Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Montana Focused Program Integrity Review

Oversight of Medicaid Personal Care Services

October 2025

Final Report

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I. Executive Summary

Objectives

The Centers for Medicare & Medicaid Services' (CMS) conducted a focused program integrity review of Montana's Medicaid Personal Care Services (PCS) program to assess the state's program integrity oversight efforts for Fiscal Years (FY) 2021 – 2023. This focused review specifically assessed the state's compliance with CMS regulatory PCS requirements within 42 CFR Parts 440 and 441. A secondary objective of this review was to provide the state with feedback, technical assistance, and educational resources that may be used to enhance program integrity in the delivery of these services.

To meet the objectives of this focused review, CMS reviewed information and documents provided in response to the CMS PCS review tool provided at the initiation of the review, CMS also conducted in-depth interviews with the state Medicaid agency (SMA) and evaluated program integrity activities performed by selected agencies under contract to provide PCS to Medicaid beneficiaries.

This report includes CMS' findings and resulting recommendations, as well as observations, that were identified during the focused review.

Findings and Recommendations

Findings represent areas of non-compliance with federal and/or state Medicaid statutory, regulatory, sub-regulatory, or contractual requirements. CMS identified **one** finding that creates risk to the Montana Medicaid program related to PCS program integrity oversight. In response to the finding, CMS identified **one** recommendation that will enable the state to come into compliance with federal and/or state Medicaid requirements related to PCS program integrity oversight. The recommendation includes the following:

State Oversight of PCS Program Integrity Activities and Expenditures

> **Recommendation #1:** CMS recommends Montana ensure state regulations and rules align with federal regulations at § 455.14 (Preliminary Investigation) and § 455.15 (Full Investigation). The state should also require PCS providers to coordinate any fraud referrals with the Surveillance and Utilization Review Section (SURS), which should in turn coordinate with the Medicaid Fraud Control Unit (MFCU) on any necessary administrative actions.

Observations

Observations represent operational or policy suggestions that may be useful to the state in the oversight of its Medicaid PCS program. CMS identified **six** observations related to Montana's PCS program integrity oversight. While observations do not represent areas of non-compliance

with federal and/or state requirements, observations identify areas that may pose a vulnerability or could be improved by the implementation of leading practices. The observations identified during this review include the following:

State Oversight of PCS Program Integrity Activities and Expenditures

Observation #1: CMS encourages Montana to allocate sufficient resources to the prevention, detection, investigation, and referral of suspected provider fraud. Detailed policies and procedures should be in place to guide the referral process. CMS also encourages Montana to enhance its data analytics capabilities and improve post-payment review procedures to increase the identification of improper payments and suspected fraud referrals to the MFCU. Montana should focus efforts on increasing fraud referrals to the MFCU, payment suspensions, and overpayment recoveries.

Observation #2: CMS encourages Montana to implement edits in the Medicaid Management Information System (MMIS) that can prevent Medicaid fraud, waste, and abuse, including safeguards against improper billing for institutional stays and services rendered after a beneficiary's date of death.

Observation #3: CMS encourages Montana to review and update the beneficiary verification process to enhance its return on investment from a PCS program integrity perspective.

Observation #4: CMS encourages Montana to provide audit education and training for providers in accordance with Montana Code 53-6-1407. CMS also encourages Montana to provide regular training opportunities for PCS providers related to topics including but not limited to PCS program rules and/or guidance, billing requirements, fraud, waste, and abuse identification, referral, and reporting requirements. CMS further encourages Montana to establish policies and procedures and provide additional training and/or guidance to ensure PCS providers are appropriately returning overpayments and reporting and referring suspected fraud, waste, or abuse to the Department of Public Health and Human Services (DPHHS).

Observation #5: CMS encourages Montana and the MFCU to consider providing periodic training for DPHHS staff on Medicaid fraud, waste, and abuse. This training would improve communication, provide guidance, and support enhanced program integrity activities, ultimately increasing the number of PCS fraud, waste, and abuse referrals.

Provider Enrollment and Screening Oversight of PCS Agency Providers

Observation #6: Consistent with CMS guidance,[1] CMS encourages Montana to assign a unique identifier or NPI for PCAs. This would facilitate more efficient and transparent

[1] https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforprofs/downloads/faqs-using-npis-for-medicaid-pcas.pdf

tracking of each PCS service rendered or reimbursed.

