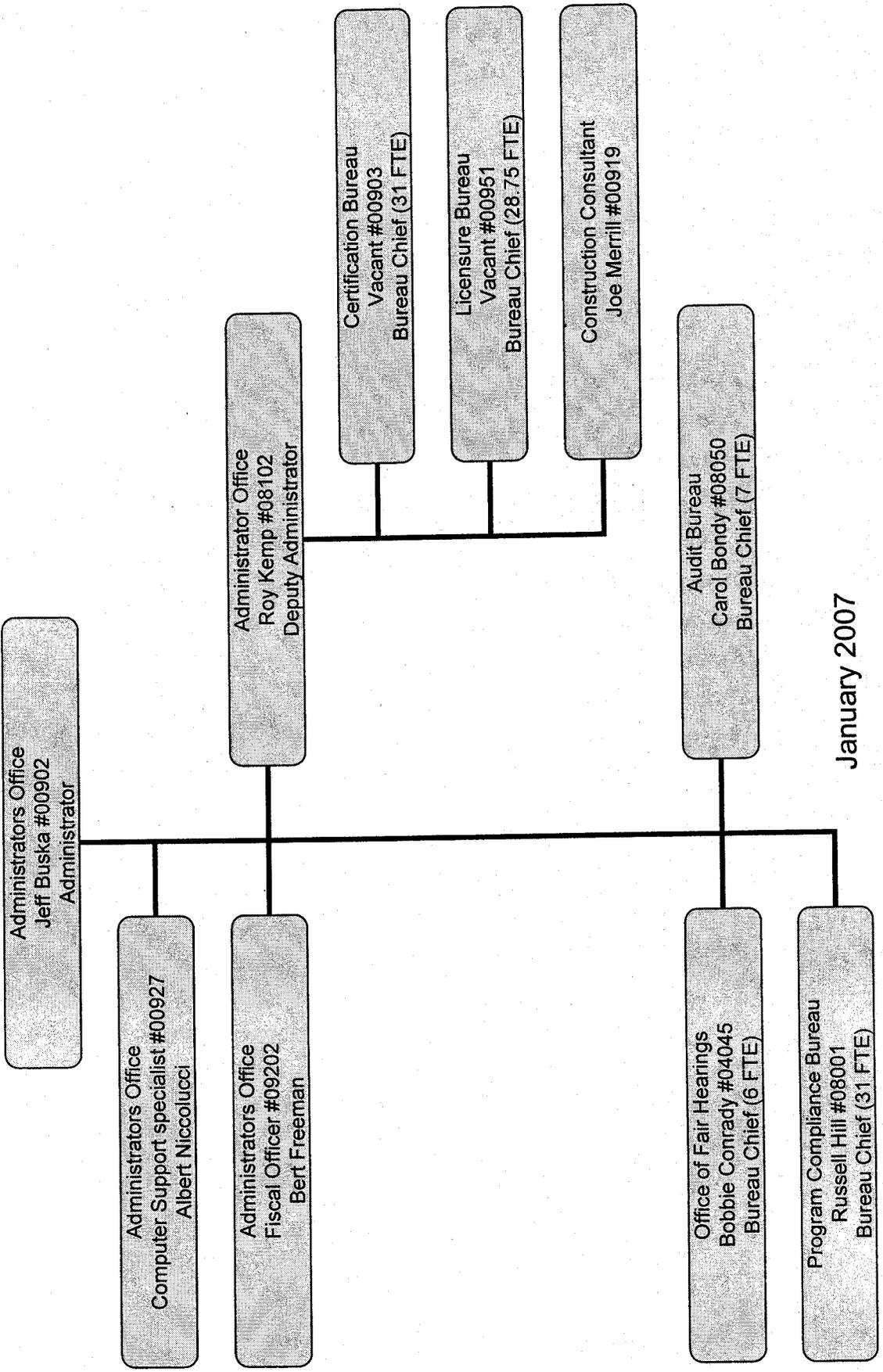


# QAD Organizational Chart

EXHIBIT 2  
DATE 2-5-07  
HB 2



January 2007

QAD - AUDIT BUREAU  
2007 LEGISLATIVE SESSION FACT SHEET

The purpose of the Audit Bureau is to conduct independent audits of department work processes and DPHHS contractors to ensure sound financial management and proper program performance. Audit results are reported to department management to enhance Federal and State program management. Audits are an essential tool to assess financial management, proper internal control, and contract and regulatory compliance.

The Audit Bureau is responsible for providing independent audits and audit related services including:

- 1) Internal audits of DPHHS financial management, compliance with State and Federal laws, the efficiency and internal controls of information systems and program performance.
- 2) Limited scope audits of DPHHS contractors to ensure good financial management and compliance with State and Federal laws.
- 3) Fraud audits as requested. The bureau works with criminal investigators and makes sure State and Federal funds are repaid.
- 4) Reviews of single audits to provide DPHHS program managers with information about contractors' financial management and compliance with program requirements.
- 5) Special request audits that compare costs to rates paid, ensure proper implementation of Federal and State programs, and contract compliance.

The Audit Bureau reports to the department director, but the bureau is located in the Quality Assurance Division for personnel management purposes. This reporting structure ensures the bureau's independence.

The Audit Bureau consists of six auditors and one bureau chief. Three auditors are CPAs. One auditor is a Certified Internal Auditor, and one auditor is a Certified Fraud Examiner.

The DPHHS Audit Bureau has existed for at least 20 years, providing single audits and limited scope audits of DPHHS contractors. The department added the internal audit function in FY 2001. The Audit Bureau is actively involved with preventing and pursuing fraud. If an audit indicates fraud is likely, the proper authorities are notified to conduct criminal investigations.

Audits are requested by DPHHS divisions and the Audit Bureau initiates internal audits after conducting risk assessments. Fraud audits originate as requests from DPHHS divisions, they result from routine bureau audits, and they come from the Fraud, Waste and Abuse Hotline calls. Audit projects are performed according to the yearly audit work plan.

The Audit Bureau currently does audits for the Disability Services Division, the Addictive and Mental Disorders Division, the Health Resources Division, the Business and Financial Services Division, and the Human and Community Services Division. Other divisions request audits as needed and the audit plan is adjusted accordingly.

### AUDIT BUREAU MAJOR ACCOMPLISHMENTS

**Detection of Fraud –** Nine fraud audits. Two resulted in criminal charges and have been prosecuted. Client funds were safeguarded and repaid and internal controls were improved to prevent future fraud. Costs identified from suspected embezzlements or misuse of client funds in 2005 and 2006, amounted to \$323,096. The largest of these was charged to the net assets resulting from Medicaid personal care assistance funds, and most of the rest were from clients' SSI funds that need to be returned to the clients because they are not costs that DPHHS can recover.

**Internal Audits –** Twenty-two audits of DPHHS internal work processes, analysis of costs versus rates paid, funds management guidance, and analysis of DPHHS electronic systems.

**Agreed Upon Procedures Audits –** Nineteen audits of DPHHS contractors to ensure good financial management and compliance with State and Federal laws. Provide guidance on business management, federal program interpretation, and analysis of new federal programs.

**Single Audit –** One large single audit of a provider that did not have an adequate accounting system. The audit recommended specific improvements to the accounting system.

**Review of A-133 Audits –** Tracking and review of approximately 90 single audits of DPHHS contractors each year. Analysis of the audit results sent to DPHHS program managers to use for program management.

**Contractor Financial Analysis to DPHHS Management –** Financial ratio analysis of DPHHS contractors provided to DPHHS management.

