Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Montana Comprehensive Program Integrity Review

Final Report

February 2014

Reviewers:
Margi Charleston
Richard Colangelo
Andrey Marinovich
Leatrice Berman Sandler

Table of Contents

Executive Summary and Introduction

The Centers for Medicare & Medicaid Services (CMS) regularly conducts reviews of each state's Medicaid program integrity activities to assess the state's effectiveness in combating Medicaid fraud, waste, and abuse. Through state comprehensive program integrity reviews, the CMS Medicaid Integrity Group (MIG) identifies program integrity related risks in state operations and, in turn, helps states improve program integrity efforts. In addition, CMS uses these reviews to identify noteworthy program integrity practices worthy of being emulated by other states. Each year, CMS prepares and publishes a compendium of findings, vulnerabilities, and noteworthy practices culled from the state comprehensive review reports issued during the previous year in the *Program Integrity Review Summary Report.*

The purpose of this review was to determine whether Montana's program integrity procedures satisfy the requirements of federal regulations and applicable provisions of the Social Security Act. A related purpose of the review was to learn how the State Medicaid Agency receives and uses information about potential fraud and abuse involving Medicaid providers and how the state works with the Medicaid Fraud Control Unit (MFCU) in coordinating efforts related to fraud and abuse issues. Other major focuses of the review include but are not limited to: provider enrollment, disclosures, and reporting; program integrity activities including pre-payment and post-payment review, methods for identifying, investigating, and referring fraud, appropriate use of payment suspensions, and False Claims Act education and monitoring.

The review of Montana's program integrity activities found the state to be in compliance with many of the program integrity requirements. However, the review team did note the state's Medicaid program is at risk because it has a number of vulnerabilities in its program integrity activities. Ranked below in order of risk to the program these are:

1) Inadequate program integrity activities, including a decline in investigations which led to a low number of referrals, failing to use its permissive exclusion authority, and the state statute for exclusion notice is inconsistent with the federal regulation**.**
2) Inadequate attention to program integrity controls by failing to suspend payments in cases of credible allegations of fraud, and a lack of communication and coordination with the MFCU.
3) Ineffective provider enrollment practices and reporting, including failing to properly search for excluded providers, failing to properly capture all required disclosures, and failing to properly handle the reporting of state and local court convictions.

These vulnerabilities include instances of regulatory non-compliance by the state as well as failure to incorporate program safeguards which, while not legally mandated, would generally be considered prudent and reasonable. These issues and CMS's recommendations for improvement are described in detail in this report.

CMS is concerned that several of the issues described in this review were also identified in CMS's 2010 review and are still uncorrected. CMS will work closely with the state to ensure that all issues, particularly those that remain from the earlier review are satisfactorily resolved as soon as possible.

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. The review guide included such areas as program integrity, provider enrollment/disclosures and relationship with the MFCU. A five-person team reviewed the responses and materials that the state provided in advance of the onsite visit. The review team also conducted an in-depth telephone interview with representatives from the MFCU.

During the week of October 30, 2012, the MIG review team visited the Department of Public Health and Human Services office. The team conducted interviews with numerous Department of Public Health and Human Services officials as well as with staff from the fiscal agent. In addition, the team conducted sampling of provider enrollment applications, program integrity cases, and reviewed other primary data to validate Montana's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the Program Compliance Bureau (PCB) within the Department of Public Health and Human Services, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment. Montana operates its Children's Health Insurance Program as a stand-alone Title XXI program. The stand-alone Children's Health Insurance Program operates under the authority of Title XXI and is beyond the scope of this review. Unless otherwise noted, Montana 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 the PCB provided.

Medicaid Program Integrity Unit

In Montana, the PCB is the organizational component dedicated to fraud and abuse activities. At the time of the review, the PCB had 12 full-time equivalent positions allocated to Medicaid program integrity functions. The table below summarizes investigative and administrative actions undertaken by the PCB in the last four complete State fiscal years (SFYs). It also lists the overpayments identified and collected over that same time period.

