MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

PRESENTATION TO THE 2023 HEALTH AND HUMAN SERVICES JOINT APPROPRIATION SUBCOMMITTEE

Office of the Inspector General

Director's Office

Department of Public Health and Human Services

THE FOLLOWING TOPICS ARE COVERED IN THIS REPORT:

- **Overview**
- **Summary of Major Functions**
- **Reaching Rural Populations 2022**
- **Highlights and Accomplishments during the 2023 Biennium**
- **Funding and FTE Information**
- **Change Packages**

OVERVIEW

The Office of the Inspector General's (OIG) mission is to promote and protect the health, safety, and wellbeing of people in Montana by providing a responsive, independent assessment and monitoring of human services through respectful relationships. OIG collaborates with other DPHHS practices 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 not all are certified. Licensing ensures all facilities and programs meet the state requirements. Certification ensures 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 important role in guarding the safety of vulnerable populations. OIG investigates each complaint to ensure facilities are operating safely to protect the health and well-being of all Montanans which allows the public to be a part of the process while providing an avenue for voicing concerns.

OIG also 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

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 regulations and work with federal regulatory agencies to help providers meet the requirements of certification.

Certification performs the following functions:

- Conduct investigations and fact-finding surveys, including complaints, emergency preparedness, focused infection control, laboratory, life safety code, 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 and nursing facilities

The Certification functions also include:

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

LICENSING

The Licensing Bureau utilizes fourteen staff to oversee the licensing of approximately 1,100 health care facilities around the state. In addition to regulation inspections, health care 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 staff licenses over eight-hundred facilities including medical and geriatric services at hospitals, home health, hospice, assisted living, and adult foster care. Licensing staff conduct regulatory activities to ensure citizens receive quality treatment and medical care at each of these facilities. All licensed facilities are subject to unannounced inspections to ensure a clean and safe environment, proper nutrition, and proper delivery of health care services.

Community Residential Facilities

OIG Residential Facilities staff license approximately three-hundred community residential facilities which provide for the care and treatment of youth in need of out-of-home placements, or for elderly or disabled adults. Residential Facilities staff also license over one-hundred programs providing outpatient mental health or substance use disorder treatment. The community residential program conducts regular inspection of all facilities and investigates complaints both 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.

INTERNAL CONTROL AND RISK MANAGEMENT

The Internal Control and Risk Management (ICRM) Bureau assists DPHHS programs to be more consistent, accurate, and efficient through independent validation by providing desk reviews of external audits, procedure reviews, internal control testing, and contract and regulatory oversight.

PROGRAM COMPLIANCE

Intentional Program Violation

The Intentional Program Violation (IPV) unit reviews allegations of recipient fraud in Children's Health Insurance Program (CHIP), Low Income Home Energy Assistance Program (LIHEAP), Medicaid, Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF) program. At the completion of an investigation, if the evidence supports that fraud has occurred the unit proceeds through the administrative disqualification process or makes a referral to a court of competent jurisdiction as required by federal law.

When fraud is determined to have occurred in the SNAP or TANF programs the recipient may be disqualified from the program for 12, 24, 120 months, or permanently, depending on the violation. SNAP disqualifications are tracked nationally to prevent individuals with an IPV 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 regulation, but an overpayment may be established.

Intentional Program Violations	Referrals	Disqualifications
Medicaid SFY 2021	109	N/A
Medicaid SFY 2022	104	N/A
SNAP SFY 2021	3,015	271
SNAP SFY 2022	1,996	318
TANF SFY 2021	207	24
TANF SFY 2022	171	40

Medicaid Eligibility Quality Control

- The Medicaid Eligibility Quality Control (MEQC) program is required by CMS to ensure 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 reviews began in calendar year (CY) 2021. Due to the Public Health Emergency (PHE), CMS amended the MEQC requirements and Montana submitted the CY2021 findings to CMS on October 31, 2022.
  - Total reviews: 225
    - Correct: 42%
    - Technical Deficiency: 40%
    - Error: 18%

Payment Error Rate Measurement

The Payment Error Rate Measurement (PERM) program is a joint effort between CMS and states to measure improper payment rates in the CHIP and Medicaid programs. PERM operates on a

three-year cycle moving through all fifty states. PERM conducts eligibility reviews, medical record reviews, and data processing reviews. National error rates are calculated using eligibility, medical record, and data processing review results. Montana's most recent PERM audit results were for Reporting Year (RY) 2021 on claims paid during State Fiscal Year (SFY) 2020. The next PERM cycle will be RY 2024 for a review of claims paid during SFY 2023.