II. Background

Focused Program Integrity Reviews

In the Comprehensive Medicaid Integrity Plan for FYs 2024-2028, CMS set forth its strategy to safeguard the integrity of the Medicaid program.[2] This plan encompasses efforts to ensure that states are adhering to key program integrity principles, including the requirement that state Medicaid programs have effective oversight and monitoring strategies that meet federal standards.

As a part of these efforts, CMS conducts focused program integrity reviews on high-risk areas in the Medicaid program, such as managed care, new statutory and regulatory provisions, non-emergency medical transportation, telehealth, and PCS. These reviews assess the effectiveness of each state's program integrity oversight functions and identify areas of regulatory non-compliance and program vulnerabilities. Through these reviews, CMS also provides states with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid.

Medicaid Personal Care Services

Medicaid PCS are services provided to eligible beneficiaries that help them to stay in their own homes and communities rather than live in institutional settings, such as nursing facilities. The PCS benefit is provided according to a state's approved plan, waiver, or demonstration and are optional Medicaid services, except when medically necessary for children eligible for early and periodic screening, diagnostic, and treatment (EPSDT) services. PCS are categorized as a range of assistance provided to persons with disabilities and chronic conditions to enable them to accomplish activities of daily living (ADLs) or instrumental activities of daily living (IADLs). An independent or agency-based personal care attendant (PCA) may provide ADL services, which include eating, bathing, dressing, ambulation, and transfers from one position to another, and IADL services, which include day-to-day tasks that allow an individual to live independently but are not considered necessary for fundamental daily functioning, such as meal preparation, hygiene, light housework, and shopping for food and clothing.

States administer their Medicaid programs within broad federal rules and according to requirements of the specific authority approved by CMS. Pursuant to 42 CFR Part 440, states can choose to provide PCS for eligible beneficiaries through their state plan, a waiver, or a Section 1115 demonstration. Because PCS are typically an optional benefit, they can vary greatly by state and within states, depending on the Medicaid authority used to cover the benefit. Under federal statute and regulations, PCS must be approved by a physician or through some other authority recognized by the state. Beneficiaries receiving PCS cannot be inpatients or residents of a hospital, nursing facility, intermediate care facility for the developmentally disabled, or institution for mental disease. Services can only be rendered by qualified individuals who have

[2] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf

met certain training and enrollment requirements, as designated by each state.

Overview of the Montana Personal Care Services Program and the Focused Program Integrity Review

The Department of Public Health and Human Services (DPHHS) is responsible for the administration of the Montana Medicaid program. Within DPHHS Office of Inspector General, the Surveillance and Utilization Review Section (SURS) is the organizational unit tasked with oversight of program integrity-related functions, including those related to PCS.

Montana administers Medicaid PCS to eligible beneficiaries under the Section 1905(a) and 1915(k) state plan authority, and Section 1915(c) Home and Community-Based Services (HCBS) waiver authority. PCS falls under HCBS, which are types of person-centered care delivered in the home and community. Detailed descriptions of the Montana Medicaid PCS Programs and their applications can be found in Appendix C.

In FY 2023, Montana's total Medicaid expenditures were approximately $2.4 billion, providing coverage to approximately 323,237 beneficiaries. Montana's Medicaid expenditures for PCS totaled approximately $28 million, and 3,852 beneficiaries received PCS. DPHHS offers both agency-based and participant-directed PCS options. Appendix C provides enrollment and expenditure data for the PCS population in Montana.

In July 2024, CMS conducted a focused program integrity review of Montana's PCS program. This focused review assessed the state's compliance with regulatory requirements at 42 CFR Parts 440, 441, 455, and 456, as well as Sections 1905(a), 1915(c), and 1915(k) of the Social Security Act (the Act). As a part of this review, CMS conducted interviews with SMA staff involved in the administration of PCS to validate the state's program integrity practices, as well as with key personnel within three PCS agencies. CMS also evaluated the status of Montana's previous corrective action plan developed by the state in response to a PCS focused review conducted by CMS in 2019, the results of which can be found in Appendix A.

During this review, CMS identified a total of one recommendation and six observations. CMS also included technical assistance and educational resources for the state, which can be found in Appendix B. The state's response to CMS' draft report can be found in Appendix D, and the final report reflects changes CMS made based on the state's response.

This review encompasses the three following areas:

A. **State Oversight of PCS Program Integrity Activities and Expenditures** – States share responsibility with CMS for ensuring that state and federal dollars are used to deliver health care services consistent with efficiency, economy, and quality to eligible individuals and are not misused for fraud, waste, or abuse. States must meet various statutory and regulatory requirements, such as program integrity safeguards in 42 CFR Parts 455 and 456, to maintain effective oversight of their Medicaid programs. In addition, pursuant to Section 12006(a) of the 21st Century Cures Act, all states were required to implement an Electronic Visit Verification (EVV) system for PCS by January

1, 2020. Failure to meet this requirement results in incremental Federal Medical Assistance Percentage (FMAP) reductions of up to 1 percent, unless the state has both made a "good faith effort" to comply and has encountered "unavoidable delays."