Table 1

SFY	Number of Preliminary Investigations Initiated*	Number of Cases Referred to MFCU**	Number of Administrative Cases	Amount of Overpayments Identified***	Amount of Overpayments Collected***
2009	482	7	5	$733,960	$731,982
2010	692	4	22	$2,595,604	$910,338
2011	322	6	15	$920,364	$747,760
2012	193	1	12	$552,080	$881,218

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a referral to the MFCU or administrative sanction. The PCB does not conduct full investigations.
**Preliminary investigations not referred to MFCU are included in the number of administrative cases.

***Overpayments identified and collected are the results of preliminary investigations and administrative cases. In the administrative cases, overpayments identified and collected vary based on the number of providers identified.

Results of the Review

The CMS review team found a considerable number of regulatory compliance issues and vulnerabilities related to program integrity in Montana's Medicaid program. Several of the issues are significant and represent risks to the integrity of the state's Medicaid program. These issues fall into three major categories listed in order of risk and discussed below. To address them, Montana should improve oversight and build more robust program safeguards.

RISK 1: Inadequate program integrity activities, including a decline in investigations which led to a low number of referrals, failing to use its permissive exclusion authority, and the state statute for exclusion notice is inconsistent with the federal regulation.

Since the 2010 CMS review, Montana has seen a 72 percent decline in the number of suspected provider fraud and abuse investigations. In SFY 2012, the number of preliminary investigations declined 40 percent from the previous year, as displayed in the table above in the Medicaid Program Integrity Unit section, with only one case referred to the MFCU.

According to Montana, staff turnover and the number of vacancies made it difficult for program integrity management to be proactive in executing the PCB's functions, such as data analysis, auditing, and the development of cases for referral. The PCB lost experienced staff, and new staff lacked the program knowledge to conduct investigations at the same capacity. At the time of the review, the PCB had 4 vacant positions out of a total of 12 FTEs. An additional contributing factor to the low number of MFCU referrals can also be attributed to the continuing communication and coordination problems with the MFCU as described in Risk 2. Although the state agency had policies and procedures in place that address the identification and investigation of fraud cases, the PCB's loss of experienced staff and corresponding loss of institutional knowledge have made it difficult for the state to perform these functions effectively.

Additionally, the state was not proactively utilizing its administrative authority provided by the regulation at 42 CFR 1002.210 to initiate terminations[1] for reasons used by the U.S. Department of Health and Human Services-Office of Inspector General (HHS-OIG). The PCB was only exercising this exclusion authority when other authorities, such as the HHS-OIG had already sanctioned providers. This issue was also identified in the 2010 CMS review. The team also noted that the state's Administrative Rule 37.85.507 – Notice of Sanction, did not include notifying the public or beneficiaries when a provider was terminated from the Medicaid program as required by 42 CFR 1002.212.

Recommendations: Conduct ongoing training on core program integrity areas for new and existing staff with an emphasis on increasing the capacity to identify suspected fraud and abuse, conduct investigations and generate fraud referrals. Utilize the authority provided by 42 CFR 1002.210 to proactively initiate exclusions of problem providers from the Medicaid program. To

[1] For reporting purposes, CMS refers to state actions in accordance with this regulation as "terminations" whether the state calls them "terminations" or "exclusions".

comply with 42 CFR 1002.212, develop and implement policy and procedures to ensure that the public and beneficiaries are notified of provider sanctions and terminations.

RISK 2: Inadequate attention to program integrity controls by failing to suspend payments in cases of credible allegations of fraud, and a lack of coordination and communication with the MFCU.

The regulation at 42 CFR 455.23(a) requires that upon the State Medicaid Agency determining that an allegation of fraud is credible, it must suspend all Medicaid payments to a provider, unless the agency has good cause not to suspend payments or to suspend payment only in part. Under 42 CFR 455.23(d) the state Medicaid agency must make a fraud referral to either a MFCU or to an appropriate law enforcement agency in states with no certified MFCU not later than the next business day after the suspension is enacted. The referral to the MFCU must be made in writing and conform to the fraud referral performance standards issued by the Secretary.

