PRESENTATION TO THE 2025 HEALTH AND HUMAN SERVICES JOINT APPROPRIATIONS SUBCOMMITTEE

OFFICE OF INSPECTOR GENERAL

Public Health and Community Affairs Practice

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OVERVIEW

The Office of the Inspector General's (OIG) mission is to promote and protect the health, safety, and well-being of people in Montana by providing a responsive, independent assessment and monitoring of human services through respectful relationships. OIG collaborates with other Department of Public Health and Human Services (DPHHS) branches to ensure that all Montana health care, residential, and youth care facilities comply with the required state and federal standards of care. OIG carries out this work through two primary regulatory functions: certification and licensing.

All health care facilities and services are licensed but may not be certified. Licensing ensures that all facilities and programs meet state requirements, while certification ensures that facilities and programs meet federal requirements related to reimbursement eligibility in Medicaid and Medicare.

OIG's system for receiving complaints regarding facility care and services allows the public to play an essential role in guarding the safety of vulnerable populations. OIG investigates each complaint to ensure facilities operate safely and protect the health and well-being of all Montanans.

OIG also reviews, audits, and recovers errant payments made through the Children's Health Insurance Program (CHIP), 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

CERTIFICATION

The Certification Bureau performs onsite surveys to determine whether a provider or supplier meets the requirements for participation in the Medicare and Medicaid programs and whether they meet the standards for delivering safe and acceptable quality care. Providers and suppliers reviewed include ambulatory surgery centers, end-stage renal disease facilities, home health agencies, hospice providers, hospitals (acute, children's, critical access, long-term acute care, psychiatric, and rehabilitation), long-term care (nursing homes), outpatient therapy, psychiatric resident treatment facilities, and portable x-ray suppliers. Certification staff support new and current providers through the certification process and serve as subject matter experts on federal regulations. They offer education on rules and work with federal regulatory agencies to help providers meet the requirements of certification. The bureau is comprised of 30 Positions Budgeted (PB).

Certification performs the following functions:

- Conduct investigations and fact-finding surveys, including complaints, emergency preparedness, laboratory, life safety code, emergency preparedness, and recertification surveys
- Certify and re-certify facilities within statutory timelines
- Advise providers and suppliers about federal regulations to assist them in qualifying for participation in the programs and in maintaining standards of health care consistent with the requirements
- Conduct periodic educational programs to present current regulations, procedures, and policies to the staff and residents at skilled nursing facilities (Medicare) and nursing facilities (Medicaid)

Other certification functions include:

- Monitor proficiency testing in laboratories in the Clinical Laboratory Improvement Amendments (CLIA) laboratory certification program
- Maintain the nurse aide registry and review and certify registrants
- Approve nurse aide training programs

LICENSURE

The Licensure Bureau has fourteen staff members to oversee the licensing of over 1,100 healthcare, residential, and community-based facilities. In addition to regulatory inspections, facility surveyors investigate a wide range of complaints at licensed facilities to ensure people have their voices heard and their needs met.

Healthcare Facilities

OIG Healthcare Facilities Program licenses over 800 facilities, including medical and senior services at hospitals, home health agencies, hospices, outpatient centers for surgical services, and assisted living facilities. Healthcare facilities staff conduct regulatory activities to ensure citizens receive quality treatment and medical care at each facility. All licensed facilities are subject to unannounced inspections to ensure a clean and safe environment, proper nutrition, documentation of services provided and needs of patients and residents, and proper delivery of health care services.

Community Residential Facilities

OIG Residential Facilities program licenses almost 200 community residential facilities that provide care and treatment for youth needing out-of-home placements or elderly or disabled adults. The program also licenses close to 100 programs providing outpatient mental health or substance use disorder treatment. Residential facilities staff conduct regular inspections of facilities and investigate complaints independently and in collaboration with appropriate partners and agencies. These activities ensure proper supervision, care, and treatment services are provided to Montanans at these facilities.