## QAD - CERTIFICATION BUREAU FACT SHEET

The mission of the federal Medicare and Medicaid Survey and Certification (S&C) Program is to assure basic levels of quality and safety for Medicare and Medicaid beneficiaries. This is accomplished by the Centers for Medicare and Medicaid Services (CMS) contracting with State Agencies to conduct onsite, objective, and outcome-based verification that basic standards of quality are being met by health care providers. The Certification Bureau is the Montana State Agency charged with these responsibilities. There are a total of 300 various types of health care facilities in the state that participate in the Medicare and Medicaid programs which are subject to oversight by the Certification Bureau (see Chart).

Each of these facility types have specific time frames established by CMS for conducting the onsite surveys by qualified staff. Adherence to these time frames is strictly scrutinized by CMS in their annual performance review of each agency. Examples of the time frames are:

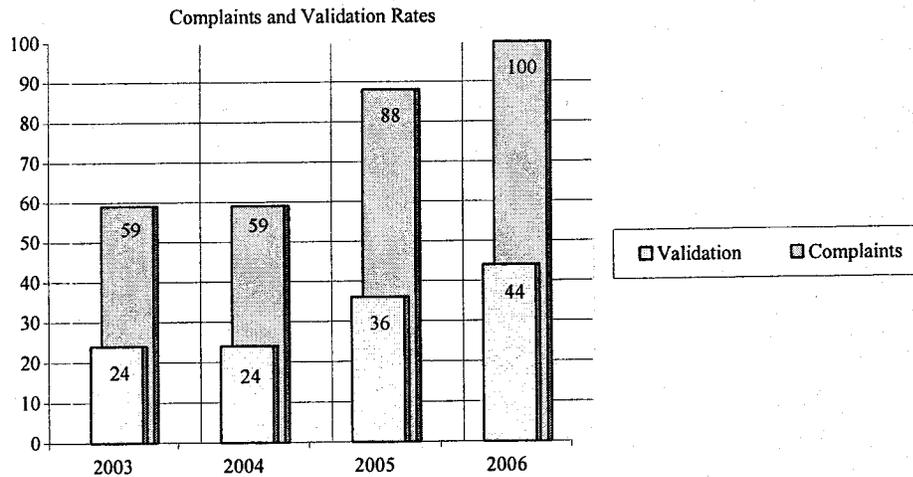
- Long Term Care Facilities (nursing homes) – 15 month maximum interval with a 12 month average
- Intermediate Care Facility for the Mentally Retarded – 12 month maximum interval
- Home Health Agencies – 36 month maximum interval with a 24 month average
- Accredited Hospitals – at the direction of CMS
- Non-Accredited Hospitals – 6 year maximum with a 3 year average
- End Stage Renal Disease Facilities – 10% sample selected by CMS annually with a 3 year average
- Ambulatory Surgical Centers, Rural Health Clinics, Hospice, and Out Patient Physical Therapists – 5% sample selected by CMS annually, 6 year average.
- Psychiatric Residential Treatment Facility (PRTF) – 5 year average

Based on the survey frequency of each provider type, the work load completed by the Certification Bureau in State FY 2006 is indicated in the following chart:

Provider Types	Facility Count	Initial Visits	Resurvey Visits	Follow-Up Visits	Complaint Visits	Total Visits
Long Term Care (LTC)	96	0	167	190	72	429
Intermediate Care Facility/Mental Retardation (ICF/MR)	1	0	2	3	2	7
Accredited Hospital	10	0	0	0	0	0
Non-Accredited Hospital	7	0	0	4	2	6
Critical Access Hospital (CAH)	43	0	17	20	2	39
Non-Accredited Home Health (HHA)	37	0	11	5	0	16
Hospice	27	1	4	4	0	9
Rural Health Clinic (RHC)	43	0	8	10	0	18
Ambulatory Surgical Center (ASC)	15	0	6	6	0	12
End Stage Renal Dialysis (ESRD)	13	0	3	1	0	4
Psychiatric Residential Treatment Facility (PRTF)	3	0	0	0	0	0
Outpatient Physical Therapy	5	0	0	0	0	0
<b>TOTALS</b>	<b>300</b>	<b>1</b>	<b>218</b>	<b>243</b>	<b>78</b>	<b>540</b>

Facilities are required to report allegations to the Certification Bureau. These include: injuries of unknown origin; misappropriation of property; neglect; mistreatment; abuse to residents by staff, volunteer, or other residents. These incidents must be logged into the CMS data base system, and are used by surveyors in the survey process. In FY 2005, there were 2,310 allegations. In FY 2006 there were 2,296 allegations.

In addition to the standard surveys conducted by the Certification Bureau, complaints received by the Bureau regarding any of the provider types are logged into a CMS data base system. These complaints are tracked by CMS for adherence to specific criteria for data entry, prioritizing the complaint for onsite investigation and reporting any deficiencies cited. The number of complaints received and investigated has risen significantly in the past 3 years as indicated in the following chart. Although the number of complaints validated by citing deficiencies has not risen as significantly as the number of complaints, there has been an increase in the number of complaints substantiated.



The bureau is also responsible for oversight of medical laboratories in accordance with the **Clinical Laboratory Improvement Amendments (CLIA)**.

The CLIA program is responsible for processing applications, maintaining a data base and provider information services for 682 labs in Montana. The CLIA surveyor conducts on-site surveys of 96 moderate and high complexity labs biennially as well as 2% of Certificate of Waiver Labs (7) and 1 or more accredited labs as assigned by CMS on an annual basis. This surveyor also conducts desk audits of proficiency testing for 96 labs across the state.

The Certification Bureau is involved in the ongoing education and training of health care workers (professionals) throughout the state in two separate programs.

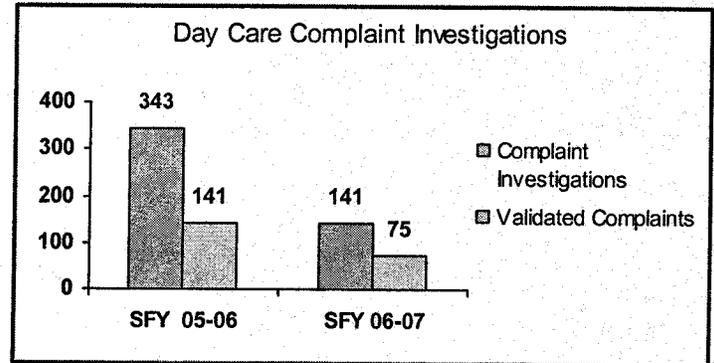
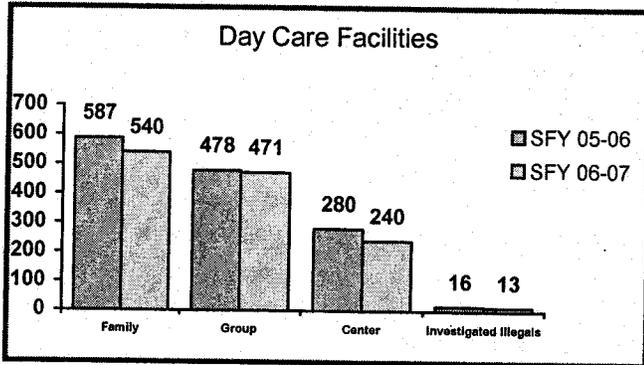
**The Nurse Aide Training Program** is responsible for approving and monitoring 75 individual Nurse Aide Training Programs conducted by private contractors, health care facilities, or educational systems such as universities or vocational/technical training institutions. The Nurse Aide Registry had 9,343 individuals listed as Certified Nurse Aides as of 01/18/2007. These individuals must be recertified biennially in accordance with CMS requirements of the program. In the past year, the data management system, as well as the nurse aide training and competency testing program have been revised and updated.

