Presentation to the 2017 Health and Human Services
Joint Appropriation Subcommittee

QUALITY ASSURANCE DIVISION

Department of Public Health and Human Services (DPHHS)

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Reference:
Legislative Fiscal Division Budget Analysis, Pages B63-B69

1. Where are we now?

1a. Mission of the Division:

To promote and protect the health, safety, and well-being of people in Montana by providing responsive, independent assessment and monitoring of human services, through respectful relationships.

1b. Contact Information:

Title	Name	Phone Number	E-mail address
Administrator	Brian Watson	406-444-2868	bwatson@mt.gov
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1c. Overview:

The Quality Assurance Division (QAD) has to primary regulatory functions. First, it is responsible for assessing and monitoring facility compliance with the standards of care by health care, child care, residential and youth care facilities. The Division provides the public an avenue to report complaints regarding facility care and services. Healthcare and childcare in Montana provide significant contributions to virtually every community in the state, and QAD helps assure their safe operation. Montana's economy through the services provided in.

Second, the division reviews, audits and recovers errant payments made though Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and Medicaid programs.

1d. Major Bureau Functions:

Licensure Bureau

Health Care Facilities
The Quality Assurance Division plays a significant role in the health and well-being of people by licensing approximately 555 health care facilities. Regulatory activities are conducted to ensure Montanans receive proper treatment and medical care. All licensed facilities are subject to unannounced inspections, helping to ensure a clean, safe environment, proper nutrition, and delivery of health care services. In addition to regular inspections, health care facility surveyors investigate complaints at licensed facilities.

Child Care Facilities
In addition to health care, the Division licenses and registers child care facilities. For parents who utilize child care services, the activities of the Division help assure a safe and secure environment for their children. Montana has approximately 900 licensed and registered providers and 150 Legally Certified Providers throughout the state, serving 20,000 of Montana's children. Regulatory efforts by the Child Care Licensing Program help ensure children in out-of-home care are provided an environment in which they can feel safe and receive age appropriate learning experiences.

Community Residential Facilities
The Division is also responsible for the licensure of approximately 400 Community Residential Facilities. Residential facilities are established to care for the wide and varied needs of youth and vulnerable adults throughout Montana. The facilities provide for the care and treatment of youth in need of out of home placements, elderly or disabled adults, the prevention, diagnosis and treatment for mental illness and substance abuse. Regulatory activities are conducted to ensure proper supervision; care and treatment are provided in the least restrictive setting as possible. The Community Residential Program conducts regular inspection of all facilities and investigates approximately 70 complaints per year.

Certification

Healthcare is one of the largest industries in Montana. The Certification Bureau is the branch of QAD which has been designated by the federal Center for Medicare/Medicaid Services (CMS) to serve as

the State Survey Agency. This is an important function because facilities surveyed and certified by the State Survey Agency are eligible to receive reimbursement from Medicare and Medicaid. Certification activities help assure Montanans receive proper treatment and medical care. All healthcare facilities are subject to inspections, which helps ensure a clean, safe environment, proper nutrition, and quality delivery of health care services to safeguard the health and well-being of everyone who uses these facilities.

Program Compliance Bureau

Quality Control (QC Reviews)
Quality assurance activities are an integral part of operating an efficient SNAP program by insuring benefits are provided to the right people, at the right time and in the right amount.

The reviews are performed by randomly sampling cases and evaluating for accuracy utilizing a systematic method of measuring the validity of SNAP eligibility and benefits. The results provide a continuous flow of information between QAD and Human and Community Services Division to create effective corrective actions to minimize future SNAP errors.

The SNAP Quality Control reviews are conducted in accordance with 7 CFR §275, Subpart C - Quality Control (QC) Reviews.

The number of SNAP cases sampled for review is dependent on the total number of SNAP cases authorized in a given month. In SFY15 - 1,983 SNAP cases were reviewed and in SFY16 - 1,591 cases were reviewed.

Intentional Program Violation (IPV) and Payment Error Rate Measurement (PERM) Unit
The IPV unit is responsible for investigating Intentional Program Violations (IPVs) in the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) and Medicaid programs. Monitoring for individuals who are not eligible to receive benefits or services and taking appropriate follow-up actions helps ensure tax payer dollars are used appropriately.

At the completion of our investigation, if the evidence supports an IPV, the unit proceeds through the administrative disqualification process**,** or make a referral to a court of competent jurisdiction as required in 7 CFR §273.16. Adult individuals who have committed an IPV in the SNAP and/or TANF programs may be disqualified for a period of time determined by the type and frequency of the violation.