PROGRAM COMPLIANCE BUREAU

Intentional Program Violation

The Intentional Program Violation (IPV) unit reviews allegations of recipient fraud in the CHIP, Low-Income Home Energy Assistance Program (LIHEAP), Medicaid, SNAP, and TANF programs. After an investigation, if the evidence supports fraud, the unit proceeds through the administrative disqualification process or makes a referral to a court of competent jurisdiction as required by federal law.

Referrals are received from the Office of Public Assistance (OPA), SNAP quality control reviewers, Fraud Hotline, or other methods.

When fraud is determined to have occurred in the SNAP or TANF programs, the recipient may be disqualified for 12 months, 24 months, 120 months, or permanently, depending on the violation. SNAP disqualifications are tracked nationally to prevent an individual with a disqualification from receiving benefits in another state. An overpayment of benefits in all applicable programs is established to recover benefits the individual was not eligible to receive. Medicaid participants do not receive a disqualification period per state and federal regulations, but overpayment may be established.

RECIPIENT FRAUD INVESTIGATIONS SFY23

	Referrals Received	Investigations Closed – No Program Violation*	Program Violations Confirmed*	Referral Remains Under Investigation
Medicaid	164	146	4	1
SNAP	1646	1665	280	2
TANF	121	136	34	0
Total	1,931	1,947	318	3

RECIPIENT FRAUD INVESTIGATIONS SFY24

	Referrals Received	Investigations Closed – No Program Violation*	Program Violations Confirmed*	Referral Remains Under Investigation
Medicaid	243	218	8	14
SNAP	1520	1442	241	52
TANF	128	106	23	10
Total	1,891	1,766	272	76

*Completed Investigations may have been referred during a prior SFY

Medicaid Eligibility Quality Control

States must conduct Medicaid Eligibility Quality Control (MEQC) reviews during the two years following the payment error rate measurement (PERM) review year. MEQC complements PERM and is intended to prompt states to take action to mitigate risks for improper payments and improve the accuracy of their eligibility determinations in between PERM review years. MEQC ensures that Montana Medicaid and CHIP eligibility is determined correctly, recipients are placed in the correct eligibility category, and the related expenses are paid at the correct federal medical assistance percentages (FMAPs).

MEQC randomly selects a monthly sample from recipients determined to be currently authorized as eligible for CHIP or Medicaid (active case review) or from recipients who have been denied or terminated from CHIP or Medicaid (negative case review).

Montana's MEQC case reviews may result in a determination of correct, error, or technical deficiency (TD).

Error

Improper application of eligibility rules or process which causes a recipient to be determined eligible when they are ineligible for Medicaid or CHIP, recipient determined eligible for the incorrect type of assistance, recipient denied or terminated improperly, redetermination was untimely, or a required element of the eligibility determination process cannot be verified as being performed.

Technical Deficiency (TD)

Improper application of eligibility rules or processes that do not change the recipient's approved eligibility or have a financial consequence.

MEQC ACTIVE CASE REVIEWS CALENDAR YEAR (CY) 2023

	Total Reviewed	Total Correct	Cases with Errors	Cases with TD's
Medicaid	223	69%	28%	3%
CHIP	78	66%	31%	3%

MEQC NEGATIVE CASE REVIEWS CY23

	Total Reviewed	Total Correct	Cases with Errors	Cases with TD's
Medicaid	187	78%	18%	4%
CHIP	196	73%	25%	2%

MEQC ACTIVE CASE REVIEWS CY24 – THROUGH SEPTEMBER 2024

	Total Reviewed	Total Correct	Cases with Errors	Cases with TD's
Medicaid	226	64%	19%	17%
CHIP	83	62%	19%	19%

MEQC NEGATIVE CASE REVIEWS CY24 – THROUGH SEPTEMBER 2024

	Total Reviewed	Total Correct	Cases with Errors	Cases with TD's
Medicaid	155	66%	21%	13%
CHIP	158	68%	17%	15%

Please note that the data for CY24 is from January 2024 to September 2024. Sampled cases for October are still under review, and cases have not been sampled for November or December 2024.

