it receives the agency's statutorily-required implementation plan following the release of this report.

State of Nebraska

LEGISLATIVE COUNCIL

Legislative Fiscal Office
PO Box 94604, State Capitol
Lincoln, NE 68509-4604

May 3, 2004

Ms. Cynthia Johnson
Legislative Research
Room 1201, State Capitol
Lincoln, NE 68509

Dear Cynthia,

I have read through the draft report, "The Nebraska Medicaid Program's Collection of Improper Payments." This document provides a good overview of the state programs that address prevention of overpayments, fraud control and collection efforts.

The Legislative Fiscal Office was requested to provide an opinion on whether the additional staff position contained in the first recommendation could be handled within existing appropriations. The salary and benefits for a fraud investigator would be approximately $36,000. Of this amount, a federal match of 50 or 75 percent would be available. General fund costs would be $9,000 to $18,000. In the past, the SURS Unit had five FTE assigned to it. The unit recently has been operating with three to four staff as positions were reassigned to address more immediate requirements such as HIPPA compliance. Bringing the unit back to its previous staffing level may more that pay for itself with additional recoveries that could be achieved.

In the recently ended legislative session, a new fraud unit was established in the Office of the Attorney General. Accompanying this bill was appropriations to cover the addition of 8.4 positions: two attorneys, 2 auditors, 2 investigators and 2.4 support staff. This unit, once functioning, should substantially assist both with the prevention of fraud and result in more aggressive collection. In light of the new responsibility and increase in resources, the additional position may not be as critical as it was before the creation of this unit.

If you require additional information or clarification, please contact me at 471-0053.

Sincerely,

Liz Hruska
Program Analyst

05031140 LH.doc

Part IV

Background Materials

BACKGROUND MATERIALS

The "background materials" are materials that (in addition to the Section's report) were available to the Committee when it issued its recommendation contained in Part III of this report. They include:

- the Section's draft findings and recommendations;
- the Agency Director's response to a draft version of the Section's report;
- the Section Director's summary of the Agency's initial response;
- additional correspondence between the Committee Chair and the Agency Director;
- a summary of testimony given at the public hearing held by the Committee; and
- a second response to the Section's draft report from the new Agency Director.

Section Draft Findings and Recommendations

In general, we found that the Medicaid program has in place all the components we determined necessary to an effective collection system. However, it could improve its efforts in some areas. To do so, the program should comply with the first recommendation below. The remaining recommendations are for consideration by the Legislative Performance Audit Committee (Committee).

Finding 1: The Medicaid program should increase its efforts to identify and recoup improper payments caused by provider or recipient fraud.

Discussion: In previous sections, we identified weaknesses in the program's provider- and recipient-fraud efforts, including:

- The failure of the SURS Unit to review potential provider fraud cases identified through systematic data analysis because of chronic understaffing;
- The question of whether the SIU has clear authority to use administrative processes to collect from Medicaid recipients who obtain services fraudulently;
- Inadequate regulations and training designed to guide and inform staff members who process eligibility determinations about the identification and referral of fraud cases; and
- The lack of accountability for errors identified through the PER Unit's reviews of eligibility determinations.

We believe that these weaknesses exist, at least in part, because no one is responsible for overseeing and enhancing the Medicaid program's overall approach to provider- and recipient-fraud cases.

Recommendation: The Medicaid program should designate a person or unit to oversee and enhance the program's efforts to identify and recover improper payments caused by fraud. Although the program does not directly administer all of the entities involved in these efforts, it could exert more leadership in this area than it has to date.

The SURS Unit, which is the federally-mandated provider-fraud unit, would be a logical choice for this responsibility. However, if this responsibility is given to the SURS Unit, the unit should also be allocated another full-time equivalent position. We believe this

position would more than pay for itself, as a result of SURS Unit collections and federal matching funds.

Whichever person or entity is assigned the responsibility, the approach taken to enhancing and coordinating fraud-based recovery efforts should include:

- Developing better policies, including improving regulatory requirements governing the responsibility of eligibility staff members to identify and refer suspected recipient-fraud cases;
- Informing staff in the Medicaid program, the SIU, and the staff members in local offices who verify eligibility of the importance of preventing, identifying, and collecting improper payments caused by fraud;
- Encouraging the development and collection of performance data that can be used for cost-benefit analyses, among other things; and
- Annually evaluating the cost-effectiveness of programs' fraud-based recovery efforts and reporting this information to the Governor and the Legislature.

Recommendation: The Committee may wish to consider introducing legislation authorizing the Special Investigations Unit to use administrative processes to collect from Medicaid recipients who obtain services fraudulently.

Finding 2: Program staff members report that many health insurance companies are uncooperative with the program's efforts to determine whether an insurance company or the Medicaid program is liable for a Medicaid recipient's services.

Recommendation: The Committee should closely monitor the level of cooperation between private health insurance companies and the Medicaid program. If the recent directive by the Director of Insurance does not lead to significant improvement, the Committee may wish to consider introducing legislation during the 2005 Legislative Session to establish penalties for noncompliance.

Finding 3: We identified three areas of concern that we were unable to audit fully in the timeframe for this audit: (1) Are eligibility workers meeting state statutory requirements for reassessing eligibility, and are there sufficient checks on their work? (2) Can the program afford to reenroll providers regularly? and (3) Should the MMIS computer system, which is the backbone of the claims-processing system, be updated?

Recommendation: The committee may wish to consider undertaking performance audits in these areas.

Finding 4: Implementing these recommendations will not significantly reduce the pressure Medicaid costs are exerting on the state budget. Nevertheless, the Medicaid program should take all cost-effective steps to reduce improper payments.

Finding 5: Significantly reducing Medicaid program costs will require reducing the program's costs for long-term care services.

Recommendation: The Health and Human Services Committee will be exploring options to reduce long-term care costs. The Legislative Performance Audit Committee may wish to follow the HHS Committee's actions in this area.

Agency Directors' Responses to the Section's Report

By law, the Legislative Performance Audit Section provides a copy of its draft report and recommendations to the agency being audited. The agency may provide written comments about the draft report, which are then included in the final audit report. Due to unusual circumstances, the current final audit report contains two agency responses. A description of those circumstances follows.