The team reviewed the files for the one case Montana referred to the MFCU since March 25, 2011 for compliance with the regulation. It was noted that the state determined a credible allegation of fraud and referred the case to the MFCU, but payments to the provider were not suspended until two weeks later. As a result, approximately $3,506 was paid to this provider after their referral to the MFCU. These payments were potentially at risk.

In addition, the state's corrective action plan (CAP) following the 2010 CMS review indicated that the MOU would be updated to ensure monthly meetings between the PCB and the MFCU and to comply with the new payment suspension regulation at 42 CFR 455.23. However, at the time of the review the MOU had not been updated to reflect these changes. Further, neither agency conducted staff training, which would have been helpful to new PCB staff when developing case referrals as well as providing them guidance on how to detect fraud schemes as they relate to the Medicaid program.

Recommendations: Ensure that in the absence of a written good cause exception, provider payments are suspended after determination of a credible allegation of fraud in accordance with the requirements at 42 CFR 455.23. Strengthen intra-agency communication between the PCB and MFCU by amending the MOU or other auxiliary agreements with mutual goals and expectations. Conduct periodic trainings to increase staff knowledge of detecting and investigating fraud, waste, and abuse to increase the number of referrals to the MFCU.

RISK 3: Ineffective provider enrollment practices and reporting, including failing to properly search for excluded providers, failing to properly capture all required disclosures, and failing to properly handle the reporting of state and local court convictions.

Exclusion Searches and Disclosures by Providers

The state was not requesting information about agents of the provider on provider enrollment forms. Failure to request information about agents prevents the state from being able to conduct complete exclusion searches of federal databases according to the regulation at 42 CFR 455.436.

Capturing Ownership and Control Disclosures at Enrollment

The 2010 CMS review team found the state was not capturing all ownership and control disclosures and relationship information from FFS and Developmental Disabilities Program providers. The state was also using different enrollment forms in its Medicaid programs, which did not capture all of the required ownership and control and relationship information. The state took steps to correct these compliance issues prior to the October 2012 CMS review by using a standard provider enrollment form and a web-based process for all Medicaid providers.

However, the state's enrollment application and web-based form failed to properly capture necessary information to comply with the regulation at 42 CFR 455.104. Specifically, the state did not capture ownership or control interest in any subcontractors in which the disclosing entity has five percent or more interest and relationship information about persons with ownership or control interests in subcontractors. Furthermore, the enrollment application and web-based form did not capture full disclosures of managing employees.

In addition, the state did not capture all the required disclosures from the fiscal agent. Since the new Affordable Care Act requirements went in to effect, the state updated the fiscal agent disclosures but failed to gather the full-range of information as required by the regulation including the enhanced address for corporate entities or the name, address, Social Security Number, or date of birth for managing employees of the fiscal agent.

Capturing Criminal History Disclosures at Enrollment

The 2010 CMS review found the state only requested disclosures of criminal convictions from the applicant and not from owners, agents, or managing employees of the providers. While the state improved in this October 2012 review, it was still not fully compliant with the regulation at 42 CFR 455.106. The state did not solicit health care-related criminal conviction history from agents.

State Agency Notifications of Exclusion and Notification of State or Local Convictions

The regulation at 42 CFR 1002.230 requires the State Medicaid Agency to notify the HHS-OIG of health care related criminal convictions. At the time of this review, the state did not have policies and procedures to report to HHS-OIG whenever a state or local court convicted an individual of a criminal offense related to health care delivery under the Medicaid program either when it was involved in the investigation or prosecution or after it learned of the conviction.

Recommendations: Modify provider enrollment forms, including the online version, and the fiscal agent contract to collect the full range of disclosures required by the regulation. Search the HHS-OIG's List of Excluded Individuals and Entities (LEIE) or Medicare Exclusion Database

and the Excluded Parties List System (EPLS) on the System for Award Management (SAM)[2] upon enrollment, reenrollment, and at least monthly thereafter for agents of the provider to ensure that the state does not pay federal funds to excluded persons or entities. Develop and implement procedures to notify HHS-OIG of state and local court convictions of crimes against Medicaid within 15 days after the state-involved conviction or within 15 days after the state learns of the conviction.