**Resident Assessment Instrument (RAI) Training:** The resident assessment process required for nursing homes and hospital swing beds uses a computerized tool (Minimum Data Set or MDS) for identifying individual resident needs and for Medicare reimbursement. This data is transmitted to the state data base and is being used by the Quality Improvement Organizations for provider training; by the provider for their own quality improvement activities; and by CMS for their federal nursing home compare site. Our job is to provide training for the providers and SA survey staff in the use of this assessment tool and patient care planning process. This training is accomplished by monthly telephone conference calls, individual consultation with provider staff by phone or email. SA staff receive periodic reviews and in-service.

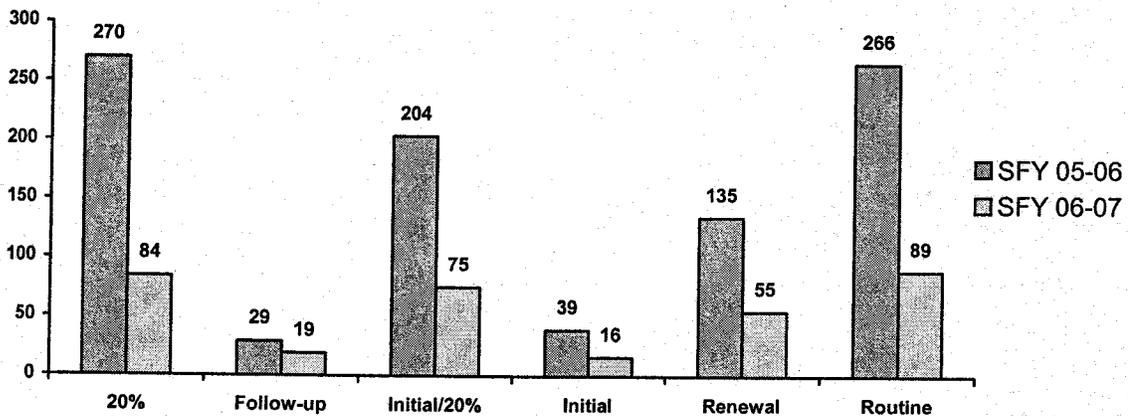
## QAD-Licensure Bureau Fact Sheet

The Licensure Bureau is responsible for the development, enforcement and revision of state licensing rules to assure the public safety and welfare in approximately 500 of health care facilities, 310 Community Residential facilities and 1200 child day care facilities. Duties of the bureau include: on-site inspections, investigations of complaints, taking enforcement action against non-compliant or unlicensed facilities; providing consultation and technical assistance to providers and applicants.

### Child Care Licensing Program



### Day Care Inspections Conducted

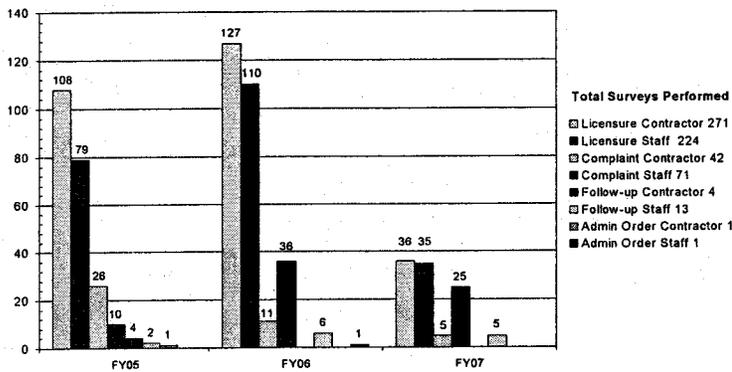


### Major Accomplishments

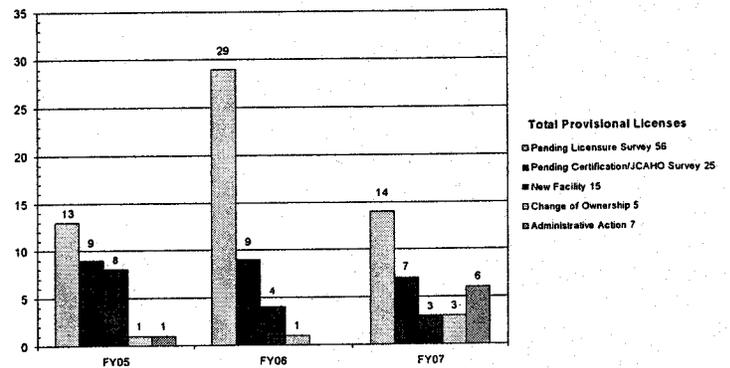
- A manual review showed that in FY06 the program conducted 398; 20% inspections, which are mandated by state law. Data collected from a report writing system indicated that 474; 20% inspections were conducted and entered. The program was only required to conduct 195.
- Established a website which houses all the Child Care Licensing program forms and print materials. This was estimated to have saved the program around \$23,000 in print and copy costs. More and more providers are accessing this site instead of calling the program for forms.
- During FY06 the program began phase I implementation of portable tablet computers for inspection purposes.

# Health Care Facility Licensure

## Licensure Surveys for Health Care Facilities



## Provisional Licenses for Health Care Facilities

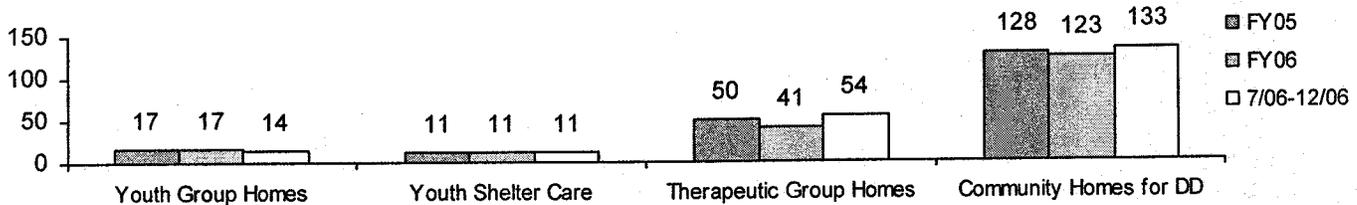


### Major Accomplishments

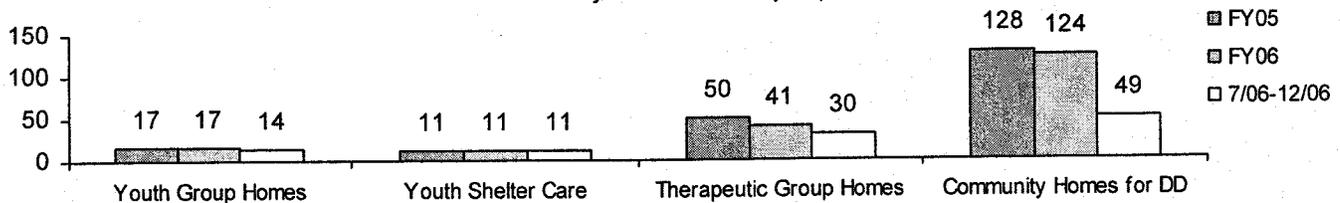
- Improved Complaint tracking system and data collection processes
- Standardized electronic filing system for facility deficiency reports
- Improved efficiency in licensure scheduling and issuance, which has decreased or eliminated the number of provisional licenses.