In April 2004, the Section provided its draft report to Mr. Steve Curtiss, then-Director of the HHSS Finance and Support Agency. In May, Mr. Curtiss submitted written comments, which the Legislative Performance Audit Committee found unresponsive. In an effort to ascertain the agency's position, the committee chair provided additional opportunities for Mr. Curtiss to respond, including a second opportunity to provide written comments. Mr. Curtiss did respond to these opportunities, but those responses were still unsatisfactory to the Committee. Ultimately, the Committee elected to hold a public hearing on the Section's report and recommendations.

At the hearing, Mr. Curtiss acknowledged that he had given little attention to the audit recommendations until the prospect of a public hearing arose. In his testimony, Mr. Curtiss attempted to dismiss the Section's recommendations, mischaracterizing some of them, and, in one case, providing information that was not made available to auditors during the audit.

Shortly after the hearing, Mr. Curtiss announced his resignation as agency director. In October, the Governor appointed Mr. Dick Nelson to replace him. The Committee provided all of the audit materials to Mr. Nelson and offered him the opportunity to comment on the Section's recommendations. He accepted, and his written comments, which indicate that he is implementing most of the Section's recommendations, are included in this section, along with the initial agency comments submitted by Mr. Curtiss' response.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

DEPARTMENT OF SERVICES • DEPARTMENT OF REGULATION AND LICENSURE
DEPARTMENT OF FINANCE AND SUPPORT

STATE OF NEBRASKA
MIKE JOHANNS, GOVERNOR

May 3, 2004

Cynthia Johnson, Director of Research
Performance Audit Section
Legislative Research Division
P.O. Box 94945
State Capitol
Lincoln, NE 68509-4945

Dear Ms. Johnson:

Thank you for the opportunity to comment on the draft Legislative Performance Audit report, *The Nebraska Medicaid Program's Collection of Improper Payments, April 2004.*

Staff who participated in the audit was given the opportunity to review the draft report.

The Department's comments follow:

INTRODUCTION

The following are technical corrections to the Introduction:

Page iii, 1st paragraph

The first sentence should read, "The Medicaid program, which is jointly funded by the federal and state governments, and administered by Health and Human Services Finance and Support, provides health coverage to eligible members of low-income families and certain disabled individuals".

SECTION I: The Medicaid Program (page 1)

The following are technical corrections to Section I:

Page 1, 5th paragraph:

"Other children" should be added to the eligible groups covered – this group comprises about 47% of all of the covered persons in Nebraska. Combining this group of children with ADC children (16.2%) equals a total of 63% of all covered persons in Nebraska as children.

Page 1, last paragraph

The acronym "ADC" should be omitted. ADC children comprise 16.2%, while "other" children represents 47%. Most "other" children are eligible under either CMAP (Medical Assistance Program for Children) or Kids Connection program (Title XIX or Title XXI of the Social Security Act, which are non-ADC programs).

Technical corrections to Section I continue::

Page 2

Table one lumps all children into the ADC category. These figures should be adjusted. Medicaid coverage for most children is non-ADC related.

Section II: Components of an Effective Collection Program (page 3)

Finding: The Nebraska Medicaid program's collection system includes all the components determined to be necessary to an effective system.

Response: We concur with this finding.

Section III: Preventing Improper Payments (page 7)

The following are technical corrections to Section III:

Page 7, 4th paragraph

The sentence that begins...."The OEFS has local offices across the state..." should read "The Health and Human Services System has local offices across the state..."

Page 7, 5th paragraph

The term "OEFS" should be replaced with "Health and Human Services System".

Page 8, 1st, 2nd and 3rd paragraphs

The term "OEFS" should be replaced with "Services".

Page 10, 4th paragraph

While there is a reference to the MMIS system, which is the Department's current claims processing system, it should be noted that the Department has recently released a RFP to locate a consultant to help analyze the feasibility of enhancing or replacing the current system.

Enforcing Recipient-Eligibility Criteria-*External Review of Eligibility Determinations*

Finding: The PER Unit's external recipient-eligibility reviews could be used more effectively.

Response: While it is not required, it would be helpful for the workers and/or supervisors to report what actions were taken, and whether the identified error had any impact on the client's eligibility.

Enforcing Recipient Eligibility Criteria-*Periodic Internal Recipient-Eligibility Reviews*

Finding: In the timeframe for this audit, we could not assess whether internal recipient eligibility reviews are occurring periodically, as required by state statute.

Response: Through supervisor reviews, operation of the N-Focus eligibility system, and quality assurance reviews, the Department believes reviews are being conducted in compliance with requirements. Additionally, the Department would like to reference LB239. On January 13, 2003, Senator Jim Jensen introduced LB239. This bill requires the Department of Health and Human Services Finance and Support to establish a resource test to be used in determining eligibility for the State's poverty level Medicaid children's programs. These programs include 150% Federal Poverty Level (FPL) for Pregnant Women and Infants, 133% FPL for Children age 1 to 5, 100% FPL for children 6 to 18 and for Pregnant Women and Children under 19 to 185% FPL (Title SSI). Resources, or assets, are items of personal or real property that are cash or can be converted to cash to be used for client's, their spouse's or their children's medical needs. The Health and Human services Committee conducted the hearing on this bill on January 30, 3003. LB239 was not advanced from this committee and was eventually indefinitely postponed at the end of this year's session. In response to the issues of LB239, Senator Jensen introduced the interim study, LF379, on March 30, 2004. LR379 will examine the use of a resource test on families in determining Medicaid eligibility of children and pregnant women.

Enforcing Provider-Enrollment Criteria-*Provider-Enrollment Review*

Finding: The Medicaid program is not re-enrolling providers as often as it should.

Response: Re-enrollment of Medicaid providers must be balanced against the additional provider time and expense of such requirements. The Department more narrowly focuses its enforcement efforts by conducting provider reviews for specific issues and/or complaints.

Determining Third-Party Liability

Finding: Some insurance companies are uncooperative with the Medicaid program's efforts to coordinate benefits, which causes an unnecessary expenditure of state funds.

Response: The Department is monitoring the Department of Insurance directive and will take the results into consideration in advancing future legislation.