B. <u>Provider Enrollment and Screening</u> – As defined by § 440.167, PCS services must be provided by an individual who is qualified to provide such services, unless defined differently by a state agency for purposes of a waiver granted under part 441, subpart G.[3] In accordance with these standards, state law often requires PCS agency staff and attendants to be subject to enhanced screening and credentialing procedures at the date of hire and annually thereafter. CMS regulations at § 455.436 require that the SMA conduct database checks to determine the exclusion status of providers, persons with an ownership or control interest, and agents and managing employees on the Department of Health and Human Services Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE), the System for Award Management (SAM), the Social Security Administration's Death Master File (SSA-DMF), and the National Plan and Provider Enumeration System (NPPES) upon enrollment and reenrollment, and check the LEIE and SAM no less frequently than monthly. In accordance with § 455.434, PCS agencies or attendants that enroll in Medicaid as providers are also subject to federal screening requirements found at § 455.410.

C. <u>State Oversight of Self-Directed and Agency-Based PCS</u> – States may elect to offer self-directed PCS through several pathways, including the state plan, Section 1915(c) waivers, and specific provisions under Sections 1915(j) and 1915(k). These options allow participants, or their authorized representatives, to exercise choice and control over the planning, budgeting, and purchase of self-directed PCS. CMS regulations at 42 CFR 441 Subpart J govern the use of self-direction under these options, outlining the requirements for oversight and support of participants' control in managing their care. Self-directed PCS under the state plan and Section 1915(c) waivers enable beneficiaries to tailor their care according to their specific needs and preferences while maintaining autonomy. Alternatively, beneficiaries may receive agency-based PCS, where a personal care agency provides oversight, management, and supervision of their services. Agency-based PCS are available through either state plan or waiver authority. In accordance with §§ 441.302 and 441.570, the SMA must ensure that adequate safeguards are in place to protect the health and welfare of individuals receiving PCS through these options and maintain financial accountability for all funds expended on PCS provided through waiver or state plan authority to uphold program integrity and compliance with federal standards.

[3] The conditions of participation for home health aides participating in PCS programs are further detailed at § 484.80.

III. Results of the Review

A. State Oversight of PCS Program Integrity Activities and Expenditures

States share responsibility with CMS for ensuring that state and federal dollars are used to deliver health care services consistent with efficiency, economy, and quality to eligible individuals and are not misused for fraud, waste, or abuse. States must meet various statutory and regulatory requirements, such as program integrity safeguards in 42 CFR Parts 455 and 456, to maintain effective oversight of their Medicaid programs.

As required by §§ 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and beneficiaries. In addition, Section 1902(a)(30) of the Act and federal regulations at 42 CFR Part 456 require the state plan to provide for the establishment and implementation of a statewide surveillance and utilization control program that provides methods and procedures to safeguard against unnecessary or inappropriate utilization of care, services, and excess payments. States often meet these requirements through implementation of a surveillance and utilization review subsystem within the Medicaid Management Information System (MMIS) and/or discrete surveillance and utilization review subsystem units that are a part of larger program integrity efforts.

In Montana, the DPHHS SURS is primarily responsible for Medicaid program integrity activities. The Program Compliance Bureau is part of the DPHHS Office of Inspector General and consists of the Program Integrity Unit, Quality Control Unit, SURS, and the Third-Party Liability Unit. Providers are selected for review based on creditable information that points to an irregularity. When an analysis of a provider's records shows that program rules have been misinterpreted or violated, a sanction may be imposed. This may range from a warning letter to a criminal charge. No sanction is imposed without the provider receiving full appeal rights.[4] However, CMS noted that Montana does not have formal, detailed internal policies documenting the referral process.

Montana has established PCS program participation and reporting requirements through Administrative Rules of Montana (ARM) Title 37, Chapters 37.34 and 37.40 and the use of the Quality Assurance Management System (QAMS) database. The QAMS database serves two purposes: (1) compliance with the Federal Quality Assurance Mandates for HCBS waivers and Community First Choice/Personal Assistance Services (CFC/PAS) and (2) to streamline, standardize, and simplify quality assurance communication between providers, Regional Program Officers (RPO), and Central Office staff in a secure and paperless environment. The QAMS database captures information for Serious Occurrence Reports and is used to document trends across the state which in turn enables the Community Services Bureau (CSB) to identify training needs and assess program policy and procedures. The CSB provides annual training, either in person or through web-based training on updated rules and regulations.