## Community Residential Program

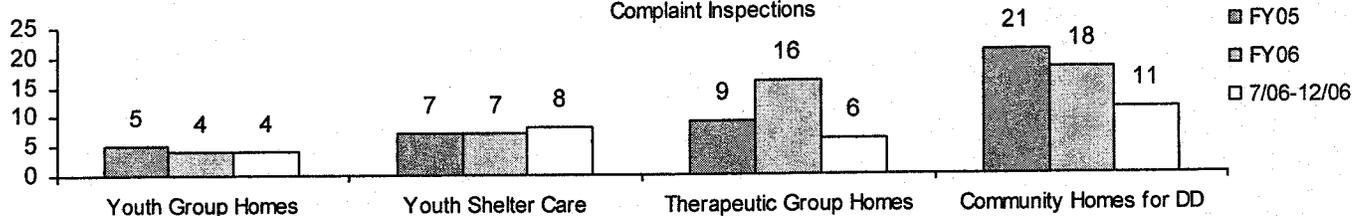
### Community Residential Facilities by Type



### Community Residential Facility Inspections



### Community Residential Facility Complaint Inspections



## QAD - OFFICE OF FAIR HEARINGS FACT SHEET

The Office of Fair Hearings provides administrative contested case hearings under the Montana Administrative Procedures Act (MAPA) by applying appropriate federal and state laws. All hearing requests against the Department with the exception of CSED issues are accepted if within proper jurisdiction. The Office of Fair Hearings receives hearing requests regarding resident discharge or transfer from long term care facilities. In addition, the Office of Fair Hearings also conducts Informal Dispute Resolution (IDR) conferences and recommends opinions when a nursing facility disputes Department survey deficiencies.

The purpose of the Office of Fair Hearings is to assure due process for adversely affected parties disputing facts and/or law involving Department administered programs by providing fair, timely and impartial administrative hearings and decisions.

The Hearing Officers independently render written legal decisions comprised of findings of fact, conclusions of law and order which decisions are final and legally binding upon the parties unless appealed to Board of Public Assistance, DPHHS Director or District Court as applicable.

### TIMEFRAMES FOR DECISIONS

Food Stamps:	60 days from receipt of hearing request
ADH Food Stamps:	90 days of date of scheduling letter
TANF Cash Assistance:	90 days from receipt of hearing request
Medicaid Applicants/Recipients:	90 days from receipt of hearing request
Medicaid Providers:	90 days of final submission of matter to Hearing Officer
All Rest:	90 days after final submission to Hearing Officer unless, for good cause shown, the period is extended for an additional time not to exceed 30 days
IDR:	60 days from final submission of documents to Hearing Officer

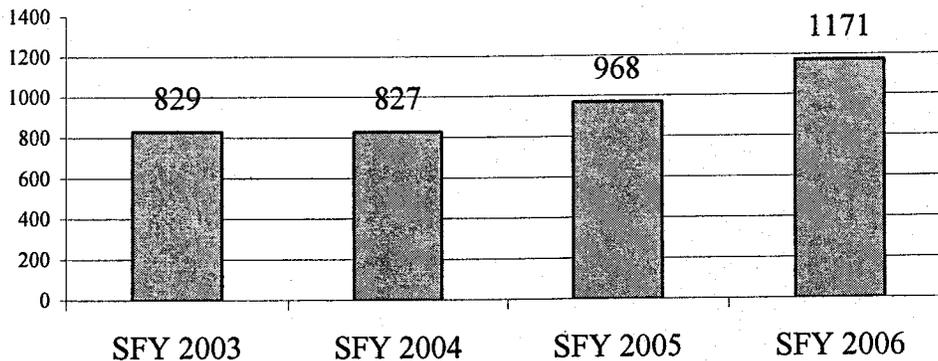
### MAJOR ACCOMPLISHMENTS

Decisions rendered within statutory timelines have improved from 81% in FY 04 to 91% in FY 06 even though appeals have increased 42% since FY 04.

Created Handbooks and provided training to WEEL, Office of Public Assistances, Work Operators, Child Care Resource and Referral agencies, and long term care facilities. The handbooks are a guide for preparation and participation in administrative hearings and informal dispute resolutions proceedings.

Development of a website to publish all hearing decisions for public research by year, program, and issue. Project is in process with programming and file conversion of redacted hearing decisions for public access.

### Fair Hearing Requests



### FAIR HEARING INVENTORY – Year to Date

SFY	Hearing Requests	Requests Withdrawn Resolved at AR	Hearing Decisions	Decisions Timely	Percent Timely	Hearings Outstanding
2003	830	395	431	321	74%	4
2004	826	423	396	317	80%	7
2005	968	548	412	344	83%	8
2006	1172	616	535	485	91%	21
2007	606	247	208	204	98%	151

Note: Based upon the date/year hearing received.

### FAIR HEARING DECISION PRODUCTION BY FISCAL YEAR

SFY	Hearing Decisions	Decisions Timely	Percent Timely
2003	449	307	68%
2004	376	303	81%
2005	403	314	78%
2006	544	496	91%

Note: Based upon date decisions rendered during July-June each year regardless of the date/year received.

### INFORMAL DISPUTE RESOLUTIONS (IDR)

Calendar Year	IDRs Requested	IDR Opinions	Timely Rendered
2005	20	18	5
2006	24	14	13

**QAD - PROGRAM COMPLIANCE BUREAU  
FACT SHEET**

Surveillance and Utilization Review Section (SURS)

- Responsible for ensuring the integrity of the Medicaid claim payments.
- Functions are accomplished through the following activities:
  - Working with fiscal intermediary to ensure sanctioned providers are not participating in the Medicaid program.
  - Coordinating administrative rule and provider manual changes with the appropriate Medicaid divisions, to ensure payments are made accurately.
  - Data analysis and statistical review of billing practices of Medicaid providers.
  - Perform retrospective claim reviews of Medicaid providers with aberrant billing practices.
- Significant accomplishments and barriers to success:
  - Recovered over \$1,100,000 in overpayments from providers during State fiscal years 2005 and 2006. Completed 106 provider reviews during SFY 2006.
  - Contracted with the Mountain Pacific Quality Health Foundation to assume prior authorization functions for Durable Medical Equipment Orthotics and Prosthetics and selected medical and surgical services.
  - Recruitment and retention of qualified candidates has been a significant issue for this section.