Reviewing Claims Prior to Payment

Finding: The efficiency of the program's computer system for claims processing is questionable.

Response: In the last five years, the Department has conducted two separate reviews of the claims processing system and both found the current system to be cost-effective, and efficient. However, given the age of the current system's technology, efficiencies may be gained from more current technology. To that end, the Department has recently released a RFP to analyze the feasibility of enhancing or replacing the current MMIS system.

Identifying the Extent and Causes of Improper Payment

Finding: We commend the Medicaid program for seeking federal funding that has allowed it to assess its payment error rate. The results should provide valuable information about how the program can prevent improper payments.

Response: The project findings will be analyzed for further action, as appropriate.

Section IV: Recouping Improper Payments (page 13)

The following are technical corrections to Section IV:

Page 15, 2nd paragraph

The term "OEFS" should be replaced with "Health and Human Services System".

SURS Unit – Surveillance and Utilization Review Subsystem
SURS Unit-*Referral for Prosecution*

Finding: The SURS Unit has failed to meet an important federal requirement due to understaffing.

Response: As discussed and confirmed by Martha Carter, the SURS Unit is not in violation of any federal requirement. LB1084 was passed in the 2004 legislative session. The Department is working with the Attorney General's Office to develop a Medicaid Fraud Control Unit.

SURS Unit-Administrative Collections

Finding: The SURS unit is cost-effective when the amount of money it recovers is compared to the amount of the General Fund expenditure for unit salaries.

Response: The figures in this section were inadvertently understated. Additional collections for the SURS prepayment edit which allows the Department to impose sanctions for recoupment of future payments for identified overpayments was not included. There were 106 cases during FY2002-03 with a total of $694,197.17 in recovered overpayments.

SIU-Special Investigative Unit

Finding: The Medicaid program in conjunction with the Office of Economic and Family Support, could do more to encourage referrals of potential recipient fraud cases.

Response: The Department believes recipient fraud referrals are completed, and will continue to direct staff to refer all potential recipient-fraud referrals, as appropriate.

SIU-*Referral for Prosecution*

Finding: It is unclear whether the SIU has legal authority to use administrative processes to recoup from recipients the cost of services it paid for as a result of fraud.

Response: The Department will continue to analyze the use and value of administrative recoupment for recipient fraud purposes.

SIU-*Administrative Collections*

Finding: The SIU is cost-effective because it collects significantly more than the salary cost of its staff members.

Response: We concur with this finding.

Section V: Collecting Post-Payment Reimbursements (page 17)

Prescribed-Drug Rebates

Finding: Prescribed-drug rebates bring in the most revenue of all the collection efforts.

Response: We concur with this finding.

Estate Recovery

Finding: The estate recovery process is cost-effective because it collects significantly more than the salary costs of the staff member who make the recoveries.

Response: We concur with this finding.

On January 12, 2004, the Health and Human Services Committee introduced LB1000. This bill harmonizes the Nebraska Estate Recovery Statute with existing federal provisions. The Social Security Act at 1917(b)(2) mandates that any estate recovery may be delayed "only after the death of the individual's surviving spouse, if any, and only at the time when he (sic) has no surviving child under age 21, ...or is blind or disabled..." Currently, Nebraska provides at 68-1036.02 that "No debt to the department shall exist if the recipient dies and he or she is survived (a) by a spouse or (b) by a child who is under twenty-one years of age or is blind or totally and permanently disabled as defined by the Supplemental Security Income criteria". The Department has been advised by CMS that it can no longer extinguish liability for an estate recovery claim because the individual is survived by a spouse, or a child under 21 or is blind or disabled. CMS has advised the Department that it must follow federal law, and can only defer estate recover until the death of the spouse, death of the blind or disabled child, or until non-disabled children turn 21. There is a minimal fiscal impact because the State cannot recover decedents' estates less than $5,000. This bill adopts this change and brings 58-1036.02 into compliance with the Social Security Act. LB1005 was passed into law and will become effective July 16, 2004.

On January 13, 2003 Senator Jim Jensen introduced LB240. This bill provides changes in medical assistance. First, this bill grants Medicaid a lien on proceeds from liable third party payers, with the lien date retroactive to the time of injury. Second, not later than 14 days after appointment of a personal representative other than a special administrator, the personal representative shall give written notice of his or her appointment to the

Department of Health and Human Services Finance and Support. The Judiciary Committee conducted the hearing on this bill on January 31, 2004. This bill was not advanced from the Judiciary Committee and was indefinitely postponed at the end of this year's legislative session.

In response to the issues of LB240, Senator Jensen introduced the interim study, LR181, on March 30, 2004. LR181 will study the use of a statutory lien for third-party liability cases when Medicaid is involved and the requirement of a notice of death from personal representatives for Medicaid recipients.

Long-Term Care

Finding: Meaningful reduction in Medicaid expenditures will require finding a way to reduce the costs of long-term care. Payment-recovery efforts are not enough.

Response: The May 1997 Nursing Home Plan is being followed by the Department which has led to reduced Long term care costs. The executive and legislative branches continue to study this issue.

Section VI: Findings and Recommendations (page 19)

Finding 1: The Medicaid program should increase its efforts to identify and recoup improper payments caused by provider or recipient fraud.

Recommendation: The Medicaid program should designate a person or unit to oversee and enhance the program's efforts to identify and recover improper payments caused by fraud. Although the program does not directly administer all of the entities involved in these efforts, it could exert more leadership in this area than it has to date.

The SURS Unit, which is the federally-mandated provider-fraud unit, would be a logical choice for this responsibility. However, if this responsibility is given to the SURS Unit, the unit should also be allocated another full-time equivalent position. We believe this position would more than pay for itself, as a result of SURS Unit collections and federal matching funds.

Whichever person or entity is assigned the responsibility, the approach taken to enhancing the coordinating fraud-based recovery efforts should include:

- Developing better policies, including improving regulatory requirements governing the responsibility of eligibility staff members to identify and refer suspected recipient-fraud cases;
- Informing staff in the Medicaid program, the SIU, and the staff members in local offices who verify eligibility of the importance of preventing, identifying, and collecting improper payments caused by fraud;

- Encouraging the development and collection of performance data that can be sued for cost-benefit analyses, among other things; and
- Annually evaluating the cost-effectiveness of programs' fraud-based recovery efforts and reporting this information to the Governor and the Legislature.

