Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Montana Comprehensive Program Integrity Review

Final Report

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INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Montana Medicaid Program. The MIG review team conducted the onsite portion of the review at the offices of the Montana Department of Public Health and Human Services (DPHHS). The review team also visited the office of the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Program Compliance Bureau (PCB) within the Quality Assurance Division, a component of DPHHS, which is responsible for Medicaid program integrity. This report describes one noteworthy practice, three effective practices, six regulatory compliance issues, and four vulnerabilities in the State's program integrity operations.

THE REVIEW

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help Montana improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Montana's Medicaid Program

The DPHHS administers the Montana Medicaid program through a fee-for-service (FFS) primary care case management system. As of January 1, 2010, the program served 80,531 beneficiaries and the State had 15,935 providers participating in the program. Medicaid expenditures in Montana for the State fiscal year (SFY) ending June 30, 2009 totaled $900,818,156. The Federal medical assistance percentage (FMAP) for Montana for Federal fiscal year (FFY) 2010 was 67.42 percent. However, with adjustments attributable to the American Recovery and Reinvestment Act of 2009, the State's effective FMAP was 77.99 percent throughout FFY 2010.

Program Compliance Bureau

The PCB, within the Quality Assurance Division, is the primary organizational component dedicated to Medicaid fraud and abuse activities. At the time of the review, the Division had 11 full-time equivalent employees. The table below presents the total number of preliminary and full investigations and amount of overpayments identified and collected for the last four SFYs as a result of program integrity activities. In SFYs 2007 and 2009, the amount of overpayments collected was larger than the amount identified because of the influx of prior year recoveries.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified	Amount of Overpayments Collected
2007	416	1	$549, 117.67	$995,770.93
2008	307	7	$699,032.58	$638,262.09
2009	451	1	$511,534.99	$719,072.42
2010	659	2	$1,996,013.04	$670,308.81 (thru 04/30/10)

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.
**Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU or administrative or legal disposition. The full investigation figures in the chart reflect referrals made to the MFCU.

Methodology of the Review

In advance of the onsite visit, the review team requested that Montana complete a comprehensive review guide and supply documentation in support of its answers to the review guide. The review guide included such areas as provider enrollment and disclosures, program integrity, and the MFCU. A four-person review team reviewed the responses and documents that the State provided in advance of the onsite visit.

During the week of August 2, 2010, the MIG review team visited the DPHHS and MFCU offices. The team conducted interviews with numerous DPHHS officials, as well as with staff from the fiscal agent, provider enrollment contractor, and the MFCU. In addition, the team conducted sampling of provider enrollment applications, selected claims, case files, and other primary data to validate the State's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the DPHHS, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, managed care, and non-emergency medical transportation (NEMT). The Children's Health Insurance Program in Montana operates as a stand-alone program under Title XXI of the Social Security Act and was, therefore, excluded from this review.

Unless otherwise noted, DPHHS provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that DPHHS provided.

RESULTS OF THE REVIEW

Noteworthy Practices

As part of its comprehensive review process, the CMS review team has identified one practice

that merits consideration as a noteworthy or "best" practice. The CMS recommends that other States consider emulating this activity.

Six-month review process

Initiated in June 1, 2007, Montana's six-month review process offers the State a means of reviewing providers who have undergone a recent change of status in the Medicaid program. Each month an analyst with the fiscal agent furnishes the surveillance and utilization review subsystem (SURS) unit with a listing of Medicaid providers who have met at least one of four conditions in the prior six months. These conditions include providers who are new to the Medicaid program, enrolled providers who terminated their participation in the past six months, providers who terminated their previous Medicaid number and received a new number, and providers with at least one other active number who received a new number in the most recent six-month period.

All providers who meet at least one of the above criteria are selected for audit. The process affords the SURS unit the opportunity for early identification of newly enrolled Medicaid providers (or providers who may be branching out in some way) who may benefit from training and education to eliminate future billing errors. Toward this end, the SURS unit has conducted 3 training and education calls with providers in SFY 2008, 35 in SFY 2009, and 56 in SFY 2010.

