Presentation to the 2019 Health and Human Services Joint Appropriation Subcommittee

Quality Assurance Division
Operation Services Branch
Department of Public Health and Human Services

The following topics are covered in this report:

- Overview
- Summary of Major Functions
- Highlights and Accomplishments during the 2019 Biennium
- Funding and FTE Information
- Change Packages

Overview

The Quality Assurance Division (QAD) collaborates with other DPHHS branches to ensure that facilities where Montanans receive services or care meet standards required by law. These standards help promote safe, stable, and nurturing environments spanning a citizen's lifetime - from child care to hospice care. The Quality Assurance Division carries out this work through two primary regulatory functions.

First, QAD is responsible for ensuring that all Montana health care, child care, residential, and youth care facilities comply with the required state and federal standards of care. Additionally, QAD's system for receiving complaints regarding facility care and services allows the public to play an important role in guarding the safety of the vulnerable populations. QAD investigates each complaint to ensure facilities are operating safely to protect the health and well-being of all Montanans.

Second, QAD reviews, audits, and recovers errant payments made through Medicaid, Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF). These actions provide optimal services and support to Montanans by ensuring public assistance dollars are spent appropriately.

Summary of Major Functions

Licensure

Health Care Facilities

The Quality Assurance Division plays a significant role in protecting the health and well-being of Montanans by overseeing the licensing of approximately 1,100 health care facilities around the state. QAD staff conduct regulatory activities to ensure citizens receive proper treatment and medical care at each of these facilities. All licensed facilities are subject to unannounced inspections to ensure a clean, safe environment, proper nutrition, and proper delivery of health care services. In addition to regular inspections, health care facility surveyors investigate a wide range of complaints at licensed facilities, which ensures people are having their voices heard and their needs met.

Child Care Facilities

Montana has approximately 1,150 licensed child care providers throughout the state, serving approximately 19,500 children. The Quality Assurance Division licenses these child care facilities to ensure they meet safety and security standards. Regulatory efforts conducted by the Child Care Licensing Program help assure children in child care facilities are provided an environment in which they can feel safe and receive age-appropriate learning experiences.

Community Residential Facilities

The Quality Assurance Division is also responsible for the licensure of approximately 300 Community Residential Facilities. The facilities provide for the care and treatment of youth in need of out-of-home placements or for elderly or disabled adults. Facilities also provide prevention, diagnosis, and treatment services for mental illness and substance abuse. Regulatory activities ensure proper supervision, care, and treatment services are provided to Montanans. The Community Residential Program conducts regular inspection of all facilities and investigates complaints, both independently and in collaboration with appropriate partners and agencies.

Certification

The Social Security Act (the Act) dictates the establishment of minimum health and safety standards that must be met by providers participating in the Medicare and Medicaid programs. Section 1864 of the Act directs the Secretary of the Department of Public Health and Human Services (DPHHS) to utilize the assistance of state health agencies when determining whether health care facilities meet federal standards; a function termed “certification.”

The Certification Bureau is designated as the agency responsible for administering the standards of compliance, as well as the performance of the certification functions. The Certification

Bureau performs surveys to determine whether a provider/supplier meets the requirements for participation in the Medicare and/or Medicaid programs and whether they meet the standards for delivering safe and acceptable quality of care.

The specific functions that Certification performs under the agreements include:

- conducting investigations and fact-finding surveys, including complaint surveys;
- certifying and re-certifying facilities within statutory timelines;
- advising providers and suppliers of the Federal regulations to assist them to qualify for participation in the programs and to maintain standards of health care consistent with the requirements;
- conducting periodic educational programs to present current regulations, procedures, and policies to the staff and residents at Skilled Nursing Facilities and Nursing Facilities.

The Certification Bureau also functions to:

- monitor proficiency testing in laboratories for in the CLIA (Clinical Laboratory Improvement Amendments) Laboratory Certification Program;
- maintain the Nurse Aide Registry and review/certify, and
- approve nurse aide training programs.

Program Compliance

Quality Control (QC Reviews)

Quality Control activities are integral to operating an efficient Supplemental Nutrition Assistance Program (SNAP) program. They ensure the timely and accurate issuance of benefits to eligible individuals. The reviews are performed by random sample and evaluate cases for accuracy using a systematic method for measuring the validity of SNAP eligibility and benefits. The results provide a continuous flow of information between Program Compliance and Human and Community Services Division to create effective corrective actions to minimize potential SNAP errors. On average, we conduct about 1,500 household reviews.