Disqualified individuals receiving SNAP benefits are tracked nationally to prevent receipt of any benefits during their disqualification period. An overpayment schedule is established to recover benefits the individual was not eligible to receive.

In SFY16, 1,297 individuals were referred for SNAP investigations and 564 individuals were disqualified. SNAP IPV overpayments recovered were $292,016. The recovery amount includes overpayments that were established in previous years.

In SFY16, 163 individuals were referred for TANF investigations and 43 individuals were disqualified from TANF. TANF IPV overpayments established totaled $140,306 and $66,553 was received in recoveries. The recoveries include overpayments that were established in previous years.

Payment Error Rate Measurement (PERM)
The PERM program is a joint effort between CMS and states to measure the Medicaid and Children's Health Insurance Program (CHIP) improper payment rates. CMS utilizes standardized data collection and random sampling methodology to review and evaluate eligibility determinations and fee-for-service (FFS) payments in the Medicaid and CHIP programs.

CMS replaced the PERM eligibility component with eligibility pilots for the 2014 through 2017 PERM cycles. State-specific eligibility error rates were not calculated during this time. CMS froze each state's eligibility error rate from the most recently completed PERM cycle.

The PERM program operates on a cycle moving through all 50 states every 3 years. States are divided into 17 states per cycle. Montana's next PERM cycle is FFY2017; reviews will begin in August 2017 with the error results expected to be released in November 2018. Montana's 2014 PERM results along with the 2014 national average are as follows:

2014 Improper Payments Report Results		
	Montana (2014)	**National (2014-2016)**
Eligibility Determination	0.40% (2011 rate freeze)	3.30% (rate freeze)
Fee For Service	5.8 %	10.6%
Overall	**5.8%**	**9.8%**

CMS continually reviews the causes of errors and implements national and state focused activities to decrease Medicaid and CHIP improper payments.

Surveillance and Utilization Review Section (SURS)
Medicaid program integrity is among the highest priorities nationally. Surveillance and Utilization Review Section (SURS), is responsible for Medicaid provider audits and enrollment issues for approximately 25,000 providers. SURS monitors Medicaid provider compliance with state and federal rules, laws and policies by performing retrospective audits of claims paid by the Medicaid program. The SURS function is required under 42 CFR§455, §466 and helps prevent the loss of public dollars to fraud, waste and abuse.

Provider education is the first step in preventing any potential fraud, waste, and abuse. SURS has consistently participated in the six Xerox Provider Trainings held every year, published numerous articles in the Claim Jumper newsletter (a Xerox publication for Medicaid providers) and delivers individual education at the close of each audit.

SURS reorganized in 2015, and modified the audit structure from an audit time frame of three years retrospective review to a common practice of six-month retrospective reviews. This gives providers more current information on billing errors and provides an opportunity to correct the findings through billing adjustments, if applicable.

Audit plans are derived from data mining and national trends. Statistical sampling is utilized to limit the burden on Medicaid providers and to increase audit efficiencies.

Records are requested and reviewed by auditors. Audit program staff include, three healthcare professionals (Licensed Practical Nurse, Licensed Clinical Social Worker, and a Clinical Laboratory Scientist), four Certified Professional Coders and two Certified Program Integrity Professionals.

SURS average review completion time in SFY16 was 43 days from the date all records were received to final determination letter sent. Audit potential outcomes may be a combination of the following:

- No adverse findings
- Education
- Claim Adjustments
- Overpayment

In SFY15, SURS opened 152 cases, closed 193, and collected $624,868 in overpayments. In SFY16, SURS opened 361 cases, closed 360, and collected $861,043 in overpayments. Cases that have a credible allegation of fraud are referred to the Medicaid Fraud Control Unit (MFCU). In SFY15, SURS made no referrals to MFCU and one case was referred in SFY16.

Montana Medicaid Recovery Audit Contract (RAC)

The Affordable Care Act (ACA) and 42 CFR §455 Subpart F requires Medicaid agencies to audit Title 19 programs (Hospitals, Nursing Homes, etc.) and identify overpayments and underpayments. This work is guided by developing agreements with Recovery Audit Contractors (RACs). Montana has been in contract with Health Management Systems (HMS); this contract expired in December 2016.

The general RAC process involves the contractor creating audit plans through the use of data mining algorithms. These plans may come from national trends or the state may request a particular audit scenario based on program requests or referrals.