Program Integrity Section

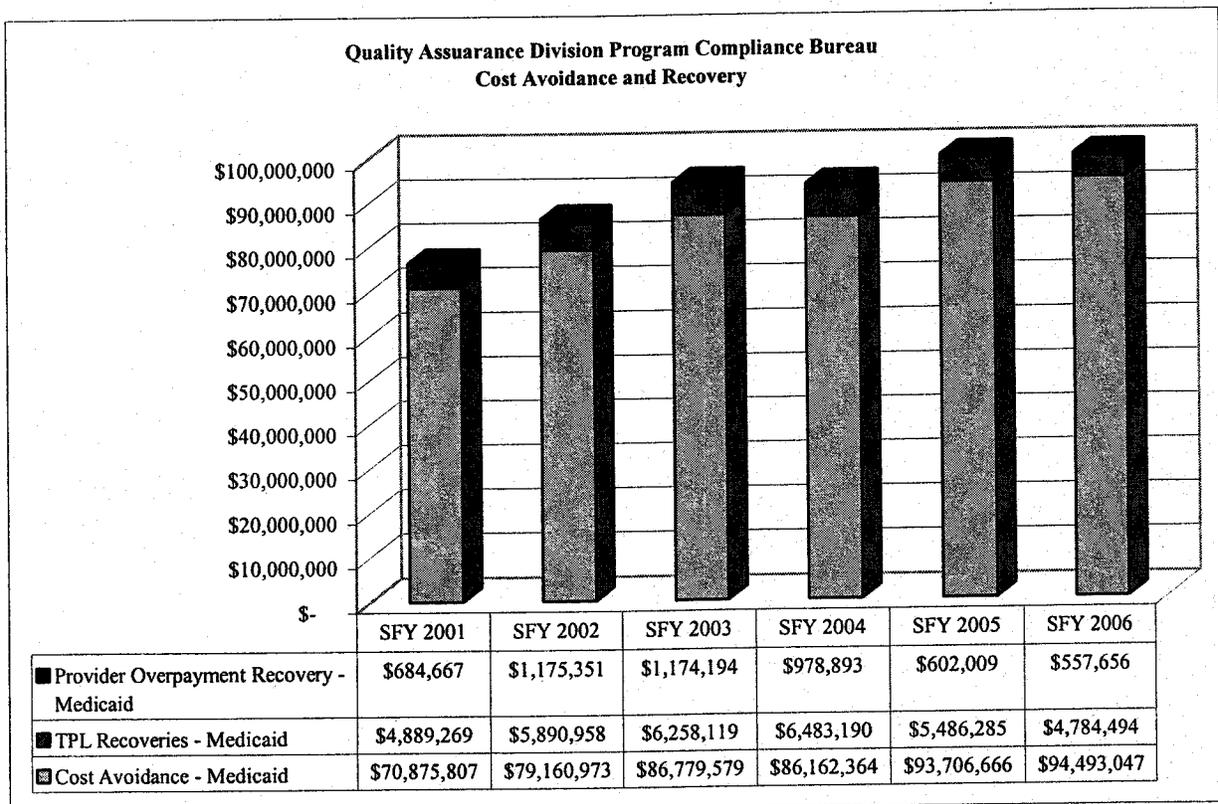
- Responsible for performing quality control reviews of the Medicaid and Food Stamp programs, investigation of Intentional Program Violations (IPV) by recipients, and the management and collection of overpayment recoveries from recipients.
- Functions are accomplished through the following activities:
  - Review of selected cases by random sample for Food Stamps and Medicaid eligibility, using knowledge of the programs and audit techniques to assess the accuracy of the eligibility determination.
  - Investigate potential cases of recipient Intentional Program Violation (IPV) received from county OPA workers and/or from general citizens on the referral hotlines.
  - Manage and establishment and collection of client overpayments.
- Significant accomplishments and barriers to success:
  - Reviewed 803 active and 510 terminated or denied Food Stamp cases. Reviewed 476 active and 195 terminated or denied Medicaid cases.
  - Investigated 755 IPV referrals. 82% of these cases resulted in a client disqualification.
  - The pending PERM reviews will be managed by this section, funding for PERM reviews is vital for success.

Third Party Liability (TPL)

- Responsible for ensuring that Medicaid is the payer of last resort.
- Functions are accomplished through the following activities:
  - Coordination of benefits with Medicare and other health insurance.
  - Operating the Medicare buy-in program to pay for Medicare premiums for eligible low-income senior citizens.
  - Operating the Health Insurance Premium Payment program for Medicaid recipients who need assistance in maintaining their health insurance.
  - Collection of Medicaid funds from other insurance, settlements, liens, estates and other sources of funding.
- Significant accomplishments and barriers to success:
  - Completed numerous system and procedural changes to improve the accuracy and timeliness of activities.
  - Participated in the change over of the Medicare claim cross-over process to enhance electronic coordination of benefits with Medicare.
  - Manage the submission of data to the Centers for Medicare and Medicaid Services related to Part D benefits. Resolved any data errors as necessary.
  - Funding for system enhancements is a barrier for this area. Many of the tasks are done manually and could be automated, thereby improving efficiency and increasing collections of costs avoided.

HIPAA Privacy

- Responsible for ensuring the departments compliance with the privacy aspects of HIPAA.



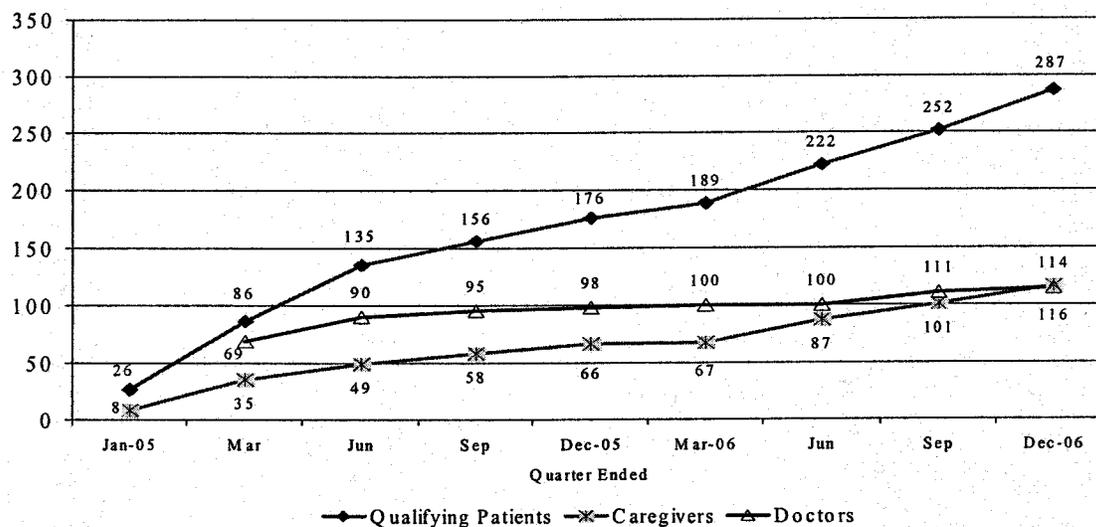
## MEDICAL MARIJUANA PROGRAM FACT SHEET

Pursuant to MCA 50-46-103(9) The department shall report annually to the legislature the number of applications for registry identification cards, the number of qualifying patients and caregivers approved, the nature of the debilitating medical conditions of the qualifying patients, the number of registry identification cards revoked, and the number of physicians providing written certification for qualifying patients. The department may not provide any identifying information of qualifying patients, caregivers, or physicians.

On January 21, 2005, the first Medical Marijuana Program (MMP) registry identification cards were issued to 26 qualifying patients and eight caregivers. Since the start of the program in November 2004, 338 applications have been received. As of December 31, 2006 the following information is provided as required for the MMP:

- 287 qualifying patients approved
- 116 registered caregivers
- 114 number of physicians providing written certification for qualifying patients
- 34 counties served
- Two applications have been denied due failure to pay the annual registration fee,
- Nine applications have been denied due to an incomplete physician's form,
- Two qualifying patients have been revoked: one because the doctor worked for the federal government thus could not complete the physician's form and one because the qualifying patient went to prison,
- Two qualifying patients died, and
- Thirty-six qualifying patient cards have lapsed.

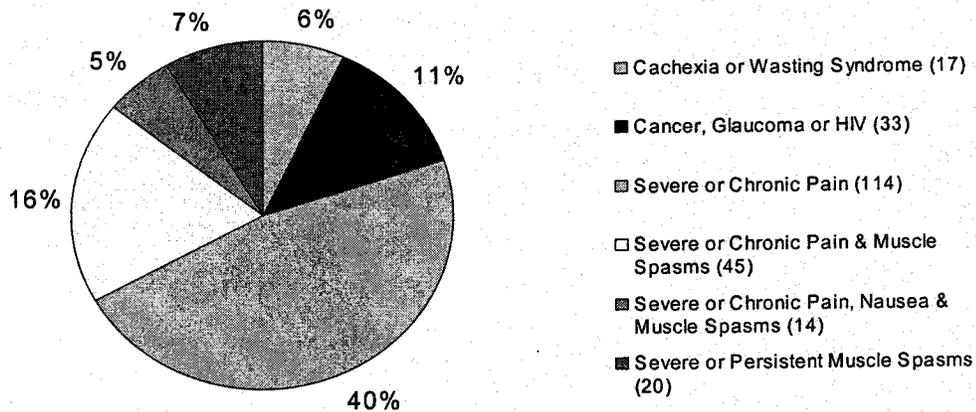
Number of Qualifying Patients, Caregivers and Doctors in Medical Marijuana Program



Medical Marijuana Program approved November 2004

Twelve of the 116 caregivers have more than one qualifying patient. These 12 caregivers serve 70 qualifying patients or 24% of the registry's patients.