Response: The Department supported plans to increase its efforts to identify and recoup improper payments caused by provider or recipient fraud. In an effort to enhance recoveries, the Department supports the Medicaid Fraud Control Unit.

Recommendation: The Committee may wish to consider introducing legislation authorizing the Special Investigations Unit to use administrative processes to collect from Medicaid recipients who obtain services fraudulently.

Response: The Department will continue to analyze the use and value of administrative recoupment for recipient fraud purposes.

Finding 2: Program staff members report that many health insurance companies are uncooperative with the program's efforts to determine whether an insurance company or the Medicaid program is liable for a Medicaid recipient's services.

Recommendation: The Committee should closely monitor the level of cooperation between private health insurance companies and the Medicaid program. If the recent directive by the Director of Insurance does not lead to significant improvement, the Committee may wish to consider introducing legislation during the 2005 Legislative Session to establish penalties for noncompliance.

Response: We agree that this issue should continue to be monitored.

Finding 3: We identified three areas of concern that we were unable to audit fully in the timeframe for this audit: 1) Are eligibility workers meeting state statutory requirements for reassessment eligibility, and are there sufficient checks on their work? 2) Can the program afford to reenroll providers regularly? and 3) Should the MMIS computer system, which is the backbone of the claims processing system, be updated?

Recommendations: The committee may wish to consider undertaking performance audits in these areas.

Response: As stated earlier, periodic eligibility reviews are being completed; routine re-enrollment of providers must be balanced with the effectiveness of that process and the provider burden such processes create; and the MMIS is under review.

Finding 4: Implementing these recommendations will not significantly reduce the pressure Medicaid costs are exerting on the state budget. Nevertheless, the Medicaid program should take all cost-effective steps to reduce improper payments.

Response: We agree that all cost-effective steps should be taken to reduce improper payments.

Finding 5: Significantly reducing Medicaid program costs will require reducing the program's cost for long-term care services.

Recommendation: The Health and Human Services Committee will be exploring options to reduce long-term care costs. The Legislative Performance Audit Committee may wish to follow the HHSS Committee's actions in this area.

Response: The executive and legislative branches continue to study this issue.

This concludes the Department's review of the draft Medicaid Performance Audit report. Please feel free to contact me if you have questions. You may also contact Cec Brady or David Cygan for further clarification on any of the above issues.

Sincerely,

Stephen B. Curtiss, Director
Department of Health and Human Services Finance and Support

cc: Cecile Brady, Deputy Medicaid Administrator
David Cygan, Administrator, Medicaid Managed Care
Bob Seiffert, Medicaid Administrator

DIRECTOR'S SUMMARY OF AGENCY RESPONSE

On 3 May 2004, the Health and Human Services Finance and Support Agency submitted a response to a draft of the Performance Audit Section's report prepared in conjunction with this audit. Neb. Rev. Stat. sec. 50-1210 requires the Section Director to "prepare a brief written summary of the response, including a description of any significant disagreements the agency has with the section's report or recommendations." The director's summary of the response follows.

Section Recommendations

The Finance and Support Agency's (agency's) response to the draft report included several technical corrections, one substantive correction, and updated information in two areas. However, in most instances, it did not indicate whether the agency agreed or disagreed with the section's findings and recommendations. In a follow-up call to a Medicaid program representative, we were told that the program does not disagree with the section's recommendations but does not consider their implementation to be a high priority.

Technical Corrections

The section will make the technical corrections provided by the agency.

Substantive Correction

The substantive correction relates to our finding that the Medicaid program's Surveillance and Utilization Review Unit (SURS Unit) is in violation of a federal requirement to analyze provider payment data as a means of identifying potential fraud cases for further investigation. The agency correctly pointed out that the failure to conduct such analyses does not violate a federal requirement. However, the SURS unit staff members recognize the value of this practice, which is strongly encouraged by the federal government. The agency did not challenge the usefulness of such analyses.

Updated Information

The agency response provided new information in two areas:

1) In the draft report, we expressed a concern about the effectiveness of the program's potentially out-dated claims-processing computer system. In its response, the agency indicated that it has let an RFP for a consultant to conduct a cost-benefit analysis of improving or replacing the system; and
2) The agency noted that the Legislature passed a bill to create a Medicaid Fraud Control Unit in the Attorney General's office. This unit will work closely with the Medicaid program's SURS Unit, but the impact of the fraud control unit on the workload of the SURS unit is unclear at this time.

In addition, the SURS Unit's final report on its participation in the federal Payment Accuracy Measurement project became available after the draft report for this audit was released. The section reviewed that report as well as a federal report that summarizes results from all states that participated in the project. Nebraska's Medicaid program estimated its payment-accuracy rate at 96%, which is in line with the rates estimated by the other states. However, the accuracy rates should be viewed cautiously because the methodology used to determine them continues to evolve.

Legislative Performance Audit Committee

Committee Members:
Senator Chris Beutler, Chair
Senator Marian Price, Vice Chair
Speaker Curt Bromm
Senator Pam Brown
Senator Pat Engel
Senator Vickie McDonald
Senator Roger Wehrbein

Nebraska Legislative Research Division
P.O. Box 94945, State Capitol
Lincoln, NE 68509-4945
402-471-2221

Section Staff:
Cynthia Johnson, Director
Martha Carter, Analyst
Angela McClelland, Analyst
André Mick, Analyst
Sandy Harman, Committee Clerk

24 June 2004

Mr. Steve Curtiss, Director
HHSS Finance and Support Agency
P.O. Box 95026
Lincoln, NE 68509-5026

Dear Mr. Curtiss:

The Performance Audit Committee met recently to discuss the Performance Audit Section's report, *The Nebraska Medicaid Program's Collection of Improper Payments*, and your written response to it. The Committee expects to hold a hearing this Fall on that report and the Section's report on its audit of billing practices at the Lincoln Regional Center. In the meantime, the Committee would like additional information on parts of your response to the Medicaid report. For your reference, copies of the report and your response are included with this letter. Please remember that all information relating to this audit, including these documents and anything related to them, is confidential.