Payment Error Rate Measurement

The PERM program is a joint effort between the Centers for Medicare and Medicaid Services (CMS) and states to measure improper payment rates in the CHIP and Medicaid programs. PERM operates on a three-year cycle, moving through all 50 states. States are divided into 17 states per cycle. Montana is a Cycle 3 state with Alaska, Arizona, the District of Columbia, Florida, Hawaii, Indiana, Iowa, Louisiana, Maine, Mississippi, Nevada, New York, Oregon, South Dakota, Texas, and Washington.

National error rates are calculated using eligibility, medical records, and data processing review results. Montana's most recent PERM audit results were for Reporting Year (RY) 2024 on claims paid during SFY23. The next PERM cycle will be RY27 to review claims paid during SFY26.

OVERALL IMPROPER PAYMENT RATE RY24

Medicaid	CHIP
National Rolling Finding – 5.09 % - Fee for Service (FFS) – 4.83% - Eligibility – 3.31%	National Rolling Finding – 6.11% - FFS – 4.72% - Eligibility – 4.44%
17-State Cycle 3 Finding – 3.17% - FFS – 5.46% - Eligibility – 1.53%	17-State Cycle 3 Finding – 3.17% - FFS – 10.97% - Eligibility – 1.47%
Montana Finding – 6.97% - FFS – 6.09% - Eligibility – 0.94%	Montana Finding – 6.40% - FFS – 2.38% - Eligibility – 4.12%

FFS Error Trends

- Average paid claim amount increased from RY21 to RY24.
  - CHIP RY21 300 sample totaling $1,939,326.36 – average $6,464.42
  - CHIP RY24 250 sample totaling $1,709,579.45 – average $6,838.32
  - Medicaid RY21 176 sample totaling $624,127.51 – average $3,546.18
  - Medicaid RY24 311 sample totaling $1,356,771.19 – average $4,362.61
- Montana had 11 provider enrollment errors in RY24 as compared to 9 in RY21. Provider enrollment errors include:
  - Missing National Provider Identifier (NPI) of the prescribing, rendering, referring, or ordering provider on the claim.
  - Prescribing or ordering providers not enrolled in Montana Medicaid.
- Montana is currently in the development phase of a new Medicaid Management Information System (MMIS). This new system will replace the legacy MMIS system in 2027 and will allow for system edits to pause payment when a claim is missing all the required NPI numbers or when a provider is not enrolled in Montana Medicaid.

Eligibility Error Trends

- CMS has issued waivers to states due to the continued efforts resulting from the Public Health Emergency (PHE). One waiver is to not review for Medicaid and CHIP recertifications being completed timely. RY21 included this error type, while many claims sampled for RY24 fell within the CMS waiver, excluding this error type. The timeliness waiver led to the lowered PERM eligibility error rate.

SNAP Quality Control

SNAP quality control (QC) activities ensure the timely and accurate issuance of benefits to eligible individuals for the SNAP program. The cases are randomly sampled for review and evaluated 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 the Human and Community Services Division (HCSD) to create practical corrective actions to minimize potential SNAP errors. QC reviewed 1,582 SNAP cases in Federal Fiscal Year (FFY) 2023. As of October 2024, QC has reviewed 1,534 cases.

Surveillance Utilization Review Section

Maintaining the integrity of the Medicaid program is a national priority. The Surveillance Utilization Review Section (SURS) helps to 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 for services by CHIP and Medicaid.

SURS prioritizes provider education. It participates in the Conduent (state fiscal agent) Provider Training, 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 records and data reviews that encompass a six-month timeframe. A follow-up review may be performed if the initial review has a 5% or more error rate. Review plans are derived from data mining, beneficiary responses to Explanation of Medical Benefits summaries (EOMBs) and Trauma Questionnaires sent by the Third-Party Liability (TPL) Unit, program requests, referrals from other departments, and national trends. SURS staff includes eight program integrity compliance specialists, certified program integrity coders, and certified program integrity professionals.