The six-month review process has also facilitated the early detection of aberrant or fraudulent billing patterns and enhanced the State's ability to deal with them. For example, at one point, the provider reviews yielded data showing a high incidence of Current Procedural Terminology code 96111 (developmental testing, extended with interpretation and report) being billed inappropriately. A subsequent query on the practitioners at a new pediatric facility determined that all the providers were incorrectly billing this code and resulted in an identified overpayment of $78,656.

Effective Practices

As part of its comprehensive review process, the CMS also invites each State to self-report practices that it believes are effective and demonstrate its commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. Montana reported the development and implementation of a program integrity audit plan, effective use of explanations of medical benefits (EOMBs), and enhanced training for program integrity staff.

Development and implementation of comprehensive program integrity audit plan

Starting on October 1, 2008, Montana developed an annual program integrity audit plan which is designed to provide for the postpayment review of Medicaid claims in high risk areas. The goals of the plan are to maximize the audit capabilities of staff within the PCB, to ensure Medicaid management information system (MMIS) integrity, to provide more effective oversight of the provider enrollment process, and to develop and implement updated SURS procedures and policies. The audit plan includes both a departmental level audit plan and an individual staff audit plan. The individual audit plan helps staff to plan, execute and complete audits in a timely manner, resulting in an increase in accountability and productivity expectations.

The 2009 audit plan covered audits of claims for blood glucose test strips, personal care services, modifiers on codes, ostomy supplies, renal dialysis, and ambulance trips for end-stage renal disease beneficiaries. Since the implementation of the audit plan, the number of audits opened grew from 481 in SFY 2009 to 659 in SFY 2010, a 37 percent increase. Total identified overpayments also increased by 290 percent from $511,535 in SFY 2009 to $1,996,013 in SFY 2010.

Effective use of EOMBs

The SURS unit within the PCB sends EOMBs for services determined to be at high risk of fraud and abuse as well as to beneficiaries receiving services from providers who are being audited. According to the program integrity director, the return rate of these notifications has been over 30 percent in the past four SFYs. The SURS unit conducts audits and preliminary investigations when EOMBs are received indicating that billed services were never provided. This has resulted in eight investigations over the past three SFYs. At the time of the review, the MFCU was investigating one EOMB-initiated case. A previous referral to the MFCU resulted in the prosecution of one provider and subsequent recoupment of $103,000. However, State referrals to the MFCU are also discussed in the Vulnerabilities section of this report.

Enhanced training for program integrity staff

All of the SURS staff have attended training at the Medicaid Integrity Institute (MII) during the past several years. Training at the MII has been supplemented with State program integrity unit training and, in the opinion of management, has resulted in lower employee turnover and increased teamwork. An improvement in staff efficiency and investigative techniques has resulted in an increase in the number of audits being conducted, in overpayments identified, and in investigations completed. In addition, 50 percent of SURS staff have become certified coders. Lastly, attendance at the MII has resulted in an increased communication with program integrity colleagues throughout the nation. For example, a staff member of the Montana SURS unit exchanged information with a Wyoming program integrity staff member regarding a Medicaid provider whose license was suspended. This enabled the SURS staff to anticipate this provider applying to the Montana Medicaid program. Although the State's enrollment procedures would probably have prevented the provider in question from enrolling, the State was prepared and subsequently denied him enrollment.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to the notice of provider payment withholding, disclosure and notification requirements, and Medicaid payments to an excluded provider.

The State's notice of payment withholding letter does not include all required information.

The regulation at 42 CFR § 455.23(b) stipulates that the Medicaid agency's notice of withholding state that payments are being withheld in accordance with the Federal regulation.

The withholding letter that DPHHS utilizes to notify providers of the withholding of payments in cases of fraud and willful misrepresentation does not meet the requirements of 42 CFR § 455.23(b) because there is no reference to the Federal regulation.

NOTE: The program integrity regulation at 42 CFR § 455.23 has been substantially revised and the amendment was effective March 25, 2011. The regulation as amended requires payment suspension pending investigations of credible allegations of fraud and referral to the MFCU, or other law enforcement agency if there is no certified MFCU in the State.

***Recommendation*:** Modify withholding letters to include language that references 42 CFR § 455.23(b) as required by the regulation.

The State does not capture all ownership, control and relationship information from FFS and Developmental Disability Program (DDP) providers.

Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is subject to periodic survey under § 455.104(b)(1) must disclose to the State surveying agency, which then must provide to the Medicaid agency, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. A disclosing entity that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. In addition, under § 455.104(c), the State agency may not contract with a provider or fiscal agent that has not disclosed ownership or control information required under this section.

Different parts of the Montana Medicaid program have their own provider enrollment processes. The review team found that several of these do not collect the full range of ownership and control disclosures required by the regulation. The current FFS provider enrollment form, dated March 11, 2010, does not ask for the required disclosures from subcontractors. Additionally, the wording did not meet the requirements of the 42 CFR § 455.104(a)(2) because the word "child" was omitted.

The Montana DDP uses different application forms and processes from the FFS program to contract with its providers. A sample of the enrollment files reviewed found that DDP providers signed a contract without the State requesting the disclosure information required in 42 CFR § 455.104(a)(1), (a)(2) and (a)(3).

NOTE: The CMS reviewed FFS applications, the DDP contract and other provider agreements for compliance with 42 CFR § 455.104 as it was effective at the time of this review. That section of the program integrity regulations has been substantially revised and the amendment was effective on March 25, 2011. The amendment adds requirements for provision of Social Security Numbers (SSNs) and dates of birth as well as more complete address information regarding persons with ownership or control of disclosing entities, and requires disclosures regarding managing employees. Any actions the State takes to come into compliance with 42 CFR § 455.104 should be with that section as amended.

Recommendation: Modify the FFS provider enrollment application and the DDP contract to capture all required ownership, control, and relationship information.

The State does not require all providers to submit business transaction information upon request.

The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or U.S. Department of Health and Human Services (HHS) information about certain business transactions with wholly owned suppliers or any subcontractors.

The State's DDP provider contracts do not contain language requiring the timely provision of the required business transaction information in 42 CFR § 455.105, upon request.

Recommendation: Modify provider enrollment contracts within the DDP program to meet the requirement at 42 CFR § 455.105(b).

The State does not request health care-related criminal convictions from FFS and DDP providers.

The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify HHS-Office of Inspector General (HHS-OIG) whenever such disclosures are made.

Montana's FFS program only requests disclosures of criminal convictions from the applicant and not from owners, agents, or managing employees of the provider.

Likewise, the State's contract with DDP providers does not contain language requiring the collection of health care-related criminal conviction disclosures from owners, agents, and managing employees of these providers and the State provided no evidence of such information being collected in practice.

Recommendation: Modify the FFS provider applications and DDP contract to meet the requirements of 42 CFR § 455.106.

The State does not report to the HHS-OIG adverse actions taken on provider applications for participation in the program.
The regulation at 42 CFR § 1002.3(b)(3) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

During the onsite interviews, representatives from the DDP program stated that they notify HHS-OIG directly of adverse actions taken for program integrity reasons on provider applications or against providers already enrolled in the Medicaid program. However, the State provided no documentation that this was being done in practice.

Recommendations: Develop and implement policies and procedures to notify HHS-OIG when actions are taken to limit a provider's ability to participate in the Medicaid program. Ensure that these policies and procedures apply to all parts of the Medicaid program with provider enrollment responsibilities.

The State enrolled and made payments to an excluded provider.
The regulation at 42 CFR § 1001.1901(b) states that when a provider has been excluded by HHS-OIG, Federal healthcare programs are prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities unless and until the provider has been reinstated by HHS-OIG.

In July 2010, Montana's FFS program adopted a new process for conducting exclusion searches on a monthly basis. The first check found three individuals that were excluded. Two individual providers had not collected payments due to new enrollment status. However, one home health elder care provider received payments from 2008 through 2010 for $44,379. At the time of the review, the program integrity director stated that termination letters had not been sent to the providers. However, all three providers had been suspended and were not able to bill.

Recommendations: Recover improper payments from the excluded provider and return the Federal portion of the payments. Modify and implement internal controls to prevent excluded providers from participating in the Medicaid program and receiving Medicaid payments. Please refer to the June 12, 2008 State Medicaid Director Letter (SMDL) #08-003 on exclusion checking which can be found on the CMS website at http:///www.cms.hhs.gov/smdl/downloads/SMD061208.pdf.