The Section found that the Medicaid program should increase its efforts to identify and recover improper payments caused by provider or recipient fraud. The Section identified several weaknesses in the program's provider- and recipient-fraud efforts, including:

- The failure of the Medicaid program's Surveillance and Utilization Review Subsystem Unit (SURS Unit) to identify potential provider fraud cases through systematic data analysis because of chronic understaffing;
- A question about whether the Regulation and Licensure Agency's Special Investigation Unit (SIU) has clear authority to use administrative processes to collect from Medicaid recipients who obtain services fraudulently;
- Inadequate regulations and training designed to guide and inform Health and Human Services Agency staff members who process eligibility determinations about the identification and referral of fraud cases; and
- The lack of accountability for errors identified through the Regulation and Licensure Agency's Program Evaluation Review Unit's (PER Unit's) reviews of eligibility determinations.

The Section stated its belief that these weaknesses exist, at least in part, because each of the Health and Human Services System's agencies is responsible for a portion of the fraud-related efforts, but no one is responsible for overseeing and enhancing these efforts. (See Section report, p. 19.) To address these concerns, the Section recommended that the Medicaid program designate a person or

unit to oversee and enhance the program's efforts to identify and recover improper payment caused by fraud. In particular, the Section recommended that:

> The SURS Unit, which is the federally-mandated provider-fraud unit, would be a logical choice for this responsibility. However, if this responsibility is given to the SURS Unit, the unit should also be allocated another full-time equivalent position. We believe this position would more than pay for itself, as a result of SURS Unit collections and federal matching funds. (See Section report, pgs. 19-20.)

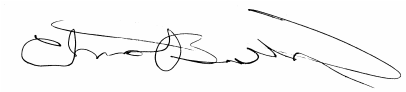
The Section went on to recommend that the person or entity assigned this responsibility should:

- Develop better policies, including improved regulatory requirements governing the responsibility of eligibility staff members to identify and refer suspected recipient-fraud cases;
- Inform staff in the Medicaid program, the SIU, and the staff members in local offices who verify eligibility of the importance of preventing, identifying, and collecting improper payments caused by fraud;
- Encourage the development and collection of performance data that can be used for cost-benefit analyses, among other things; and
- Annually evaluate the cost-effectiveness of programs' fraud-based recovery efforts and reporting this information to the Governor and the Legislature.

In your initial response to this recommendation, you expressed general support for enhanced fraud control efforts but did not indicate whether you agree or disagree with: (1) the Section's recommendation for better coordination among the entities that play a role in identifying and collecting improper payments resulting from provider or recipient fraud; or (2) the specific responsibilities recommended to enhance and coordinate fraud-based recovery efforts. It is also unclear whether you agree that legislation is necessary to allow the SIU to use administrative processes to collect from Medicaid recipients who obtain services fraudulently when evidence of fraud exists but is insufficient for prosecution. (See Agency Response, p.7.)

The Committee would appreciate clarification of your position on these issues, including an explanation of any areas with which you disagree with the Section's recommendations. We would appreciate a response to this request by Friday, July 9. If you have any questions, please feel free to contact me or Martha Carter in the Performance Audit Section.

Sincerely,



Senator Chris Beutler, Chairperson
Legislative Performance Audit Committee

c. Legislative Performance Audit Committee Members
Michael Calvert, Legislative Fiscal Analyst
HHSS Policy Cabinet Members

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
EPARTMENT OF SERVICES • DEPARTMENT OF REGULATION AND LICENSURE
DEPARTMENT OF FINANCE AND SUPPORT

STATE OF NEBRASKA
MIKE JOHANNS, GOVERNOR

July 23, 2004

RECEIVED
JUL 23 2004
LEGISLATIVE RESEARCH

Senator Chris Beutler, Chairperson
Legislative Performance Audit Committee
P.O. Box 94945, State Capitol
Lincoln, NE 68509-4945

Dear Senator Beutler:

Thank-you for the opportunity to further clarify the Department's response to the Performance Audit Section's draft report concerning the Medicaid Program. You asked whether the Department agrees or disagrees with:

(1) The Section's recommendation for better coordination among the entities that play a role in identifying and collecting improper payments resulting from provider or recipient fraud.
(2) The specific responsibilities recommended to enhance and coordinate fraud-based recovery efforts.

Finally, you have asked for clarification whether legislation is necessary to allow the SIU to use administrative processes to collect from Medicaid recipients who obtain services fraudulently when evidence of fraud exists but is insufficient for prosecution.

First, concerning the recommendation for better coordination, the Department supported the establishment of the Nebraska Medicaid Fraud and Control Unit (MFCU), which became effective in July 2004. The Department and the Nebraska Department of Justice have entered into a Memorandum of Understanding which sets out the general procedures which will be employed. The agreement establishes a Liaison Committee to implement the terms of the agreement and develops written guidelines for procedures. The Department will fully support the implementation of the MFCU and believes it is important to focus concurrent efforts toward implementation of this new group. When these new substantial efforts are more fully implemented, a further evaluation as to whether additional coordination efforts are warranted may be necessary. The MFCU is expected to significantly enhance the overall functioning of Medicaid fraud monitoring and enforcement. The Unit will have access to other states' best practices in this area and will be able to report to the state and federal governments both the successes and areas of needed improvement at the

administrative and legislative levels. In light of the recent creation of the MFCU, the Department does not advocate for additional coordination efforts at this time.

Next, the Department believes many of the policies and regulatory requirements governing the responsibility of eligibly staff members to identify and refer suspected recipient-fraud cases are in place. Staff are informed of the importance of preventing and identifying improper payments. Your report did find that the data showed that there was a positive cost benefit for the units involved. The Department would be happy to work with the Legislature to further define other cost effectiveness measures or reports the Legislature would find of value.