SURS works collaboratively with the Department of Justice Medicaid Fraud Control Unit (MFCU) on cases of suspected and credible allegations of fraud. In SFY23, SURS made two credible allegations of fraud referrals and two suspected fraud referrals to MFCU. In SFY24, SURS made one credible allegation of fraud referral and three suspected fraud referrals to MFCU.

The SURS unit collected $708,076 in provider overpayments during SFY23 and $1,003,186 during SFY24.

Third-Party Liability

The TPL Unit ensures Medicaid is the payer of last resort. It is responsible for recovering funds from medical claims paid by Medicaid when a liable third party should have. Third parties can be defined as automobile and homeowner insurance companies (casualty insurance), court settlements or awards, or estates of deceased recipients. The TPL Unit also comprises programs that cost-avoid Medicaid dollars through the Coordination of Benefits (COB), Health Insurance Premium Payment (HIPP), and State Buy-In programs.

The TPL Unit works with the OPA, state fiscal agents, and other third-party administrators to identify and record all health insurance coverage for Medicaid members. Having the coverage on file allows Medicaid to coordinate benefits and reject claims based on the allowable coverages of the third-party policy.

The COB, HIPP, and State Buy-In programs offer Medicaid opportunities for cost avoidance and saving Medicaid dollars. Cost avoidance is paid by a third party before or instead of Montana Medicaid. The HIPP program determines if paying the premiums for a recipient's individual or group health plan is more cost-effective or if Medicaid is the primary payer. The Buy-In program pays Medicare premiums for Medicaid-eligible

constituents; therefore, Medicare pays first and Medicaid second. COB rejects claims when a known entity should have paid as primary over Medicaid.

Programs resulting in recoveries of Medicaid dollars include estate, lien, and tort recovery. Estate recovery recoups money for medical claims paid for a Medicaid recipient who has passed away and is 55 or older, or a deceased recipient of any age who resided in a nursing home. The lien recovery program places a medical assistance lien on real property when a Medicaid member enters a nursing home without intending to return. Liens are released if the member does return home. Tort pursues recovery by placing a lien with the liable third party for claims paid by Medicaid on behalf of the recipient that the liable third party should have paid.

Finally, TPL recovers Medicaid, SNAP, and TANF overpayments by establishing repayment agreements with the members.

The TPL unit continues to review internal procedures and modify processes in the recovery and cost-avoidance programs. To accomplish these functions, it has eight staff members and a supervisor.

- In SFY23, Montana avoided $292.4 million in Medicaid payments and recovered $14.3 million
- In SFY24, Montana cost avoided $272.2 million in Medicaid payments and recovered $12.4 million

PROGRAM SUPPORT AND IMPROVEMENT SECTION

The OIG Program Support and Improvement Section includes the Certificate of Need Program, State Rural Hospital Flexibility Program, radiation registration, nonprofit community benefits and financial assistance, community needs determination, hiring coordination, and OIG management and office support.

Certificate Of Need

Since 1975, 35 states and Washington DC have utilized Certificate of Need (CON) Programs to help maintain quality of care, control a portion of community health care costs, and promote rational distribution of certain health care services. Montana CON requires individuals or health care facilities seeking to initiate or expand long-term care services to submit letters of intent and applications to the department. The *State Long-Term Care Facilities Plan* is a guideline in determining service needs.

The department and many people and organizations across the state and nation access the information collected each year from annual health care facility reports for planning purposes.

In recent years, Montana has seen a trend of long-term care facility voluntary closures and an increase in critical access hospital (CAH) swing bed use. In the past two years,

projected unmet bed needs in communities with long-term care remains low. However, high swing bed use in several communities without long-term care facilities could indicate a need for long-term care beds.