Intentional Program Violation (IPV)

The IPV unit is responsible for investigating Intentional Program Violations (IPVs) in Medicaid, Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF). If the evidence supports an IPV at the completion of an investigation, the unit proceeds through the administrative disqualification process or makes a referral to a court of competent jurisdiction as required in 7 CFR §273.16. Adult individuals with an IPV in SNAP/TANF programs may be disqualified for a period determined by the type and frequency of the violation. SNAP disqualifications are tracked nationally to prevent individuals with an IPV from receiving benefits in another state. An overpayment of benefits is established to recover benefits the individual was not eligible to receive. Medicaid participants do not receive a disqualification period per state and federal policy, but an overpayment may be established.

IPVs	Referrals	Disqualifications	Overpayment Established
Medicaid SFY17	0	0	$0.00
Medicaid SFY18	13	0	$72,634
SNAP SFY17	1,327	502	$1.4 M
SNAP SFY18	1,797	429	$1.6 M
TANF SFY17	238	81	$46,516
TANF SFY18	301	95	$55,451

Surveillance and Utilization Review Section (SURS)

Maintaining the integrity of the Medicaid program is a national priority. The Surveillance and Utilization Review Section (SURS) is required under 42 CFR§455, §466 and helps prevent the loss of public dollars due to fraud, waste, and abuse. SURS monitors Medicaid provider compliance with state and federal policies, rules, and laws by performing retrospective reviews of claims and documentation paid by the Medicaid and Children's Health Insurance Program (CHIP).

Provider education is a key component of the SURS mission. SURS participates in the Conduent (state fiscal agent) Provider Trainings, publishes numerous articles in the Claim Jumper newsletter (a Conduent publication for Medicaid providers), and delivers individual education at the close of each review.

SURS performs provider record and data reviews that encompass a six-month timeframe. A follow-up review may be performed if there is a 5% or more error rate in the initial review. Review plans are derived from data mining, beneficiary responses to Explanation of Medical Benefits summaries (EOMB's), program requests, and national trends. Records are requested and reviewed by Program Integrity Compliance Specialists. SURS unit staff include two healthcare professionals (Licensed Practical Nurse and a Clinical Laboratory Scientist), four Certified Professional Coders, and three Certified Program Integrity Professionals.

	FY17	FY18
Reviews Opened	400	379
Reviews Closed	437	437
Average Completion Time	57 days	53 days
Overpayments Collected	$613,361	$644,106

**Collections contain previous years established overpayments*

SURs works collaboratively with the Department of Justice Medicaid Fraud Control Unit (MFCU) on cases of suspected and credible allegations of fraud. In FY17, SURS made three credible allegations of fraud referrals to MFCU. In FY18, SURS made four credible allegations of fraud referrals and two suspected fraud referrals to MFCU.

Third Party Liability (TPL)

The Third Party Liability unit (TPL) ensures that Medicaid is the payer of last resort and recovers funds that have been paid when a third party was responsible. Legally responsible third parties include health, home, and auto insurers, Medicare, and worker's compensation. TPL operates in accordance with 42 CFR §433 Subpart D.

The TPL unit works with the Office of Public Assistance, State Fiscal Agents, and other Third Party administrators to identify and record all health insurance coverages for Medicaid members. Having the coverage on file allows Medicaid to coordinate benefits and reject claims based on the allowable coverages of the TPL policy.

Health Insurance Premium Payments (HIPPS) and State Buy-In programs offer Medicaid opportunities for cost avoidance. Cost avoidance is the amount paid by a third party prior to or instead of Montana Medicaid. The HIPPS program determines if it would be more cost effective to pay the private insurance premium or to have Medicaid serve as the primary payer. The Buy-In program pays Medicare premiums for Medicaid eligible constituents; therefore, Medicare pays first and Medicaid second. This system results in saving Medicaid dollars and cost avoidance.

Additional programs resulting in recoveries of Medicaid dollars include Estate, Lien, and Tort recovery. Estate recovery recoups money for medical claims paid on behalf of a Medicaid member who is age 55 years or older. The Lien recovery program places a lien on real property at the time a Medicaid member enters a nursing home without the intent of returning home. Liens are released if the member does return home. Tort recovery files claims with home and auto insurance, worker's compensation, restitution or other court settlements, ensuring Medicaid is the payer of last resort.

- In FY17, Montana cost avoided $195.9 million in Medicaid payments and recovered $9.4 million.
- In FY18, Montana cost avoided $206.1 million in Medicaid payments and recovered $8.8 million.