Vulnerabilities
The review team identified four areas of vulnerability in Montana's program integrity practices. These included the failure to make use of available provider sanctions, shortcomings in the MFCU referral process, incomplete searches for excluded individuals, and a policy of not requiring SSNs on provider applications.

Not utilizing available provider sanctions.
The Administrative Rules of Montana allow PCB to impose multiple sanctions against providers including, but not limited to, the suspension of payments, prepayment reviews, and State-initiated exclusions. However, the State does not conduct prepayment reviews, nor does it suspend or withhold payments to providers who are suspected of fraud and abuse. The withholding of provider payments only occurs after specific overpayment amounts have been established. By not initiating the withholding of payments at earlier time periods when there is reasonable evidence of fraud or abuse, the State becomes financially vulnerable.

In order for PCB to sanction a provider, the Medicaid Abuse Sanction Committee (MASC) must meet and vote on the sanction. This committee was established in 2004 but has only met several times since its inception. It comprises representatives from the State agency's Quality Assurance Division and Health Resource Division, along with the Senior Medicaid Policy Officer, and PCB Chief. If an overpayment is identified, the SURS unit can send a letter to the committee recommending administrative action. However if the provider appeals, the State is reluctant to move forward with sanctions until all appeals have been exhausted. The State has not initiated an exclusion from the Medicaid program in the past four years. For example, even if a provider has been federally excluded, the PCB is still expected to meet with the MASC before corresponding State action is taken. This process does not allow PCB to respond with speed or agility to cases of fraud and abuse.

Recommendations: Utilize all available provider sanctions upon reasonable suspicion of Medicaid fraud and abuse. Develop and implement processes that facilitate quick and effective sanctions against fraudulent providers.

Not implementing the CMS performance standards for fraud referrals to MFCUs in a timely manner and a lack of collaboration between the State and the MFCU.
On September 30, 2008, CMS issued a guidance document entitled *CMS Performance Standard for Referrals of Suspected Fraud from a Single State Agency to a Medicaid Fraud Control Unit*. The Medicaid agency in Montana did not adopt these standards until April 1, 2010, when it incorporated them into a new MFCU referral form. However, the MFCU representative interviewed by the team was not familiar with the new referral form. There have been no cases referred to the MFCU since the implementation of the new form so its use could not be verified.

Additionally, the review team noted that the State agency averaged fewer than three referrals per year to the MFCU during the last four SFYs, making only one referral in SFY 2009 and two in SFY 2010. The low number of referrals was due in part to a lack of readiness to accept cases on the part of the MFCU attorney. The MFCU attorney indicated that he did not believe he could successfully prosecute fraud and abuse cases against providers due to a lack of clarity in State rules. As examples, he cited language in the State rules on usual and customary rates, midwife reimbursement, and therapist recordkeeping. In contrast, State agency representatives believed that most of the rules are enforceable and do not hinder prosecution of cases except in the area of usual and customary rates.

***Recommendations*:** Use CMS fraud referral performance standards guidance to develop more referrals of suspected fraud cases for the MFCU. As part of the process of improving the quality and quantity of fraud referrals, the PCB and the MFCU should meet with program staff to develop a strategy for revising State rules on reimbursement, coverage and service provision that are unclear and hinder prosecution of fraud.

Not conducting complete searches for individuals and entities excluded from participating in Medicaid.

The regulations at 42 CFR §§ 455.104 through 455.106 require States to solicit disclosure information from disclosing entities, including providers, and require that provider agreements contain language by which the provider agrees to supply disclosures upon request. If the State neither collects nor maintains complete information on owners, officers, and managing employees in the MMIS, then the State cannot conduct adequate searches of the List of Excluded Individuals/Entities (LEIE) or the Medicare Exclusion Database (MED).

The CMS issued a State Medicaid Director Letter (SMDL) #08-003 dated June 16, 2008 providing guidance to States on checking providers and contractors for excluded individuals. That SMDL recommended that States check either the LEIE or the MED upon enrollment of providers and monthly thereafter. States should check for providers' exclusions and those of persons with ownership or control interests in the providers. A follow-up SMDL (#09-001) dated January 16, 2009 provided further guidance to States on how to instruct providers and contractors to screen their own employees and subcontractors for excluded parties, including owners, agents, and managing employees. A new regulation at 42 CFR § 455.436, effective March 25, 2011, now requires States to check enrolled providers, persons with ownership and control interests, and managing employees for exclusions in both the LEIE and the Excluded Parties List System (EPLS) on a monthly basis.