CY23:

- Two long-term care facility closures
- One request to add swing beds
- 14 changes of ownership
- Three applications to reopen facilities

CY24 to date:

- Two applications from 2023 were approved; the applicant withdrew the other
- One long-term care facility voluntary closure
- One involuntary long-term care facility closure
- One letter of intent to convert CAH swing beds to a long-term care facility (application due in December)

State Rural Hospital Flexibility Program

The State Rural Hospital Flexibility (Flex) Program was established by the Balanced Budget Act of 1997. Montana has received Flex funding from the Health Resources and Services Administration since 1999. The current funding period is five years (Sept. 1, 2024 – Aug. 31, 2029), with $928,510 to be awarded each year.

The Flex Program aims to support Montana's 50 CAHs, CAH-owned rural health clinics, and emergency medical services (EMS). The Flex Program ensures residents in rural communities have access to high-quality health care services and is a resource for strategic planning, assessment, and identification of CAH needs. Flex provides training and education opportunities in the areas of quality improvement, operational and financial improvement, population health improvement, EMS improvement, and if requested, assistance with CAH designation. Montana utilizes a primary contract and longstanding partnership with the Montana Health Research and Education Foundation of the Montana Hospital Association for most activities. The Public Health and Safety Division completes additional DPHHS in-house activities.

HIGHLIGHTS AND ACCOMPLISHMENTS DURING THE 2025 BIENNIUM

CERTIFICATION

After engaging with providers (nursing homes, hospitals, hospice and home health agencies, etc.) and their associations, the Bureau conducted a needs assessment on how best to assist providers in meeting their regulatory obligations. In conjunction with this assessment and in response to provider suggestions, the Bureau repurposed a health facility surveyor position to become the health facility trainer. This position was developed and operationalized to take a proactive approach and to develop training for providers and surveyors to ensure consistent and equitable training on CMS regulations. The objective of the providers and the bureau is to realize a shared goal of reducing the number, severity, and frequency of citations.

LICENSURE

In 2024, the Licensure Bureau became fully staffed for the first time in almost five years by filling the bureau chief position. The bureau also reclassified a position to develop a facility surveyor supervisor position. Historically, the two programs under the Licensure Bureau, Healthcare Facility Licensing and Community and Residential Facility Licensing operated independently and separately. With the fulfillment of the bureau chief and facility surveyor supervisor positions, the bureau has taken steps to unite the two programs and make consistent multiple processes, including surveying, writing reports, and the tools used to conduct inspections. The bureau is implementing cross-training of staff amongst the two programs. Cross-training of staff will ensure that schedule and complaint inspections can be completed even in the event of staff absences or vacant positions. The plan will also result in cost savings for travel and lodging.

As part of the Governor's Red Tape Relief initiative, the bureau reviewed, updated, and amended the Administrative Rules of Montana (ARM) for minimum standards for all health care facilities, adult daycare facilities, and retirement homes. As a result of the 2023 Legislative Session, new rules were established for the licensure of rural emergency hospitals and abortion clinics. Furthermore, the 2023 session prompted the department to amend the ARMs for private alternative adolescent residential and outdoor programs (PAARP) and further revise the minimum standards for all health Care facilities.

The Licensure Bureau conducts four provider training sessions throughout the state each year. The Bureau maintains its accessibility to providers and the public by providing technical assistance through the licensing portal, regulatory discussions, and inspection evaluations.

PROGRAM COMPLIANCE BUREAU

Intentional Program Violation (IPV) unit took a proactive approach to combating fraud, waste, and abuse of public assistance programs by applying for the 2024 SNAP Fraud Framework Implementation Grant. Montana will receive $424,388 to upgrade the current system to detect and prevent fraudulent online submissions for Medicaid, SNAP, and TANF benefits. Technology can identify the misuse of public assistance benefits by utilizing pre-determined fraud indicators to produce a list of cases with a high probability of fraud. Some examples of pre-determined indicators are not reporting all household members, not reporting new or increased income streams, or continuing to receive benefits after moving out of state. Better capturing and analyzing information associated with online application submissions will allow the IPV unit to track and identify potential recipient fraud while streamlining investigation and disposition reporting. DPHHS will spend several months designing, developing, and testing the enhanced technology before deployment in the summer of 2025.