Montana Medicaid Recovery Audit Contractor (RAC)

The Affordable Care Act (ACA) and 42 CFR §455 Subpart F requires Medicaid agencies to develop agreements with Recovery Audit Contractors (RACs) to audit Title 19 programs (Hospitals, Nursing Homes, etc.). Montana currently has a waiver from CMS for the requirement to have a RAC.

Highlights and Accomplishments During the 2019 Biennium

Improvements in Child Care Licensing

The Licensing Program has made many changes to increase the safety of children and promote health in licensed child care facilities. Previously, child care centers were inspected every 1-3 years and 20% of family and group facilities were inspected annually. Now, all licensed child care facilities are inspected every year. Also, training requirements for child care facility staff increased and all staff are now required to be certified in First Aid and CPR. Background check requirements are more robust with all child care facility staff required to have FBI fingerprint background checks, CPS checks, and sex offender registry checks. An online provider application and training tracking system were developed to assist providers in the application and renewal processes. Finally, all licensed facilities are required to have disaster and emergency preparedness plans and supplies. These changes contribute to safe and secure environments for all children while in child care facilities.

Modernizing Technology

In the last year, the Certification Bureau assisted our providers in rolling out significant updates to both the Home Health regulations and the Long-Term Care regulations. The Long-Term Care survey process and procedure update introduced the use of a computer-based surveying system. Compared with other states, the Certification Bureau implemented these updates with minimal disruptions.

Increasing Efficiencies in Program Compliance

Quality Control
The Program Compliance Bureau's Quality Control unit was recognized by the Food and Nutrition Services for initiating a more efficient process for staff who determine state eligibility to access the final dispositions of quality control reviews to remedy problems in a timely manner.

In addition, the QC unit is working to reduce travel costs and time on the road by implementing the use of video conferencing when conducting mandatory face-to-face interviews. The unit is providing training for all QC staff on the use of One Note, which will decrease paper usage, equipment costs, and the time needed to print and scan documentation.

Third Party Liability
The Third Party Liability unit reviewed all internal procedures and modified the process of identifying liable third parties. Due to these efforts, staff achieved a 41% increase in recovery to Montana Assistance Programs. TPL recovered $14.8 M for FY15-16 and $20.9 M for FY17-18.

Reaching Rural Populations

Rural Hospital Flexibility Grant
This year marks the twentieth year DPHHS was awarded a Rural Hospital Flexibility (Flex) grant of $806,474 from the U.S. Department of Health and Human Resources Health Resources and Services Administration (HRSA) to support Montana's Critical Access Hospitals. An additional $52,631 will support a DPHHS Emergency Medical Services Sustainability project. These federal dollars provide rural health services where Montanans live. Due to the rural nature and geography of Montana, it can be difficult to serve citizen where they are, so the Flex grant has contributed to innovative solutions to support the workforce and technology development. These improvements help reduce the costs associated with delivering services to rural communities. Montana was first state to pilot the Flex grant and has developed a model for other states to develop critical access in rural markets.

Medical Marijuana

Senate Bill 333 established requirements for the regulatory framework for Montana's Medical Marijuana industry. The objective of the program is to develop a well-regulated program so that people with a debilitating medical condition can continue to safely access the medicine they need.

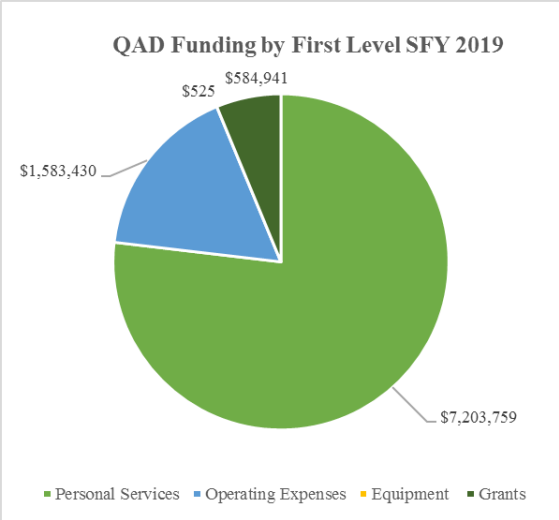
The Medical Marijuana program regulates an industry that has previously had little oversight, while still maintaining provider viability (and thus availability of medicine to cardholders) and creating financial incentives to attract the labs necessary to operate and maintain a safe program. The major provisions of SB333 include licensing requirements, inspection standards, tracking system requirements, and marijuana testing protocols.