In July 2010, the Montana Medicaid agency instituted a process of conducting exclusion searches in the FFS program that is generally consistent with the CMS guidance. The first exclusion check found three individuals that were excluded. The chief limitation on the current exclusion checking process for the bulk of FFS providers is that Montana does not require its providers to list their SSNs. The drawbacks of this policy are discussed in the next vulnerability. In contrast, neither the State component that oversees Montana's DDP providers nor the providers themselves follow the directives on exclusion checking issued in the SMDLs of June 12, 2008 (#08-003) and January 16, 2009 (#09-001). There is no evidence that regular exclusion checks are made of principal parties affiliated with DDP providers. Also, in contrast to the practice of the Medicaid fiscal agent, the DDP enrollment process does not capture the names of affiliated owners, agents, and managing employees and store them in a searchable format within the MMIS or an alternate data repository. This precludes automated exclusion checks on all relevant individuals from being undertaken on an ongoing basis.

Lastly, the State's NEMT contract does not solicit any employee information during the contracting process. Thus, the State would have no way of knowing if excluded individuals are working for the NEMT broker in positions of responsibility or authority.

Recommendations: Develop policies and procedures for appropriate collection and maintenance of disclosure information about disclosing entities, and about any person with a direct or indirect ownership interest of 5 percent or more, or who is an agent or managing employee of the disclosing entity, or who exercises operational or managerial control over the disclosing entity. Search the LEIE (or the MED) and the EPLS upon enrollment, reenrollment, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded person or entities.

Montana's FFS provider enrollment application form does not require provision of the provider's SSN.

The Medicaid agency's FFS provider enrollment form does not require providers to provide SSNs. Instead, the enrollment form makes it "optional" to list an SSN. This obstructs the State's ability to effectively search the LEIE if there are duplicate names or a party of interest's name has been changed.

The program integrity regulation at 42 CFR § 455.104 has been substantially revised and the amendment was effective on March 25, 2011. The amendment adds requirements for provision of SSNs and dates of birth as well as more complete address information regarding persons with ownership or control of disclosing entities, and requires disclosures regarding managing employees. Any actions the State takes to come into compliance with 42 CFR § 455.104 should be with that section as amended.

Recommendation: Revise provider enrollment forms to require SSNs.

CONCLUSION

The State of Montana applies some noteworthy and effective practices that demonstrate program strengths and the State's commitment to program integrity. These practices include:

- a six-month review process for providers,
- development and implementation of a comprehensive program integrity audit plan,
- effective use of EOMBs, and
- the provision of enhanced training for program integrity staff.

The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of six areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, four areas of vulnerability were identified. The CMS encourages DPHHS to closely examine each area of vulnerability that was identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require Montana to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of Montana will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If Montana has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of Montana on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.

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August 31, 2011

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Dear Robb;

This letter is in response to the audit of Montana's Program Integrity Procedures that was conducted by the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) during the week of August 2, 2010. We have reviewed the comprehensive final report attached to the August 5, 2011 correspondence from Angela Brice-Smith. Montana expresses our appreciation for the recognition given to our noteworthy practices. We also wish to acknowledge your staff for the professional approach in the conduct of this audit and the opportunity to review and comment on the draft report.

This response provides a corrective action plan for each regulatory compliance issue consistent with the recommendations contained in the report and addresses the vulnerabilities identified in your comprehensive final report.

1) **Audit Recommendation**: Modify withholding letters to include language that references 42 CFR § 455.23(b) as required by the regulation.

    a) The Program Compliance Bureau (PCB) has modified its provider withholding letter for cases involving fraud and willful misrepresentation to include the required language of 42 CFR 455.23 (b). In order to accomplish this, the Department is implementing an Administrative Rule of Montana (ARM) change. Our current ARM requires a provider be notified ten days prior to any withholding whereas the federal rule requires the provider be notified within five days of taking such action. We expect the rule change to be in effect no later than November 1, 2011.