### Predominate Medical Conditions\*



\*Represents seven out of 11 debilitating medical conditions

The registration fee charged to qualifying patients is based on actual program costs and has dropped since the inception of the MMP.

Effective Date	MMP Registration Fee
1/1/05	\$200.00
7/1/05	100.00
7/1/06	50.00

The reason for the decline in the registration fee is that the initial methodology used by the department to determine the number of patients expected in the first year of the MMP was based upon a rate per 100,000 of the population of persons from states that were already administering a MMP. It was estimated that Montana would have 295 patients in the first year – there were 176.

Revenue and Total Costs for MMP			
	Revenue	Total Costs*	Revenue Less Total Costs
1/1/05 – 6/30/05	\$26,800.00	\$19,157.60	\$7,642.40
7/1/05 – 6/30/06	\$11,350.00	\$14,084.32	-\$2,734.32
7/1/06 – 12/31/06	\$5,800.00	\$7,443.54	-\$1,643.54

Year to date Revenue less expenses is: \$3,264.54

\* Includes total direct program expenses plus indirect costs.

DEPARTMENT OF HEALTH AND HUMAN SERVICES / CMS  
REVIEW OF STATE MEDICAID PROGRAM INTEGRITY PROCEDURES  
DATED SEPTEMBER 2005  
FACT SHEET

In its audit, conducted in May 23-26, 2005, CMS had one finding and 15 recommendations. The Department concurred with the finding and all recommendations. Corrective action has been implemented in all areas.

CMS Finding

Montana did not comply with the provisions of 42 CFR 455.106 (b) (1) and (2) with respect to notifying the HHS/OIG of disclosed criminal conviction information and any action taken on a provider's application related to such a disclosure. The state does not currently have a policy or procedure to meet this requirement, but has indicated that one will be established.

- Corrective Action: The Department's Fiscal Agent, ACS enrollment policy has been amended to support compliance with 42 CFR 455.106 (b)(1) and (2)

CMS Recommendations

Provider Enrollment

- A. Out-of-state licenses are not verified like in-state licenses are. Out-of-State licensure boards should be contacted to verify the validity of licenses presented during the enrollment process.
- B. The state does not have a plan to routinely re-enroll providers into the Medicaid program.
- C. The state should institute a procedure to routinely capture owner and managing employee disclosure information and verify that they have not been excluded from participating in the program. This verification should be done before enrollment and routinely afterwards, as described in this report.
- D. The SURS unit should be made aware of any exclusion information for applicants wanting to enroll into the Montana Medicaid program.

Corrective Actions:

- ACS has developed a comprehensive list of state licensure boards with phone numbers and web site addresses. Enrollment procedures now include a verification of license validity for all out-of-state providers.
- ACS has instituted provider enrollment policy that requires a re-verification of providers, by provider type, every two years. Included in the re-verification process is a provider certification of information currently on file, licensure and tax information.
- ACS provider enrollment policy now requires that enrollment staff search all owners and managing employees listed on the Montana Medicaid enrollment form in the MEDICARE EXCLUSION DATABASE (MED).
- ACS policy has been amended to assure SURS is alerted to the identification of any applicant identified as an "excluded individual". A refresher enrollment training session was conducted by ACS to ensure that all enrollment staff are aware of, and are working in accordance with the policy.

Medicaid Fraud - Multiple recommendations related to enhancing fraud detection and documentation were made. Corrective Actions have been instituted for each recommendation as follows:

- A. The MFCU DPHHS Memorandum of Understanding (MOU) was rewritten and completed in February 2006. SURS and MFCU worked together to complete the agreement.
- B. The Montana Medicaid website has been updated to easily locate Medicaid fraud numbers.
- C. Each pending case that is discussed with MFCU at the bimonthly meeting is documented on the case tracking/monitoring system.
- D. The Medicaid Review Committee (MRC) minutes specifically identify the MFCU representative in attendance and the MRC summary prepared by the Compliance Specialist contain a special section that identifies dates of contact with the MFCU and the results of those contacts.
- E. Efforts to increase the number of potential fraud and abuse cases developed and referred to the MFCU include expanded user expertise with Fraud detection software (Omni Alert), and heighten response to national fraud alert bulletins. Referrals are made to MFCU whenever a Medicaid providers practices are questionable.
- F. All referrals to the MFCU are tracked on a spreadsheet. This will allow the referrals to be sorted, aged and searched for specific case and reporting purposes.
- G. In partnership with ACS and MFCU, SURS has instituted additional training for the Compliance Specialists in Query Path, Omni Alert (super-users), and additional fraud investigational techniques.
- H. SURS should seek out partnerships with other fraud and abuse players such as the FBI and AUSAs and Medicare Program Safeguard Contractors (PSC).
  - Corrective Action: SURS is a partner with Montana AIMS council (Advocates in Medicare Savings) a development of the National Senior Medicare Patrol Project. Access to the FID (Fraud Investigation Database) assists in partnering fraudulent Medicare billers with Medicaid billers

Miscellaneous:

QAD should resume referring patient abuse cases to county attorneys where the responsibility lies for prosecution.

Corrective Action:

- The Program Integrity Unit is working with the Public Assistance Bureau and the Office of Public Assistance to reinstitute a policy addressing recipient referrals to this section.
- The SURS policy has been amended to require use its case tracking/management system to its potential. Monthly Supervisor case reviews include a review and determination that all required fields in database have been accurately completed.
- Continue to develop and incorporate the use of provider self audit techniques. SURS instituted a provider self audit policy and protocol effective August 2006.
- SURS has instituted use of the Medicare offset option 42 CFR 405.375 for collecting uncollectible overpayments for "failure to pay" Medicaid providers who are active Medicare billers.

DEPARTMENT OF HEALTH AND HUMAN SERVICES / OIG  
REVIEW OF MONTANA'S ACCOUNTS RECEIVABLE SYSTEM FOR MEDICAID  
PROVIDER OVERPAYMENTS PERIOD OCTOBER 1, 2002 - SEPTEMBER 20, 2004  
DATED MARCH 2006.  
FACT SHEET

Audit conducted in May 2005

This report is part of a multistate audit. The objective was to determine whether the State reported Medicaid provider overpayments in accordance with Federal requirements.

Findings

DPHHS did not report 195 Medicaid provider overpayments totaling \$3,685,465 (\$2,731,303 Federal share) in accordance with Federal requirements. In addition, the DPHHS delayed reporting 68 overpayments totaling \$1,278,197 (\$944,216 Federal share) within required timeframes, resulting in \$66,526 of higher interest expense to the Federal Government.

Recommendations - OIG recommended that DPHHS:

- 1) include on the CMS-64 the unreported overpayments, the uncollected portion of overpayments that were settled at reduced amounts, and the unreported MFCU-identified overpayments and refund \$2,731,303 Federal share;
- 2) determine the value of overpayments identified after our audit period and include them on the CMS-64;
- 3) reduce overpayments only when it can support that providers are bankrupt or out of business;
- 4) develop policies and procedures to ensure that overpayments are reported on the CMS-64 in accordance with Federal regulations; and
- 5) report all future overpayments within 60 days.