RY 2021 Medicaid findings

- Overall Improper Payment Rate: Montana – 10.66%; National Cycle–3 Rate – 13.68%
- Fee for Service: Montana – 3.15%; National Cycle–3 Rate – 13.91%
- Eligibility: Montana – 7.76%; National Cycle–3 rate – 9.27%

RY 2021 CHIP findings

- Overall Improper Payment Rate: Montana – 19.39%; National Cycle–3 Rate – 22.93%
- Fee for Service: Montana – 2.63%; National Cycle–3 Rate – 26.07%
- Eligibility: Montana – 17.22%; National Cycle–3 rate – 20.54%

Montana remains below the national error rates.

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 reviews 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 effective corrective actions to minimize potential SNAP errors. QC reviewed 964 SNAP cases in Federal Fiscal Year (FFY) 2021: a decrease from FFY 2020 (1,292 cases). The decrease in case reviews is primarily due to the number of recipients not eligible due to receiving unemployment benefits. In FFY 2022, QC reviewed 1,402 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, and is required under federal law. 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.

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 five percent 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. SURS staff includes eight Program Integrity Compliance Specialists made up by Certified Professional 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 SFY 2021, SURS had no credible or suspected fraud referrals to MFCU. In SFY 2022, SURS made two credible allegations of fraud referrals and one suspected fraud referral to MFCU.

The SURS unit has collected the following overpayment amounts over the last several state fiscal years.

State Fiscal Year	Overpayments Collected
SFY 2021	$814,095
SFY 2022	$513,680

Third-Party Liability

The Third-Party Liability Unit (TPL) ensures 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.

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 coverage 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 fifty-five 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.

Finally, TPL recovers overpayments of Medicaid, Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance to Needy Families (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. The TPL unit has a total of eight staff and a supervisor to accomplish these functions.

- In SFY 2021, Montana cost avoided $244.3 million in Medicaid payments and recovered $15.1 million
- In SFY 2022, Montana cost avoided $257.8 million in Medicaid payments and recovered $12.8 million

REACHING RURAL POPULATIONS 2022

MONTANA RURAL HOSPITAL FLEXIBILITY GRANT

This year's FY 2022 – 2023 award marks the twenty-third year DPHHS was awarded the Rural Hospital Flexibility (Flex) grant from the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA) Federal Office of Rural Health Policy (FORHP). The funding supports Montana's forty-nine Critical Access Hospitals (CAH) and CAH-owned Rural Health Clinics. This year's award is for $880,105, which is a nine percent increase from last year's award due to the Consolidated Appropriations Act of 2022. These federal dollars provide rural health services where Montanans live. Since most of Montana is considered rural and frontier, it can be difficult for CAHs to serve citizens where they are. The Flex grant contributes innovative solutions to support workforce and technology development as well as training and educational opportunities for CAH staff. These improvements help reduce the costs associated with delivering services to rural communities while improving the health of Montanans.

Montana piloted what became the Flex grant back in the mid-to late 1980s and has shared models with the other forty-four Flex states for activities in quality improvement, financial and operational improvement, population health improvement, and Emergency Medical Services (EMS) improvement. The Flex Program plans to incorporate a stream-lined version of the proposed EMS quality improvement activity into the work plan with the additional funding received this year. Although this year was not as challenging for the Flex program as in the previous two years with COVID-19 restrictions and limitations, some activities continue to be offered in a virtual format.