2) **Audit Recommendation:** Modify the FFS provider enrollment application and the DDP contract to capture all required ownership, control, and relationship information.

   a) As we noted in our March response to the draft report, the Department updated its enrollment and disclosure procedure with our fiscal agent via numbered letter #3329 dated December 22, 2010. This correspondence is attached for your reference.

   b) The Department submitted a customer service request (CSR) to our fiscal agent to modify the FFS provider enrollment application to capture all required ownership, control and relationship information according to 42 CFR § 455.104, specifically to include the required disclosures from subcontractors and the word "child" that was omitted from our application. Additionally this CSR is updating our system to comport with the requirements of the rule published in the federal register on February 2, 2011 (CMS-6028-FC). Our fiscal agent estimates that the CSR will be completed December 1, 2011 due to competing projects that are currently utilizing resources.

   c) Contracts issued by the Developmental Disabilities Program (DDP) for Medicaid funded services on or after July 1, 2011 require the contractor to disclose to the department prior to the entry into a contract and at any time thereafter, in conformance with the applicable provisions of 42 CFR §455.104, each person or corporation with an ownership or control interest in the Contractor or in any subcontractor of the Contractor. Contracts issued for services on or after July 1, 2011 also require disclosure of the name of any managing employee of the contractor No later than November 1, 2011 DDP will issue amended contracts to address requirements of the March 25, 2011 amendment of 42 CFR 455.104 requiring the provision of social security numbers and the disclosure of other identifying information.

      i) As of July 2011, DDP made disclosure of control, ownership and relationship information a requirement of the contracting process for existing and new contractors. By November 1, 2011, DDP will develop a checklist of requirements for each contract as an additional tool for monitoring.

3) **Audit Recommendation:** Modify provider enrollment contracts within the DDP program to meet the requirement at 42 CFR § 455.105(b).

   a. Contracts issued by the DDP for Medicaid services on or after July 1, 2011 require the contractor, in conformance with the applicable provisions of 42 CFR 455.105, to disclose within 35 days of the department's request, ownership of any subcontractor with which the contractor has had more than $25,000 in business transactions during the 12 month period ending on the date of the request.

4) **Audit Recommendation:** Modify the FF5 provider applications and DDP contract to meet the requirements of 42 CFR § 455.106.

a) Please note our response (2) (a) and (b) and (6) (b). The State will modify the FFS provider enrollment application and the DDP contracts to capture disclosures of criminal convictions from the applicant owners, agents, or managing employees of the provider.

b) As noted in (2) (b) DDP renewed contracts in July of 2011. Those new contracts contain the required language.

5) **Audit Recommendation:** Develop and implement policies and procedures to notify HHS-OIG when actions are taken to limit a provider's ability to participate in the Medicaid program. Ensure that these policies and procedures apply to all pads of the Medicaid program with provider enrollment responsibilities.

a) The State will adapt the Program Compliance Bureau's reporting procedures to the HHS-OIG throughout the Medicaid program in reference to provider enrollment. The procedures are listed in the attached letter #3329 dated December 22, 2010. The State realizes that the procedures listed in the attached letter under the heading Excluded Individuals and Entities Validation/Re-validation must be updated to include reporting disclosures on owners, managers, family members and agents. The Department expects to have procedures in place throughout the Medicaid program by November 1, 2011.

b) The Department has access and will require our fiscal agent to monitor providers against the Medicaid Children's Health Insurance Program State Information Sharing System (MCSIS) for terminated information.

6) **Audit Recommendation:** Recover improper payments from the excluded provider and return the Federal portion of the payments. Modify and implement internal controls to prevent excluded providers from participating in the Medicaid program and receiving Medicaid payments. Please refer to the June 12, 2008 State Medicaid Director Letter (SMDL) #08-003 on exclusion checking which can be found on the CMS website at http:///www.cms.hhs.gov/smd/downloads/SMD061208.pdf.

a) The Program Compliance Bureau has terminated the elder care provider's enrollment and is working to collect the overpayment of $115,241.63. The provider is currently exercising their due process rights afforded to them by State law. The federal portion of $89,876.95 was returned to CMS on 03/31/2011 via the CMS-64 line 10C.

b) The State automated the process of checking the FFS provider data against the MED Database on a monthly basis in July of 2010 as reported by your reviewers. In addition we updated our enrollment procedures in December 2010 and all enrolling providers must provide their social security number and employer identification number under the FFS enrollment process. Applications are screened for completeness which includes ensuring that all providers have disclosed all owners, agents and managing employees, familial relationships, convictions/sanctions and demographics. In addition the State performs a check of disclosed persons against the LEIE and EPLS. We have also submitted a CSR to our fiscal agent to automate checking our FFS provider data against the LEIE. Our fiscal agent is also required to check the MCSIS.