Once an audit scenario is approved by the department, providers are notified and records are requested. The RAC program has set a records request limit of 300 claims every 90 days so as not to overburden providers with requests.

Once records are received, the contractor uses licensed healthcare professionals to review medical records and issue findings. Results are then sent to RAC and subject to a secondary accuracy check by the RAC Coordinator. If there is concurrence on behalf of the state, overpayment or underpayment notifications are sent to providers.

Providers have the right to dispute any RAC decision through the appeals process of the Quality Assurance Division (QAD), which consists of Administrative Reviews, Fair Hearings, the Office of Public Assistance, and District Court.

The Montana Medicaid RAC program collected $485,113 in SFY 2015, and $871,840 in SFY 2016.

Monies are not collected from providers until claims are fully adjudicated. Once funds are received by the state to satisfy overpayments, the contractor is paid a 10% contingency of the overpayments collected.

Third Party Liability (TPL)

Third Party Liability (TPL) gathers information on third parties who are liable to pay claims prior to Medicaid payment or are required to reimburse Medicaid for claims that have already been paid.

Legally responsible third parties include Medicare, traditional health insurance, workers' compensation, and auto insurance. TPL is administered in accordance with 42 CFR §433 Subpart D.

In SFY15 Montana recognized a Medicaid cost avoidance of $179 million and recovered $7.1 million to Medicaid. In SFY16 the cost avoidance was $165.4 million and recovered $6.8 million to Medicaid. Cost avoidance is the amount paid by a third party prior to or instead of Montana Medicaid.

Montana Medical Marijuana Registry

QAD is responsible for operating the medical marijuana registry under the law. The Registry identifies individuals as being a registered cardholder or provider thereby offering limited legal protection for the use and cultivation or manufacture of marijuana to alleviate the symptoms of approved debilitating conditions. As a result of November's ballot initiative 182, the program will need to be modified. The Department intends to utilize the rulemaking process to implement the new provisions of the law including licensing, testing, and inspection requirements.

Highlights and Accomplishments during the 2017 biennium

Achieved CMS Performance Requirements - State Survey Agency

Meeting the CMS performance standards is important for all Montanans as the Bureau's work ensures residents receive nutritious food, are kept clean, and receive the medical care they need to promote quality of life at this fragile stage of their lifespan. Certification successfully satisfied the state contract performance requirements of the CMS Mission and Priority Document. The federal performance standards were met for nursing homes in areas of frequency of data entry, documentation of survey deficiencies, and adherence to federal conditions of participation. In addition, federal performance standards were also met for, home health agencies, end stage renal dialysis facilities, hospices, ambulatory surgical centers and rural health clinics in the areas of frequency of data entry, documentation of survey deficiencies, timeliness of Emergency Medical Treatment and Labor Act (EMTALA) investigations, and adherence to federal conditions of participation. Finally, several new providers or added services to exiting providers, received initial surveys to allow reimbursement for services rendered under the Medicare and Medicaid programs. These providers included end stage renal disease, portable X-Ray, hospice, hospital, and rural health clinics.

Certified Nurse Aid Registry

The department has been using an enhanced database and online application system, called Versa, for the employer verification of Certified Nurse Aids (CNA) and Home Health Aides (HMA). Versa is an off-the-shelf product that was configured to the Nurse Aide Registry's unique needs. The CNA registry continues to educate the public, health care facilities, and all CNA's/HHA's about the online application system. The new system will allow CNA's to apply, renew, verify, and update their information online. Most importantly, the system is searchable by the public looking for information on specific CNA's/HHA's.

Health Care Facility Licensing System

The QAD Licensure Bureau is engaged in the ongoing implementation of a new Health Care Facility Licensing System called Versa. The Division is working collaboratively with the Technology Services Division (TSD) and a vendor, Iron Data, to finalize Versa. With the addition of Versa, the Licensure Bureau is now able to track facilities from the time they open, closely monitor changes and inspections, and maintain records of deficiencies and violations. The system also includes an online search feature that allows the public to look up facility information, including inspection reports. In

the future, the system will be capable of taking online applications and payments, making health care licensing much more efficient for licensees.

Community Setting Evaluation Specialist

In March 2014, the Centers for Medicare and Medicaid Services (CMS) required that states demonstrate compliance with the new Home and Community Based Services (HCBS) Setting rules. The intent of these new federal regulations is to give residents receiving HCBS services full access to the benefits of community living while enjoying those services in the most integrated setting appropriate. As a part of Montana's transition efforts to demonstrate compliance with these new rules, a Community Setting Evaluation Specialist position was created and filled in June 2016. This position works closely with other DPHHS programs including Senior and Long-Term Care Division, Developmental Disabilities Program, Addictive and Mental Disorders Division, and Children's Mental Health Bureau.