In addition to the primary Flex grant, the Consolidated Appropriations Act of 2022 also provided funding to establish a Rural Emergency Hospital (REH) Technical Assistance Center, which ties into the Flex Program. Montana received an approximately eight percent increase in supplemental funding for engaging rural communities to inform them about the new REH model, share resources developed by the REH Technical Assistance Center, and engage state and regional partners. The supplemental REH funding for FY 2022 – 2023 totals $70,408, bringing the total Flex funding to $950,513 this year.

HIGHLIGHTS AND ACCOMPLISHMENTS DURING THE 2023 BIENNIUM

INTEGRITY EFFORTS

In efforts to increase identification and reduce fraud, waste, and abuse, SURS has partnered with two groups: the Healthcare Fraud Prevention Partnership (HFPP) and Unified Program Integrity Contractor (UPIC). SURS plans to use these partnerships to examine emerging trends and develop strategies to address them. This will aid SURS in their ability to better detect potential fraud, waste, and abuse with Medicaid providers.

The Intentional Program Violations Unit (IPV), Third-Party Liability Unit (TPL), and SNAP Quality Control Unit received approval September 12, 2022, to utilize the CLEAR program which will help OIG to locate individuals, identify assets, and verify components of investigations.

The OIG worked with the US Department of Health and Human Services to successfully prosecute a few of the most egregious cases of fraud. One such case resulted in a court finding of $114,000 in restitution owed to the federal government and the state of Montana.

COVID-19 RESPONSE

As a result of COVID-19, healthcare facilities were required to restrict or limit visitation within a facility to reduce the risk of exposure to the coronavirus. To assist facilities in these efforts, the Healthcare Facility Licensing Program developed procedures to provide remote oversight to ensure continued licensing of healthcare facilities. Providers sent documentation for review through the state's secure File Transfer System for program staff to review. Zoom meetings allowed staff to conduct virtual tours of facilities to observe call systems, facility cleanliness, and food quality. Complaint investigations are also conducted remotely unless an on-site visit is required due to allegations of abuse or neglect.

The Certification Bureau completed remote and onsite evaluations of Infection Control Programs for certified health care facilities, nursing homes, hospitals, home health agencies, and hospice programs. More than fifty remote infection control program evaluations were conducted, and three-hundred onsite infection control surveys were completed. These CMS Focused Infection Control Surveys were conducted in seventy-one nursing homes, twenty hospitals, eight home health agencies, and five hospice providers. A complaint or outbreak is defined as one or more staff or residents who are COVID-19 positive. Certification surveyors and supervisors continue to monitor facilities as the state continues to respond to the pandemic.

BOUNDS LICENSING DATABASE

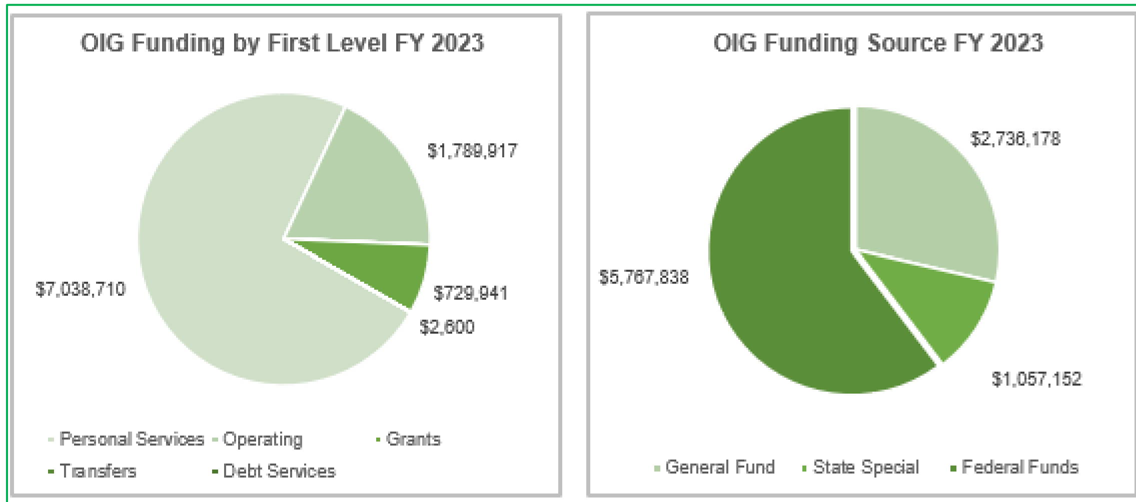
The Licensure Bureau implemented a new licensing database named BOUNDS, which is developed by Jump Technologies and allows for more provider access online. Providers are now able complete and submit applications, make electronic payments, enter plans of corrections and other reports, and retrieve documentation from the Department directly through the provider portal. The Public Facility Search portal, linked through the BOUNDS system, improves accessibility, and simplifies searching for facility information.