With changes in current regulations, we believe HHSS would have the authority to pursue Medicaid overpayments using some collection methods. We would suggest that the best group for that activity would be the Issuance and Collection Center (ICC) instead of the SIU. Some legislation may be required to allow for certain types of collection activities such as tax offsets. Some additional analysis would be required to determine the staffing level and related appropriation required for this activity. An analysis would also be required to determine the benefits of this activity in light of the fact that most individuals who have fraudulently received Medicaid benefits have limited assets, and the likelihood of recovery may be very low.

If you have further questions, please do not hesitate to contact me.

Sincerely,

Stephen B. Curtiss, Director
Department of Health and Human Services Finance and Support

SBC/kjo

Legislative Performance Audit Committee

Nebraska Legislative Research Division
P.O. Box 94945, State Capitol
Lincoln, NE 68509-4945
402-471-2221

25 August 2004

Mr. Steve Curtiss, Director
HHSS Finance and Support Agency
P.O. Box 95026
Lincoln, NE 68509-5026

Dear Mr. Curtiss:

As you know, the Legislative Performance Audit Committee will hold a public hearing on September 10th on its recent audits of improper payment collections by the Medicaid program and billing processes at the Lincoln Regional Center. The Committee requests your testimony at the hearing, and this letter outlines the Committee's specific concerns.

In regards to both audits, the Committee would like an update on any actions that have been taken to implement the Section's recommendations. In addition, in regards to the Medicaid audit, the Committee would like you to address the areas in which you disagree with the Section's recommendations, as reflected in your 23 July 2004 letter. These areas are outlined below.

The Section's primary recommendation in the Medicaid audit report is that the Medicaid program should increase coordination between the offices responsible for identifying, investigating, and collecting repayment from recipients and providers who obtain services or payments fraudulently. Currently, those functions are spread across the three HHSS agencies: the Services agency local office workers' identify potential fraud cases and refer them to the appropriate office for investigation; the Regulation and Licensure Agency's Special Investigations Unit (SIU) investigates and collects overpayments in recipient fraud cases; and the Finance and Support Agency's Surveillance and Utilization Review Subsystem (SURS) unit investigates and collects overpayments in provider fraud cases. The Section identified several weaknesses in the program's provider- and recipient-fraud efforts, which it believes exist, at least in part, because of inadequate coordination among these entities.

In your letter, you state that the Medicaid program is currently coordinating its efforts with those of the newly created Medicaid Fraud Control Unit (MFCU) in the Attorney General's office, and that you do not support additional coordination efforts until those relating to the MFCU have been completed. While the Committee fully supports coordination between the Medicaid program and the Attorney General's office, it is unclear to us how those efforts will address the issues raised by the Section, which require additional coordination *within* the HHSS system. In addition, we do not believe such coordination should be so onerous that it could not be undertaken while the relationship with the MFCU is being established. Please be prepared to address these concerns at the hearing.

In your letter you also disagree with two of the Section's specific findings that support the above recommendation. First, the Section found that local agency workers should be better informed of the importance of preventing and identifying improper payments and of the process for referring suspected fraud cases for investigation. Your letter states that staff are informed of the importance of preventing and identifying improper payments. Please be prepared to describe how this information is provided to staff.

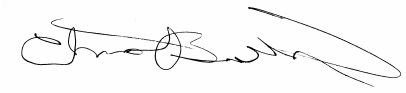
Second, the Section recommended clarification of the SIU's authority to pursue recipient-fraud cases through administrative processes. Your letter suggests that: (1) the Issuance and Collection Center should be responsible for pursuing these cases; (2) additional staffing and appropriations might be necessary to fulfill this function; and (3) additional efforts may not be beneficial because the likelihood of recovery may be low. Please be prepared to answer the following questions on this subject:

1) Currently, the ICC is responsible for overpayment collections for several public assistance programs, but not for Medicaid. In addition, if the ICC suspects fraud, it refers the case to the SIU, which investigates recipient fraud in several programs. It is unclear why it would be more efficient to add one type of fraud case to the ICC workload while the other types of cases remain with the SIU. Please be prepared to explain the rationale for this suggestion.
2) The Section's recommendation does not envision a significant expansion of the SIU's activities relating to Medicaid recipient fraud. Instead, it is intended to ensure that the SIU has the same authority for Medicaid recipient fraud cases that it has for recipient fraud cases in other programs. Currently, the SIU may use the administrative disqualification hearing process for ADC, Child Care Subsidy, and Food Stamps cases. The SIU typically uses this option when it has solid evidence of fraud, but that evidence is insufficient for prosecution. While we agree that recovery in many such cases may be low, we also believe that there may occasionally be a case, for example if Medicaid has paid for several months of long-term care, that could involve a significant recovery. The Section's recommendation is intended to ensure that the SIU could, at its discretion, pursue such a case. Please be prepared to discuss any objections you have to this idea.

As required by the Legislative Performance Audit Act, the Section is publicly releasing materials relating to the audits that will be the subject of the September hearing. For your information, a complete packet of these materials is enclosed. Please note that, in contrast to previous audit related information you have received, these materials are *not* confidential. In addition, we are enclosing a copy of the Section's recently completed memo on HHSS' efforts to collect overpayments in non-Medicaid public assistance programs. It is possible that the Committee will have questions at the hearing regarding this memo as well.

I would be happy to meet with you prior to the hearing to discuss the issues presented in this letter. Please contact my office if you would like to schedule such a meeting. If you have any other questions about the committee's concerns, please contact me or Martha Carter at 471-0072.

Sincerely,



Chris Beutler, Chairperson
Legislative Performance Audit Committee

c. Members of the Performance Audit Committee

Summary of Testimony Received During the Medicaid Hearing

On 10 September 2004, the Legislative Performance Audit Committee (Committee) held a hearing on two performance audits—*The Lincoln Regional Center's Billing Process* and *The Nebraska Medicaid Program's Collection of Improper Payments*—recently conducted by the Legislative Performance Audit Section (Section).

The Committee chair, Senator Chris Beutler, opened the hearing with comments summarizing the events leading to the hearing and expressing hope that the Health and Human Services System (HHSS) agencies and the Committee could have an open dialogue resulting in agreement on how to resolve issues the Section discussed in its audit reports.