DPHHS agreed to the recommendations and the actions taken to date are:

- 1) The overpayments identified as unreported were included on a CMS-64 report and the federal share repaid to CMS.
- 2) Procedural changes have been made to improve the notification and recognition process from SURS identified overpayments. Accounting steps have been modified to ensure timely repayment of reported overpayments.
- 3) QAD sent a memo to all Medicaid Administrators on August 4, 2005 regarding a moratorium on negotiations and settlements because the OIG informed DPHHS that they did not believe that a state Medicaid program has the authority to negotiate a settlement when a provider overpayment is identified. Only a hearing officer or a judge can reduce the amount of a settlement because this is considered to be a "judgment", not an "agreement".

- 4) A department policy was drafted to promote consistency in the notification and recognition of Medicaid overpayments across the department.
- 5) Business process changes have been outlined to ensure timely reporting of Medicaid overpayments identified by ACS.

Actions To Do:

- Finalize department policy on notification and recognition of Medicaid overpayments.
- Finalize business process changes have been outlined to ensure timely reporting of Medicaid overpayments identified by ACS.
- Improve communications between MFCU and DPHHS.

FOOD AND NUTRITION SERVICE'S (FNS) STATE AGENCY OPERATIONS REVIEW  
REPORT OF FOOD STAMP PROGRAM  
DATED NOVEMBER 2006  
FACT SHEET

November 3, 2005 FNS Report based upon July 25, 2005 FNS Review

1. Overall timeliness of Food Stamp Hearings was at 89% which was found untenable and must be corrected.
2. Requirements set out were for the Office of Fair Hearings to analyze and determine the causal factor(s) for the lack of timely hearing decisions and take immediate corrective action(s).

January 4, 2006 Corrective Action Plan as Provided to FNS

1. Office of Fair Hearing analysis identifies contributing factors:
  - a. Hearing Officer delay due to backlog of decisions because of heavy workload.
  - b. Hearing Officer error in calculating due date of hearing decisions.
  - c. Administrative Review delays caused by Offices of Public Assistance (OPA).
  - d. Continuations requested by DPHHS and OPAs.
2. Corrective action implemented by Office of Fair Hearings:
  - a. Food Stamp cases take priority over other DPHHS program appeals.
  - b. The Bureau Chief will set the case due date on the route slip when assigned to Hearing Officer.
  - c. The Bureau Chief will prepare a fact sheet listing the applicable timeframes.
  - d. Coding will be done correctly after receiving training by the Bureau Chief.
  - e. The Administrative Review timeframe will be reduced from 20 to 15 days. Public Assistance Bureau will amend Policy Manual and administrative rule; Office of Fair Hearings will change the Administrative Review Report form; process will be put in place to fax documents on the same day as appeal received with hardcopies following.
  - f. The Hearings Office data system (HITS) enhancement will be requested to allow earlier follow up; Administrative Assistant will schedule an alert on Outlook calendar for follow up; current status inquiries will be sent earlier with possible scheduling of hearing without Administrative Review.
  - g. Hearing Officers will schedule hearings 10 to 15 days from date case assigned; Hearing Officers will require exhibits to be submitted no later than 5 days before the hearing; Public Assistance Bureau will amend Policy Manual to state new timelines; Hearing Officers will expand use of their calendars by setting more hearings in a day; Hearing Officers will make greater effort to use time wisely and stay on task each day; individual performance indicators using HITS will be implemented for better evaluation of performance.

- h. No OPA continuances will be allowed unless it can be accomplished within timeframes; Parties will no longer be allowed additional time after the hearing to file documents.
- i. Based upon an increase in workload and complexity of appeals overall, an additional FTE will be recommended through the EPP process. (Request made for 2007, declined in EPP planning process.)

November 22, 2006 FNS Report based upon August 29, 2006 FNS Review

1. Report identified the timeliness of Fair Hearings had improved only to 92% and Administrative Disqualification Hearings had improved only to 87%.
2. Findings were set out as:
  - a. Heavy workload still exists.
  - b. Hearing Officers' errors in calculating due dates of hearing decisions has been corrected with training.
  - c. Administrative Reviews had improved from 72.8% to 79.2% which causes an impact on the overall fair hearing process.
  - d. Continuances requested by OPA are due to waiting for federal regulation clarification or interpretation.
  - e. Action has taken place to make Food Stamps appeals a priority.
  - f. The Bureau Chief has established a fact sheet for timeframes and routing slip process for reducing untimeliness of decisions.
  - g. Administrative Review timeframes have changed.
  - h. Continuances are not allowed by OPAs unless within timeframes.

Corrective Action Assessment concludes:

1. Ongoing corrective actions have demonstrated an improvement in fair hearing timelines.
2. As OPAs play a major role in fair hearing timelines, Administrative Review timeliness need to improve.

Corrective Action Required:

1. DPHHS must continue the corrective action procedures and processes developed in January 2006 to address fair hearing deficiencies.
2. These actions must remain in effect until the deficiencies have been reduced sufficiently with improved timeliness or have been eliminated per federal regulation.
3. DPHHS must continue to monitor and evaluate OPAs timeliness with Administrative Review timeframes.
4. The corrective action plan will remain in effect until FNS has determined it is no longer necessary based on data analysis.

QAD - ADDITIONAL LIEN AND ESTATE RECOVERY COSTS (DP 80008)  
FACT SHEET

The Department of Public Health and Human Services (DPHHS) operates the Medicaid program, a requirement of operating the Medicaid is that the State must operate a Lien and Estate recovery program. DPHHS operates its Lien and Estate recovery program under the authority of MCA sections 53-6-167 and 53-6-171.

Until June 30, 2003 DPHHS contracted with a 3<sup>rd</sup> party to operate the Lien and Estate recovery program, and paid this contractor a percentage of collections. In State Fiscal Year 2003 DPHHS paid \$309,105 for these services and recovered slightly over \$2,000,000. Effective July 1, 2004 DPHHS began operating the Lien and Estate recovery program with internal staff (no new staff was added to take over this program). In State Fiscal Year 2006 DPHHS recovered almost \$2,300,000 from the Lien and Estate recovery program.

The majority of the lien and estate recovery cases are handled on a very routine basis. However, there are instances (such as abandonment of property, no probate filings, title discrepancies, lack of heirs, back taxes, and other legal issues) that require legal assistance and potentially property repairs and payment of back taxes to resolve the cases. Currently, there is no funding to pursue these more difficult cases, and there is a backlog of cases from the previous contractor that need to be resolved. In addition to the current backlog we anticipate there will be future cases that will require additional resources to resolve the cases.

This request for funding is being made to protect the interest of the State and maximize recoveries under the Lien and Estate recovery program. This request is "self-funding" in that by resolving these cases DPHHS will increase recoveries and use a portion of these increased recoveries to pay for the program expenses. At this time we do not know exactly needs to be done with each property, therefore this funding request is based on an estimated expense per property, some may be easier and others may be more difficult. Below is a summary of budget projections:

	Total Budget	Per Property Amount
Number of properties to be resolved per year	40	40
Estimated recoveries	\$800,000	\$20,000
Legal fees and expenses	\$67,080	\$1,677
Property repairs, taxes, utilities, maintenance	\$116,000	\$2,900
Estimated expenses	\$183,080	\$4,577
Net Recoveries	\$616,920	\$15,423

During State fiscal year 2006 DPHHS began working on several of the oldest cases. Thus far in State fiscal year 2007 DPHHS has recovered on 8 of these cases and collected over \$250,000.