TPL tort recovery team opened approximately 1,200 Global Settlement cases for Medicaid recipients with Asbestos-related illnesses in 2021, in addition to all other Global Settlement notifications received by the tort recovery team. TPL took a proactive approach to find efficiencies to process the vast amount of tort cases, including specialized queries to pull medical claim reports for multiple recipients at once, and uploading documentation to the tracking system. Tort began seeing recoveries from these cases in 2023 and 2024, for a total recovery in Global Settlements of $745,181. The combined recoveries in Global Settlements for 2021 and 2022 were $177,223.

PROGRAM SUPPORT AND IMPROVEMENT SECTION

The Flex EMS Sustainability Project will bring $250,000 of additional Flex funding per year for the next five years (9/1/2024 - 8/31/2029). These funds will implement the Montana Frontier EMS Leadership Academy, a partnership with Montana Flex, EMS and Trauma Systems, the Montana Office of Rural Health and Area Health Education Centers located at Montana State University, and six participating EMS agencies.

This project aims to address challenges rural EMS agencies face and strengthen the volunteer and paid EMS workforce through innovative strategies for recruitment, retention, and financial and operational needs. After identifying gaps in existing leadership training materials, the curriculum will be developed and tailored to the content-specific needs of EMS leaders. Training modules will be offered for seamless access to online courses and resources utilizing evidence-based practices and teaching from EMS leaders and subject matter experts. Through career advancement programs, mentoring, and the addition of new curriculum modules each year, the project offers a robust and dynamic solution to bolster rural EMS leaders.

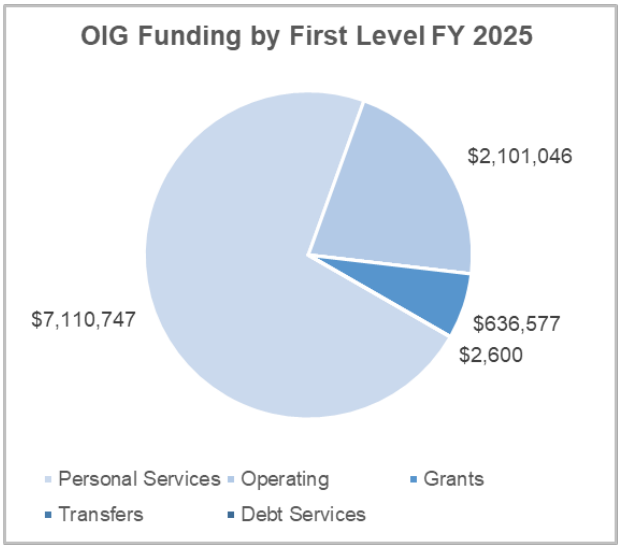
This initiative will serve as a replicable model, scaling solutions across Montana and nationally to empower rural EMS leaders by providing essential training, resources, and support. The Montana Frontier EMS Leadership Academy's aim is to ensure quality emergency care in even the most remote communities, safeguarding the health and well-being of Montanans for years to come.

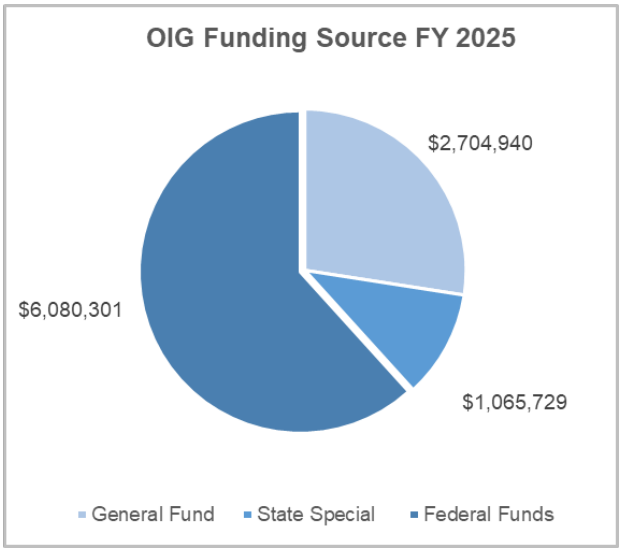
Anticipated outcomes include:

- increase the number of paid EMS providers
- increase the number of EMS volunteers
- increase the number of advanced trained providers
- increase the eligible runs/transports that are submitted for billing
- increase job satisfaction of EMS employees and volunteers
- increase the percent collected on billed transports
- increase the number of agencies that have position descriptions for the service manager and medical director
- enhance leadership capabilities for frontier EMS agencies

FUNDING AND PB INFORMATION

OFFICE OF INSPECTOR GENERAL	FY 2025 BUDGET	FY 2026 REQUEST	FY 2027 REQUEST
PB	88.5	88.5	88.5
Personal Services	$7,110,747	$7,687,923	$7,705,166
Operating	$2,101,046	$1,979,312	$1,981,366
Equipment	$0	$0	$0
Local Assistance	$0	$0	$0
Grants	$636,577	$636,577	$636,577
Benefits and Claims	$0	$0	$0
Transfers	$0	$0	$0
Debt Services	$2,600	$2,600	$2,600
TOTAL COSTS	**$9,850,970**	**$10,306,412**	**$10,325,709**
	FY 2025 BUDGET	**FY 2026 REQUEST**	**FY 2027 REQUEST**
General Fund	$2,704,940	$2,860,587	$2,869,307
State Special Fund	$1,065,729	$1,073,186	$1,073,401
Federal Fund	$6,080,301	$6,372,639	$6,383,001
TOTAL FUNDS	**$9,850,970**	**$10,306,412**	**$10,325,709**





CHANGE PACKAGES

PRESENT LAW ADJUSTMENTS

SWPL 1 – Personal Services

The budget includes $617,536 in FY 2026 and $634,779 in FY 2027 to annualize various personal services costs including FY 2025 statewide pay plan, benefit rate adjustments, longevity adjustments related to incumbents in each position at the time of the snapshot, and vacancy savings.

	General Fund	State Special	Federal Funds	Total Request
FY 2026	$160,205	$7,457	$449,874	$617,536
FY 2027	$167,447	$7,672	$459,660	$634,779
Biennium Total	$327,652	$15,129	$909,534	$1,252,315

SWPL 3 – Inflation Deflation

This change package includes reductions of $6,334 in FY 2026 and $4,280 in FY 2027 to reflect budgetary changes generated from the application of deflation to state motor pool accounts.

	General Fund	State Special	Federal Funds	Total Request
FY 2026	($4,558)	$0	($1,776)	($6,334)
FY 2027	($3,080)	$0	($1,200)	($4,280)
Biennium Total	($7,638)	$0	($2,976)	($10,614)

NEW PROPOSALS

NP 8001 - REALIGN APPROPRIATION WITH REVENUE RURAL HOSPITAL FLEX PGM

This new proposal reduces the appropriation of federal revenue to the Rural Hospital Flexibility program to align appropriation with anticipated expenditures. This change package requests a reduction of $115,400 in federal revenue in each year of the biennium.

	General Fund	State Special	Federal Funds	Total Request
FY 2026	$0	$0	($115,400)	($115,400)
FY 2027	$0	$0	($115,400)	($115,400)
Biennium Total	$0	$0	($230,800)	($230,800)

NP 8002 - REALIGN APPROPRIATION WITH REVENUE CLINICAL LABORATORY IMPROVEMENT

This new proposal reduces the appropriation of federal revenue to the Title 18 Clinical Laboratory Improvement Amendments program to align appropriation with anticipated expenditures. This change package requests a reduction of $40,360 in federal revenue in each year of the biennium.

	General Fund	State Special	Federal Funds	Total Request
FY 2026	$0	$0	($40,360)	($40,360)
FY 2027	$0	$0	($40,360)	($40,360)
Biennium Total	$0	$0	($80,720)	($80,720)