Ms. Martha Carter, lead auditor for the Medicaid Improper Payments (Medicaid) performance audit, summarized the main findings and recommendations made as a result of the audit. Ms. Carter explained that the auditors identified 10 components that should be in place in an effective collection system. She explained further that the state program included all 10 components but that some of them could be administered more efficiently. She also gave examples of ways in which the program could be more effective, including:

- Fully staffing the Surveillance and Utilization Review Subsystem unit, which identifies cases of potential provider fraud;
- Compiling and maintaining cost-benefit data relating to cases of provider and recipient fraud and the programs' other collection efforts; and
- Better coordinating the activities of the offices involved in provider and recipient fraud efforts, which are spread across the three HHSS agencies.

Steve Curtiss, then-Director of the HHSS Finance and Support Agency testified next. He disagreed with the Section's assessment of inefficiencies and with the need for the agency to institute the Section's recommendations.[1]

[1] On 2 October 2004, Mr. Curtiss announced his resignation as head of the HHSS Finance and Support Agency. Later that month, the Governor appointment Mr. Richard Nelson, former director of the HHSS Regulation and Licensure Agency to replace Mr. Curtiss. Mr. Nelson subsequently provided comments to the Committee that support the Section's findings and recommendations. (For more information, see the agency directors' responses in this report.)

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

DEPARTMENT OF SERVICES • DEPARTMENT OF REGULATION AND LICENSURE
DEPARTMENT OF FINANCE AND SUPPORT

STATE OF NEBRASKA
MIKE JOHANNS, GOVERNOR

February 23, 2005

RECEIVED
FEB 24 2005
LEGISLATIVE RESEARCH

Senator Chris Beutler, Chair
Legislative Performance Audit Committee
P.O. Box 94945, State Capitol
Lincoln, NE 68509-4945

Re: Department of Health and Human Services Finance and Support Response to the Nebraska Medicaid Programs' Collection of Improper Payments Audit

Dear Senator Beutler and members of the Committee:

I want to thank the Committee for an opportunity to review the Performance Audit Section's Report of the Medicaid Program's collection activities in my new capacity as Director of the Department of Health and Human Services Finance and Support.

I appreciate the report's general finding that Medicaid does have in place all components necessary to an effective collection system. This is very important to the Committee, the public, and us. I also appreciate receiving the report's recommendations for improvements and the opportunity to comment on them.

Finding 1.

The report does find that overall responsibility for collection could be strengthened by better coordination. Three HHSS programs have responsibility for identifying, investigating or collecting overpayments. They are: the Surveillance and Utilization Review Section (SURS), which is primarily responsible for provider overpayment activities; the Special Investigations Unit (SIU), which is primarily responsible for recipient fraud and financial abuse investigations; and the Issuance and Collection Center (ICC), which is primarily responsible for recipient civil collection of overpayments. We agree that there needs to be consistent coordination between these units.

SURS deals solely with Medicaid provider issues. As a part of its activities, it requests refunds of overpayments. Because provider payments can involve large sums of money, SURS is equipped to and does regularly collect provider overpayments resulting from its own efforts or from criminal or civil litigation, particularly in nationwide class action suits. SURS also refers cases of suspected criminal activity to the recently created Medicaid Fraud Control Unit (MFCU) in the Attorney General's Office, and, on occasion, to the U.S. Attorney. SURS participates in a statewide criminal investigation task force that includes the offices of the Nebraska Attorney General and the U.S. Attorney. HHSS recently installed a decision support software system and has focused some of its first

programming on efforts that will support SURS in its efforts to gather information necessary to perform its surveillance function. This enhanced data capability will increase efficiency of the current staff.

SIU investigates fraudulent or abusive practices by recipients that result in improper qualifications for benefits or recipients' receipt of improper payments across the whole range of HHSS aid distribution and provider payment programs, including Medicaid. When it has sufficient evidence of such activities, it brings administrative disqualification cases where permitted and refers possible criminal cases to MFCU, county attorneys or the U.S. Attorney for prosecution. Medicaid recipients cannot be administratively disqualified, although they can be criminally prosecuted. SIU also participates, along with SURS, in the criminal investigation task force. Historically, SIU did do collection activities, although it seldom dealt with Medicaid issues. This is because it is very rare that a fraudulent or abusive practice would result in funds going to a Medicaid recipient. Medicaid pays providers directly, meaning that there is little opportunity to recoup overpayments from future, ongoing payments as can be done with overpayments in other kinds of aid cases. SIU's collection activities are limited to those that are incidental to their fraud and abuse investigations. When someone offers to return money during an investigation, they aren't turned down. HHSS also receives restitution payments that are a part of criminal convictions resulting from SIU investigations.

Several years ago, ICC was given primary responsibility for collecting overpayments from recipients in all classes of cases, including food stamps, child care, foster care facilities, foster parents, Aid to Dependent Children, and Aid to Aged, Blind, and Disabled. At that time, most civil collection activities in SIU were moved to ICC. We found that centralizing this responsibility was more efficient and avoided duplication. We have since added Medicaid recipient collections to the ICC as well and for the same reasons.

In the past year, HHSS has taken steps to better coordinate the efforts of these three programs so that each knows and understands its role in the over-all integrity and accountability effort. The Legal Division has met with and advised the three units to ensure each unit knows and understands the legal parameters affecting their role. When ICC, in the process of reviewing overpayments, finds evidence suggesting fraudulent or abuse practice, they refer the matter to SIU for investigation. On the other hand, when an SIU investigation identifies an improper payment that does not justify a fraud or abuse proceeding, it refers its findings to ICC.

The Medicaid Deputy Director has been assigned the responsibility of coordinating collection of Medicaid overpayments. SURS, SIU, and ICC will be reporting their efforts quarterly. We will continue enhancing policies and procedures that will facilitate

coordination and accountability. We believe this assignment appropriately addresses your recommendation for establishing clearer accountability for coordination.

HHS Finance and Support, as the Single State Agency for Medicaid, has the legal authority to enforce collection of Medicaid overpayments. Within HHSS, Finance and Support has delegated to SIU and ICC administrative responsibilities to contact Medicaid recipients and arrange or accept repayment of overpayments. We do not believe that legislation granting legal authority to SIU to collect Medicaid overpayments is either necessary or appropriate.

Finding 2.