Child Care Licensing

The Child Care Licensing Program is in the process of updating regulations and policies relating to health and safety, training and inspections for child care facilities. These changes are necessary in order to comply with the Child Care and Development Block Grant Act of 2014.

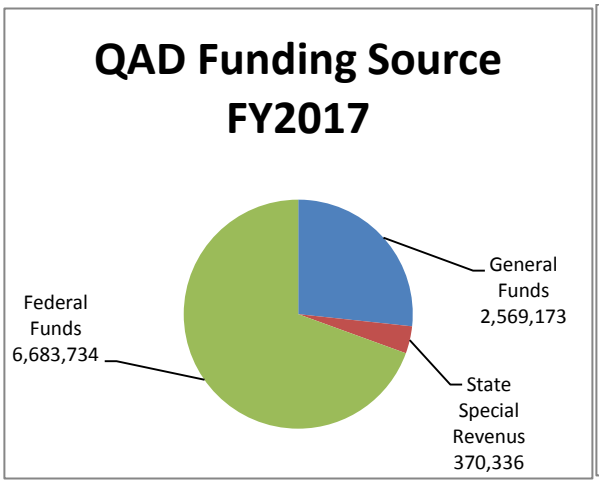
IPV Highlights and Accomplishments

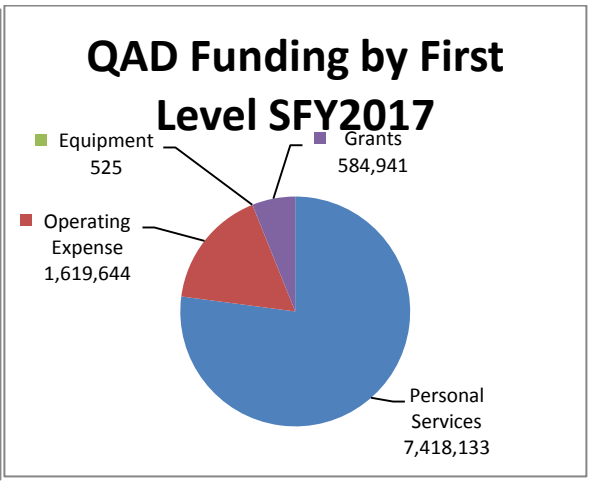
The IPV unit began a new process of following up on IPV cases to ensure overpayments are established. During SFY 2016, over $1 million has been established in SNAP IPV claims, which is more than double from SFY 2015. The IPV unit continues to work on the backlog of IPV cases that need overpayments established and expects this number to continue to grow.

The SNAP cost avoidance as a result of IPV disqualifications in SFY 2016 totaled $1,321,900 (benefits not issued due to a disqualification).

1e. Current Budget/Expenditures:

Quality Assurance Division	2017 Budget	FY 2018 Request	FY 2019 Request
FTE	104.23	104.23	104.23
Personal Services	7,418,133	7,269,500	7,292,443
Operating	1,619,644	1,677,066	1,678,987
Equipment	525	525	525
Grants	584,941	584,941	584,941
Benefits & Claims	0	0	0
Debt Services	0	0	0
Total Request	**9,623,243**	**9,532,032**	**9,556,896**
General Fund	2,569,173	2,539,635	2,546,120
State Special Fund	370,336	393,446	394,071
Federal Fund	6,683,734	6,598,951	6,616,705
Total Request	**9,623,243**	**9,532,032**	**9,556,896**





2. QAD: Where do we want to be in two years?

2a. 2019 Biennium Goals and Objectives:

(Break out objectives by which Bureau they affect, if possible)