Important note to reader: DPHHS does not file liens on any property except real property, and only for Medicaid recipients who are permanently residing in a nursing home, and who do not have residing in the house 1) a spouse, 2) dependent child who is under 21 years of age, blind, or

permanently and totally disabled, or 3) sibling who was residing in the recipient's home for a period of at least 18 months immediately prior to the recipient's institutionalization.

LFD Issue: The Legislative Fiscal Division has raised a question about the need for future funding to resolve these types of difficult cases. It is the intent of the division to resolve these difficult cases in a timely manner, and we anticipate a reduction in the number of cases requiring additional attention, however, there will continue to be cases that will require additional resources to resolve. Accordingly, we do expect the backlog to reduce, and we anticipate a level case load in the future, however, it is not possible to estimate that caseload at this time.

**QAD - PAYMENT ERROR RATE MEASUREMENT (PERM) PROGRAM  
FACT SHEET**

The Improper Payments Information Act (IPIA), Public Law 107-300, enacted on November 26, 2002, requires the Centers for Medicare and Medicaid Services (CMS) to produce national error rates for Medicaid and the State Children's Health Insurance Program (SCHIP).

To implement the requirements of IPIA, CMS developed the Payment Error Rate Measurement (PERM) program. On August, 28, 2006 CMS published in the Federal Register an interim final rule for the PERM program. The effective date of this rule is October 1, 2006.

Under PERM, reviews will be conducted in three areas:

- (1) fee-for-service (FFS),
- (2) managed care, and
- (3) program eligibility for both the Medicaid and SCHIP programs.

CMS has developed a national contracting strategy for measuring the first two areas, FFS and managed care, mentioned above. Because States administer Medicaid and SCHIP eligibility according to each State's unique program, CMS believes the State needs to conduct the eligibility reviews. These reviews must be conducted by a division that is independent from the division responsible for the eligibility determination. Therefore, QAD will be responsible for measuring the third area, program eligibility, for both programs. In addition, QAD will be responsible for coordinating communications, documents, and data with the Federal contractors for their claim reviews.

CMS will use PERM to measure Medicaid and SCHIP improper payments in a subset of States each year. PERM reviews will be on a rotational basis so that each state will be measured for improper payments, in each program, once and only once every three years. The States that will be measured for fiscal years (FY) 2007-2009 (which will rotate thereafter) are as follows:

**States Selected for Medicaid and SCHIP Improper Payment Measurements**

FY 2007	North Carolina, Georgia, California, Massachusetts, New Jersey, Tennessee, West Virginia, Kentucky, Maryland, Alabama, South Carolina, Colorado, Utah, Vermont, Nebraska, New Hampshire, Rhode Island
FY 2008	New York, Florida, Texas, Louisiana, Indiana, Mississippi, Iowa, Maine, Oregon, Arizona, Washington, District of Columbia, Alaska, Hawaii, <u>Montana</u> , South Dakota, Nevada
FY 2009	Pennsylvania, Ohio, Illinois, Michigan, Missouri, Minnesota, Arkansas, New Mexico, Connecticut, Virginia, Wisconsin, Oklahoma, North Dakota, Wyoming, Kansas, Idaho, Delaware

QAD will conduct the eligibility reviews and report the results from the eligibility reviews for Medicaid and SCHIP to CMS, who in turn will use this information to calculate a national eligibility error rate. Likewise, QAD will work with the national contractors to conduct the claim reviews, which will report the results and calculate a national claim error rate.

#### QAD PERM Eligibility Review Requirements

- Montana is scheduled for Federal Fiscal Year 2008 (10/1/07).
- Required to review Medicaid and SCHIP separate.
- Required to submit a sampling plan for each program including both the active and negative case samples, developed in compliance with applicable regulations to CMS' statistical contractor for approval.
- QAD will review 500 active eligibility cases and 200 inactive for Medicaid and SCHIP, each.
- Costs will apply to the SCHIP administrative cost cap.

#### QAD PERM Coordination with Federal Contractors

- Under the national contracting strategy, CMS will use Federal contractors to measure Medicaid and SCHIP FFS and managed care improper payments. CMS has engaged three contractors:
  - Statistical Contractor (SC). The SC collects adjudicated claims data, determines the sample size, draws the sample, and calculates the State and national error rates;
  - Documentation/Database Contractor (DDC). The DDC collects and stores State medical and other related policies, and requests the medical records from providers for the FFS medical reviews; and
  - Review Contractor (RC). The RC conducts the medical and data processing reviews.
- Federal contractors will review 800 claims for Medicaid and SCHIP, each.
- QAD will coordinate and communicate all Medicaid program information requirements with the federal contractors.

#### Action Plan

- Start planning the computer and human resources necessary. Data collection and extraction is vital.
- Secure funding for SFY 2008 and 2009.
- Develop staff recruiting and training program.
- Hire program officer to coordinate activities in July 2007.
- Develop and submit sampling plan in August 2007.
- Be ready to begin eligibility reviews in October/November 2007.
- Submit claim payment policies, etc. to Federal contractor in October 2007.
- Submit 1<sup>st</sup> quarter claims data to Federal contractor in January 2008.
- Complete eligibility reviews in February 2009, exclusive of error resolution.
- Federal contractors complete reviews in September 2009, exclusive of error resolution.

LFD Issue – Page B-109 LFD Budget Analysis for the 2009 Biennium  
Vacant positions in SURS unit and the impact on recovery of Medicaid funds

The ability of SURS to identify and recover improper payments of Medicaid funds is dependent on a number of issues, including but not limited to analytical tools and resources, consistent program rules and procedures, and the quality of the SURS staff.

During the past couple of years the SURS unit has been impacted by significant staff turnover, and difficulty recruiting qualified staff. Much of the staffing problems are due to salary constraints, recruiting of SURS staff by other divisions or private industry, and nationwide shortage of nurses. In order to address the staffing issues SURS taken the following actions:

- Modified position descriptions to allow for recruiting of licensed healthcare professional, rather than only focusing on nurses.
- Offered training positions for employees who exhibited potential for success in SURS but needed additional training and coaching.
- Extended pay exceptions to several employees who are proven high performers.
- Changed the interview process to ensure a better fit of a potential employees' skills to the SURS position requirements.

In addition SURS is planning to implement pay plan 20 by the end of fiscal year 2007 and hopes to be able to use this pay system to enhance recruitment and retention efforts.

When looking at Medicaid recoveries it is also important to note there have been other changes implemented by SURS that may increase recoveries in the future. A summary list of those changes is below:

- Began utilizing statistical sampling methods and probe samples rather than 100% reviews, in an effort to improve staff efficiency and reduce the burden on the providers.
- Developed and implemented a provider self-audit process, to allow providers to conduct audits themselves and report the results to SURS. SURS retains the ability to review the audit results and challenge those results.
- Implemented "6-month" review for newly enrolled providers in an attempt to identify billing aberrations early and intervene early.
- All staff have received enhanced training in using the computerized audit tools available to the SURS staff.
- Modified the "look back" period from 6 years to 3 years, in an effort to focus on the more timely reviews.

During past several state fiscal years SURS has benefited from "global settlements" resulting in increase SURS recoveries of Medicaid funds. Below is a summary of the global settlements:

<b>State fiscal year</b>	<b>Global settlement amount</b>
2003	\$36,247
2004	\$317,422
2005	\$345,040
2006	\$34,599

As of January 2007 SURS has a full complement of 10 staff members.

In summary, SURS recoveries are impacted several issues, including staff retention and recruitment. QAD is hopeful that these change noted and planned will result in continued recoveries of improper payment of Medicaid funds.