Effective Practices

As part of its comprehensive review process, CMS also invites each state to self-report practices that it believes are effective and demonstrate its commitment to program integrity. CMS does not conduct a detailed assessment of each state-reported effective practice. The state reported a centralized provider enrollment process.

Centralized Provider Enrollment Process

The state requires all FFS providers, non-emergency medical transportation providers, personal care services agencies, and waiver providers to be enrolled into the Medicaid program using a standard enrollment form and provider agreement that is also available online. The presence of a centralized enrollment process gives Montana the capacity to perform automatic exclusion and debarment checks of these providers.

Notwithstanding the value of the centralized process, CMS did find problems with the provider enrollment process, which were addressed earlier in this report. When the identified concerns are addressed, Montana's provider enrollment process will be strengthened.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Montana to consider utilizing:

- Access the Regional Information Sharing System (RISS):
  - To find appropriate provider enrollment applications and provider agreements to assist in complying with the full range of current disclosure requirements and consider posting requests for states to share their provider enrollment packets to address the issues identified in Risk 3.
  - For various Program Integrity Fundamentals course materials which can be downloaded and utilized as in-house training resources.
- *Review the Best Practices for Medicaid Program Integrity Units' Interactions With Medicaid Fraud Control Units* guidance document published by the Medicaid Integrity Group to address the issues identified in Risk 2. This document is located at: http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/2008-Best-Practices-Medicaid-PI-Unit-Int-with-MFCU.pdf

[2] In July 2012, the EPLS was migrated into the new System for Award Management (SAM).

- Work with your MFCU to update and strengthen the current interagency MOU to include more robust training and meetings for new staff to address the low number of referrals.
- Attend the Small States program integrity calls and other Regional Program Integrity Directors call to collaborate with states for tips on successfully managing program integrity activities when staff is limited.
- Further, since the Program Integrity Director was relatively new to the position at the time of the review, we will be offering her a new program integrity director's orientation.

Summary

The identification of significant areas of risk and findings of non-compliance with federal regulations is of great concern and should be addressed immediately. CMS is also particularly concerned about uncorrected, repeat problems that remain from the time of the agency's last comprehensive program integrity review.

To that end, we will require the State to provide a CAP for each of the areas of concern within 30 calendar days from the date of the final report letter. The CAP should address all specific problems identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will occur and identify which area of the state is responsible for correcting the issue. The state should provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications or agreements. Please provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state 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 Montana to build an effective and strengthened program integrity function.

Official Response from Montana
March 2014

MONTANA DPHHS Healthy People. Healthy Communities.

Department of Public Health and Human Services

Quality Assurance Division ♦ 2401 Colonial Drive, 2nd Floor ♦ Helena, MT 59602-2953 ♦ fax: 406-444-0778

Steve Bullock, Governor

Richard H. Opper, Director

March 28, 2014

Peter Leonis
Director of the Division o of Field Operations
CMS/Center for Program Integrity
Medicaid Integrity Group/Division of Field Operations
26 Federal Plaza, Room 37-130
New York, NY 10278

Dear Mr. Leonis,

The October 2013 Medicaid Integrity Group (MIG) Draft Report based on the Montana MIG audit performed November 2012, identified three vulnerabilities. The Montana Quality Assurance Division – Program Compliance Bureau has prepared the formal response to each of the areas of risk.

We received the draft report in October 2013 requesting our comments. The draft report was reviewed by staff and comments were submitted to the MIG.

Montana's final report was completed on February 28, 2014. The review indicated three areas where the MIG determined Montana was at risk of being non-compliant.

As a result of these findings Montana has submitted a corrective action plan for each of the risk areas.

If you have any questions or concerns, please contact Michelle Truax at (406) 444-4120 or by e-mail at MTruax@mt.gov .

Thank you for the opportunity to informally and formally respond to the MIG Audit findings.

Sincerely,

Mary E. Dalton

Mary E. Dalton
Medicaid Director – DPHHS

Cc: Marie Matthews, Operations Services Branch Manager – DPHHS
Michelle Truax, Quality Assurance Bureau Chief - DPHHS