HEART INITIATIVE

The Licensure Bureau revised the Administrative Rules of Montana for Substance Use Disorder Facilities as part of the HEART Initiative, Youth Care Facility rules to implement requirements of the Family First Act, and Assisted Living Facilities pursuant to SB 272 and HB 566.

FUNDING AND FTE INFORMATION

OFFICE OF INSPECTOR GENERAL	FY 2023 Budget	FY 2024 Request	FY 2025 Request
FTE	89.5	92.5	92.5
Personal Services	$7,038,710	$7,161,633	$7,206,130
Operating	$1,789,917	$1,848,838	$1,864,111
Grants	$729,941	$729,941	$729,941
Debt Services	$2,600	$2,600	$2,600
TOTAL COSTS	**$9,561,168**	**$9,743,012**	**$9,802,782**
	FY 2023 Budget	**FY 2024 Request**	**FY 2025 Request**
General Fund	$2,736,178	$2,749,570	$2,762,268
State Special Fund	$1,057,152	$947,140	$958,097
Federal Fund	$5,767,838	$6,046,302	$6,082,417
TOTAL FUNDS	**$9,561,168**	**$9,743,012**	**$9,802,782**



CHANGE PACKAGES

PRESENT LAW ADJUSTMENTS

SWPL 1 – Personal Services

The request includes reductions of $97,564 in FY 2024 and $55,238 in FY 2025 to annualize various personal services costs including FY 2023 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 2024	($94,018)	($126,644)	$123,098	($97,564)
FY 2025	($85,859)	($117,852)	$148,473	($55,238)
Biennium Total	($179,877)	($244,496)	$271,571	($152,802)

SWPL 3 – Inflation Deflation

The request includes an increase of $62,763 in FY 2024 and $78,036 in FY 2025 to reflect budgetary changes generated from the application of inflation to specific expenditure accounts. Affected accounts include those associated with supplies & materials, communications, repair & maintenance, state motor pool, and other services

	General Fund	State Special	Federal Funds	Total Request
FY 2024	$15,453	$7,436	$39,874	$62,763
FY 2025	$19,123	$9,514	$49,399	$78,036
Biennium Total	$34,576	$16,950	$89,273	$140,799

PL 8002 – Align Appropriation with Revenue

This present law change package aligns federal authority with anticipated revenue in the Office of the Inspector General Division.

	General Fund	State Special	Federal Funds	Total Request
FY 2024	$0	$0	($13,249)	($13,249)
FY 2025	$0	$0	($13,249)	($13,249)
Biennium Total	$0	$0	($26,498)	($26,498)

NEW PROPOSALS

NP 8001 – FTE Quality Control Federal Mandate

This new proposal requests the transfer of 3.00 FTE from the Healthcare Facilities Division to the Office of Inspector General Division. The Centers for Medicare & Medicaid Services (CMS) requires states to conduct Medicaid Eligibility Quality Control (MEQC) activities to ensure that Montana Medicaid and Child Health Insurance Program (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 Program (FMAP). This change package requests $461,959 in total funds over the biennium including $184,783 in general fund, $18,479 in state special, and $258,697 in federal funds.

	General Fund	State Special	Federal Funds	Total Request
FY 2024	$91,957	$9,196	$128,741	$229,894
FY 2025	$92,826	$9,283	$129,956	$232,065
Biennium Total	$184,783	$18,479	$258,697	$461,959