7) **Vulnerability:** Not utilizing available provider sanctions.
Recommendation: Utilize all available provider sanctions upon reasonable suspicion of Medicaid fraud and abuse. Develop and implement processes that facilitate quick and effective sanctions against fraudulent providers.

a) The State requests a correction to the CMSIMIG final report. On page 8, your report states—For example, even if a provider has been federally excluded, the PCB is still expected to meet with the MASC before corresponding State action is taken. Please note that the PCB can terminate enrollment when a federal exclusion occurs without meeting with the Medicaid Abuse and Sanction Committee (MASC). This process is stated in our MASC policy.

b) Please note our response to Audit Recommendation (1). 42 CFR 455.23 directly correlates to credible allegations of fraud and suspensions of payments which can be classified as a sanction under Montana Administrative Rule.

c) PCB will review their Medicaid Abuse Sanction Policy, the corresponding administrative rule, and the new federal requirements surrounding credible allegation of fraud and suspension of payment. PCB will update its MASC policy if applicable to comply with federal mandates by December 01, 2011.

8) **Vulnerability:** Not implementing the CMS performance standards for fraud referrals to MFCUs in a timely manner and a lack of collaboration between the State and the MFCU.
Recommendation: Use CMS fraud referral performance standards guidance to develop more referrals of suspected fraud cases for the MFCU. As part of the process improvement of the quality and quantity of fraud referrals, the PCB and the MFCU should meet with program staff to develop a strategy for revising State rules on reimbursement, coverage and service provision that are unclear and hinder prosecution of fraud.

a) PCB did implement the performance standards for fraud referrals in a timely manner. However, SURS did not make any referrals upon implementation.

b) SURS will communicate with MFCU and seek an update to our MOU to meet on a monthly basis versus the current bi-monthly standard. Additionally we will seek to update our MOU to comply with the "credible allegation of fraud" and suspension of payments per the amendments to 42 CFR 455.23. The respective agencies anticipate a completion date of December 1, 2011.

c) PCB will facilitate discussions with MFCU, SURS, and program staff to develop strategies for revising State rule on reimbursement, coverage and service provision that are unclear and hinder prosecution of fraud.

9) **Vulnerability:** Not conducting complete searches for individuals and entities excluded from participating in Medicaid.
Recommendation: Develop policies and procedures for appropriate collection and maintenance of disclosure information about disclosing entities, and about any person with a direct or indirect ownership interest of 5 percent or more, or who is an agent or managing employee of the disclosing entity, or who exercises operational or managerial control over the disclosing entity. Search the LEIE (or the MED) and the EPLS upon enrollment, reenrollment, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded person or entities.

a) Please note our response (2) (a) and (b) and (6) (b).

b) The State requests a correction to the CMS/MIG final report. On page 9, your report states—Lastly, the State's NEMT contract does not solicit any employee information during the contracting process. Thus, the State would have no way of knowing if excluded individuals are working for the NEMT broker in positions of responsibility or authority. CMS removed all other citations in reference to the NEMT contracts. The State respectfully requests that CMS remove the reference on page 9.

10) **Vulnerability:** Montana's FFS provider enrollment application form does not require provision of the provider's SSN.
Recommendation: Revise provider enrollment forms to require SSNs.

a) Please note our response (2) (a) and (b) and (6) (b).

Montana appreciated the opportunity to work with the Medicaid Integrity Group. If you have any questions regarding the responses above, please contact Jeff Buska, Administrator, Quality Assurance Division, 406-444-5401.

Signed:

Mary E. Dalton
State Medicaid Director

Attachment

Cc Laurie Lamson, Operation Services Branch Manager
Duane Preshinger, Medicaid System Support Program Director
Jeff Buska, Quality Assurance Division Administrator
Tern Thompson, Program Compliance Bureau Chief
Jennifer Irish, SURS Supervisor