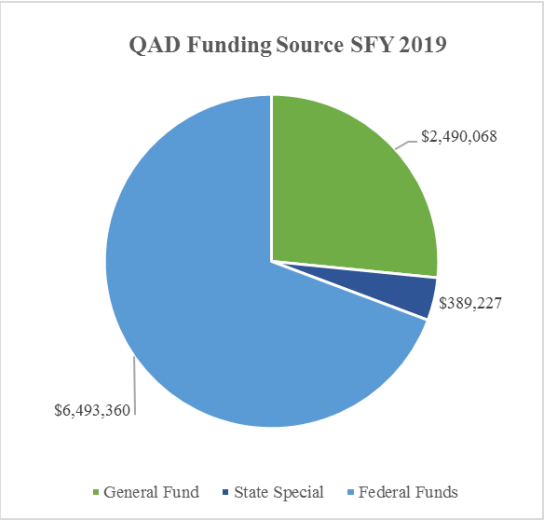
These Medical Marijuana rules went into effect on April 10, 2018. This year, the program moved to a larger physical location that offers private workspace to process confidential data and to accommodate the growing team of license technicians and inspectors, which is now up to 18 people. Since that date, the program has accomplished the following:

- Launched Complia, the state licensing system and Metrc, the state seed-to-sale program.
- Inspected approximately 75% of the licensed providers and are working to get all providers into the Metrc system.
- Established a kiosk where patients can submit applications with the assistance of medical marijuana staff.
- Created processes and procedures for cardholder registration, provider licensing, and inspections protocols for labs, cultivation sites, and marijuana infused products providers.
- Introduced a call center software program that tracks and records calls, wait times, and abandon rates. The program regularly takes about 200 calls a day from law enforcement, patients, and providers and helps an average of 10 patients a day submit their applications through the kiosk.

Funding & FTE Information

Quality Assurance	SFY 2019 Budget	SFY 2020 Request	SFY 2021 Request
FTE	104.23	122.23	122.23
Personal Services	$7,203,759	$8,579,662	$8,578,897
Operating Expenses	$1,583,430	$2,453,035	$2,498,676
Equipment	$525	$525	$525
Grants	$584,941	$584,941	$584,941
Benefits & Claims			
TOTAL COSTS	$9,372,655	$ 11,618,163	$ 11,663,039
	SFY 2019 Budget	**SFY 2020 Request**	**SFY 2021 Request**
General Fund	$2,490,068	$2,646,518	$2,646,984
State Special	$389,227	$2,331,304	$2,378,134
Federal Funds	$6,493,360	$6,640,341	$6,637,921
TOTAL FUNDS	$9,372,655	$11,618,163	$11,663,039





Change Packages

Present Law Adjustments:

SWPL 1 – Personal Services
The budget includes $363,613 in FY 2020 and $358,959 in FY 2021 to annualize various personal services costs including FY 2019 statewide pay plan, 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 2020	$152,619	$69,828	$141,166	$363,613
FY2021	$152,160	$69,453	$137,346	$358,959
Biennium Total	$304,779	$139,281	$278,512	$722,572

SWPL 3 – Inflation/Deflation
This change package includes an increase of $10,083 in FY 2020 and $12,513 in FY 2021 to reflect budgetary changes generated from the application of inflation to specific expenditure accounts. Affected accounts include those associated with the statewide Motor Pool operated by the Department of Transportation.

Fiscal Year	General Fund	State Special	Federal Funds	Total Request
FY 2020	$3,831	$437	$5,815	$10,083
FY2021	$4,756	$542	$7,215	$12,513
Biennium Total	$8,587	$979	$13,030	$22,596

PL 8001 – Medical Marijuana
This present law adjustment including 18.00 FTE, operating expenses and personal services, requests $3,790,724 in total funds for the biennium, including state special funds of $1,871,812 in FY 2020 and $1,918,912 in FY 2021 to provide existing services for the Medical Marijuana program in the Quality Assurance Division. During the 2019 Biennium, these expenses were primarily funded by an appropriation in SB 333 passed by the 2017 Legislature which was not included in the base budget.

Fiscal Year	General Fund	State Special	Federal Funds	Total Request
FY 2020	$0	$1,871,812	$0	$1,871,812
FY2021	$0	$1,918,912	$0	$1,918,912
Biennium Total	$0	$3,790,724	$0	$3,790,724