Department of Public Health and Human Services **Public Health & Safety Division**	
Goals and Objectives for the 2017 Biennium	
Goal: To actively contribute to the Department's efforts to protect the health, safety, and well-being of Montanans through: - **Providing regulatory oversight, utilizing applicable state and federal laws that promote various Montana health care facilities.** - **Program integrity oversight, and audit functions.** - **Maintaining a confidential Montana Medical Marijuana Program registry compliant within established parameters and establish a licensing and testing process for the program's regulation.**	
Objective(s) (by Division)	**Measures**
Train certified health care providers (facilities) on changes made by Centers for Medicare and Medicaid Services (CMS). Many changes anticipated with long term care requirements and communication of these changes will benefit the recipients and providers alike.	Fewer deficiencies issued by Certification Bureau associated with quality of care areas such as resident behaviors, quality of life and quality of care.
Perform certification functions for respective health care facilities and providers.	Complete certification functions in accordance with state or federal rules, regulations and timelines. Number of registered Certified Nurses Aids who have completed apprenticeships, training programs and past the final exam.
Increase compliance with licensing regulations through provider education and consistent application of statutes and rules.	Fewer deficiencies cited during inspections.
Complete licensure functions for health care facilities, community residential facilities and child care facilities.	Complete licensure inspections and issue licenses and certificates within established timelines in accordance with state or federal rules.
Program integrity oversight to maximize cost avoidance and recoveries.	Take all reasonable measures to identify the legal liability of "third parties" for health care services provided to Medicaid recipients.
Operate the Montana Marijuana Program effectively and efficiently.	All reasonable measures are taken to comply with the new provisions of the law as outlined in ballot initiative 182. Design and implement licensure and testing program.

3. QAD: How are we going to get there?

3a. Present Law Adjustments:

SWPL - 1 - Personal Services -
The budget includes a reduction of $148,633 in FY 2018 and $125,690 in FY 2019 to annualize various personal services costs including FY 2017 statewide pay plan adjustments and increases to state share costs for health insurance passed by the 2015 Legislature, benefit rate adjustments, longevity adjustments related to incumbents in each position at the time of the snapshot, and vacancy savings.

Fiscal Year	General Fund	State Special	Federal Funds	Total Request
FY 2018	$ 67,484	$ (30,954)	$ (185,163)	$ (148,633)
FY 2019	$ 73,501	$ (30,374)	$ (168,817)	$ (125,690)
Biennium Total	$ 140,985	$ (61,328)	$ (353,980)	$ (274,323)

SWPL - 2 - Fixed Costs -
The request includes $32 in FY 2018 and $130 in FY 2019 to provide the funding required in the budget to pay increases in fixed costs assessed by other agencies within state government for the services they provide. Examples of fixed costs include liability and property insurance, legislative audit, warrant writer, payroll processing, and others. The rates charged for these services are approved in a separate portion of the budget.

Fiscal Year	General Fund	State Special	Federal Funds	Total Request
FY 2018	$ 8	$ 3	$ 21	$ 32
FY 2019	$ 29	$ 12	$ 89	$ 130
Biennium Total	$ 37	$ 15	$ 110	$ 162

SWPL - 3 - Inflation Deflation -
This change package includes an increase of $1,215 in FY 2018 and $3,038 in FY 2019 to reflect budgetary changes generated from the application of inflation and deflation factors to specific expenditure accounts. Affected accounts include food, postage, natural gas, electricity, gasoline, and others.

Fiscal Year	General Fund	State Special	Federal Funds	Total Request
FY 2018	$ 480	$ (82)	$ 817	$ 1,215
FY 2019	$ 927	$ (46)	$ 2,157	$ 3,038
Biennium Total	$ 1,407	$ (128)	$ 2,974	$ 4,253

PL - 8001 - Recovery Audit Contract (Biennial) -
This biennial present law adjustment requests $153,685 each year of state special and federal special revenue for the biennium to maintain existing services for the Recovery Audit program in the Quality

Assurance Division. The requested funding would provide payment to the recovery audit contractor for an amount up to 12.5 percent of funds recovered while investigating waste, fraud and abuse in the healthcare system.

Fiscal Year	General Fund	State Special	Federal Funds	Total Request
FY 2018	**$ 0**	**$ 54,143**	**$ 99,542**	**$ 153,685**
FY 2019	**$ 0**	**$ 54,143**	**$ 99,542**	**$ 153,685**
Biennium Total	**$ 0**	**$ 108,286**	**$ 199,084**	**$ 307,370**

3b. New Proposals:

NP - 555 - Appropriation Rebase
The Executive Budget includes targeted budget reductions across most agencies. The Executive proposes Quality Assurance Division Appropriation Rebase totaling $97,510 per year was included in the agency reduction plan submitted in compliance with 17-7-111, MCA.

Fiscal Year	General Fund	State Special	Federal Funds	Total Request
FY 2018	**$ (97,510)**	**$ 0**	**$ 0**	**$ (97,510)**
FY 2019	**$ (97,510)**	**$ 0**	**$ 0**	**$ (97,510)**
Biennium Total	**$ (195,020)**	**$ 0**	**$ 0**	**$ (195,020)**