Finding number two involves the need to improve coordination of benefits with health insurers. We are pleased that we have been part of a cooperative effort with your Committee to introduce legislation, LB 589, to require licensed insurers and ERISA plans to cooperate with HHSS in coordinating benefits. The legislation is pending in committee at this time, but we are hopeful that LB 589 will be enacted this legislative session.

Finding 3.

The third finding involves three questions. The first question is whether eligibility workers are meeting statutory requirements for reassessing Medicaid eligibility. We believe they are. LB 8 (Special Session 2002) changed the requirements for eligibility review from annual to semi-annual. LB 8 also required an annual report to the Legislature on the outcomes of those semi-annual reviews. Our report for SFY 2004 was filed with the Clerk of the Legislature on December 1, 2004. We welcome further inquiry if the Committee chooses this area for further study.

The second question concerns the frequency of reenrollment of Medicaid providers. Reenrollment raises issues both of efficiency and affordability. Legal precedent establishes that providers have a limited property interest in maintaining enrollment in the Medicaid program. Except in the limited instance of managed care, Medicaid is required to enroll any willing provider who meets the minimum qualifications. Reenrollment, therefore, is pretty much limited to determining whether a required credential is still valid or whether the provider has been excluded from participation in Medicare or Medicaid following a due process hearing. Given that Medicaid currently has more than fifteen thousand enrolled providers, periodic reenrollments would be a major challenge. We have chosen, instead, to rely on reports of disciplinary actions taken against licensees and exclusion orders. Such reports are received routinely by HHSS enrollment personnel and

unqualified providers are removed. Balancing the burden and expense that would be placed on both providers and the Medicaid program against the protections in our current system, we believe the current system is appropriate and cost-effective. This does not mean that we may not move to a more frequent enrollment process when we can eliminate the paper-laden, manual process that is currently in place. We look forward to transitioning to more efficient electronic processes including reenrollment in the near future.

The discussion of electronic processes brings us to the third question in this Finding: whether the current Medicaid Management Information System (MMIS) should be updated. MMIS correctly is identified in your report as the backbone of the claims-processing system. In the Governor's budget proposal, he is recommending appropriations to fund the replacement of MMIS with a modern, efficient system. Currently 90% federal match is available to help fund the replacement. We have identified cash funds that will be available in SFY 2006-07 to pay the state portion. We invite the Committee's support of this appropriation.

Finding 4.

We agree that the Medicaid program should continue taking cost-effective steps to reduce improper payments. We have recounted above a number of steps we already have taken. We will be continuing this effort.

Finding 5.

Long-term care services are a significant portion of the Medicaid budget. The greatest portion of the Medicaid budget, however, is actually spent on persons who are blind and disabled. Finance and Support has released initial data on the current Medicaid program as a part of our effort to inform the debate on Medicaid reform. We have also testified in support of LB 709. We believe that a wide-ranging look at Medicaid is the most effective way of controlling the growth of costs in this program.

Sincerely,

Richard P. Nelson

Richard P. Nelson, Director
Department of Health and Human Services Finance and Support

RPN/kjo

PERFORMANCE AUDIT COMMITTEE REPORTS

Performance Audit Reports

- *The Nebraska Medicaid Program's Collection of Improper Payments (May 2005)*
- *The Lincoln Regional Center's Billing Process (December 2004)*
- *Nebraska Board of Parole (September 2003)*
- *Nebraska Department of Environmental Quality: Administering the Livestock Waste Management Act (May 2003)*
- *HHSS Personal-Services Contracts (January 2003)*
- *Nebraska Habitat Fund (January 2002)*
- *State Board of Agriculture (State Fair Board) (December 2001)*
- *Nebraska Environmental Trust Board (October 2001)*
- *Nebraska Department of Roads: Use of Consultants for Preconstruction Engineering (June 2001)*
- *Department of Correctional Services, Inmate Welfare Fund (November 2000)*
- *Bureau of Animal Industry: An Evaluation of the State Veterinarian's Office (March 2000)*
- *Nebraska Ethanol Board (December 1999)*
- *State Foster Care Review Board: Compliance with Federal Case-Review Requirements (January 1999)*
- *Programs Designed to Increase The Number of Providers In Medically Underserved Areas of Nebraska (July 1998)*
- *Nebraska Department of Agriculture (June 1997)*
- *Board of Educational Lands and Funds (February 1997)*
- *Public Service Commission: History of Structure, Workload and Budget (April 1996)*
- *Public Employees Retirement Board and Nebraska Public Employees Retirement Systems: Review of Compliance-Control Procedures (March 1996)*
- *Leaking Underground Storage Tank Program (December 1995)*
- *School Weatherization Fund (September 1995)*
- *The Training Academy of the Nebraska State Patrol and the Nebraska Law Enforcement Training Center (September 1995)*
- *Nebraska Equal Opportunity Commission (January 1995)*
- *The Interstate Agricultural Grain Marketing Commission (February 1994)*

Preaudit Inquiries

- *The Nebraska State Patrol's Record of its Investigation of State Treasurer Lorelee Byrd (November 2004)*
- *HHSS Public Assistance Subprograms' Collection of Overpayments (August 2004)*
- *NDEQ Recycling Grant Programs (October 2003)*
- *HHSS Reimbursement and Overpayment Collection (August 2003)*
- *Grain Warehouse Licensing in Nebraska (May 2003)*
- *HHSS Personal-Services Contracts (July 2002)*
- *Livestock Waste Management Act (May 2002)*
- *Nebraska Telecommunications Universal Service Fund (April 2001)*
- *State Board of Health (November 2001)*
- *State Board of Agriculture (State Fair Board) (August 2001)*
- *Game and Parks Commission Cash Funds (August 1999)*
- *Education Technology (January 1998)*
- *Nebraska Research and Development Authority (April 1997)*
- *Nebraska's Department of Agriculture (June 1996)*
- *Nebraska's Department of Correctional Services Cornhusker State Industries Program (April 1996)*
- *DAS Duplication of NU Financial Record-Keeping (February 1995)*
- *Municipal Infrastructure Redevelopment Fund (November 1994)*
- *Petroleum Release Remedial Action Act (November 1994)*