[4] Surveillance Utilization Review Section (SURS)

In Montana, if a credible allegation of fraud is suspected, the case is referred to the Montana Department of Justice (DOJ) Medicaid Fraud Control Unit (MFCU) as required by a Memorandum of Understanding (MOU) between the DOJ and DPHHS. If the MFCU declines the referral, Montana lacks alternative law enforcement options for further action, and administrative remedies must be applied instead. Notably, during the review period, there were no suspected PCS fraud cases referred from SURS to the MFCU. Additionally, the MOU mandates that the MFCU provide annual fraud detection training to DPHHS staff, which did not occur within the review period.

The CMS review team observed that Montana's program integrity resources are insufficient to effectively prevent, detect, investigate, and refer suspected PCS provider fraud. The SURS lacks critical tools, such as advanced data analytics software, sufficient investigative staff, and established policies and procedures. Enhancing data analytics capabilities could allow SURS to identify billing anomalies within the PCS program and increase the number of suspected fraud investigations and audits—key elements of an effective program integrity system. Program integrity functions, such as provider payment suspension in coordination with MFCU and adverse actions like terminations, are a result of these functions aimed at stopping the flow of likely improper payments.

Under Montana Code Title 53, Chapter 6, Part 14, Medicaid Overpayment Audits must be completed within 90 days. Auditors may request up to six months of provider records for claims paid by Medicaid within the prior three years. The state is limited to the administrative rule requirements in place; unless a significant error rate is noted, the state must adhere to these time constraints and cannot request additional records. The DPHHS interpretation and use of the regulation appears to limit the SURS activities when it determines an overpayment is associated with claims from a particular PCS provider. However, this rule does not appear to have any impact regarding fraud, waste, and abuse investigations.

Overpayments identified as part of the PCS oversight and compliance reviews are documented in the QAMS. Once an overpayment is identified, the CSB staff document the overpayment in the QAMS database, which is submitted to the provider along with an overpayment letter. The provider documents their response in QAMS. If QAMS does not receive a response within the due date, the CSB staff are required to issue a follow-up within 10 days. The CSB staff initiates repayment through an adjustment in the claims system.

In accordance with Montana Code 53-6-1407, DPHHS is required to provide education and training programs for providers at least twice per year and discuss audit results, common issues and problems, mistakes identified through audits, and opportunities for improvement related to billing and documentation. Montana's Medicaid provider website provides ongoing educational opportunities for all provider organizations. However, CMS noted that DPHHS did not provide education and training to providers as required by state policy during the review period. CMS also noted that agency-based PCS caregivers/providers are not required to have annual training on Medicaid fraud.

Montana's MMIS claims system has a variety of pre-payment edits in place that evaluate services billed. Edits include validation of the provider eligibility/enrollment, service codes by

provider type and specialty, service codes by beneficiary eligibility, duplicate services for beneficiaries by the same or a different provider, services requiring prior authorization, and service limits. However, it appears edits are not in place to ensure PCS are not billed for after the beneficiary's date of death or when a beneficiary was an inpatient or resident of a hospital or nursing facility during the same time period[5]. CMS noted a lack of SURS data analytics and post-payment reviews to determine date of death and inpatient hospital overlap for PCS services.

As required by § 456.23, Montana must have a post-payment claims review process that allows state personnel to develop and review beneficiary utilization profiles, provider service profiles, exception criteria, and identify exceptions so the agency can correct misutilization practices of beneficiaries and providers. While Montana has a post-payment review process in place, it lacks adequate program integrity resources to effectively prevent, detect, investigate, and refer suspected PCS provider fraud. Montana has not upgraded their post-payment process to keep up with modern-day program integrity demands of the Medicaid program, especially PCS which is typically regarded as a high-risk program. Montana's current method will not produce effective program integrity returns as evidenced by the lack of PCS referrals over an extended period of time. During the review period, Montana SURS was unable to detect a single credible allegation of fraud in the PCS program and consequently made no case referrals to the MFCU. This same situation was reported in the previous Montana focused program integrity review report, issued in February 2020. This situation, along with legislative barriers, places Montana in a vulnerable position and at risk for PCS fraud in its state Medicaid program. Detailed information on post-payment actions taken as a result of PCS provider audits can be found in Appendix C.

To meet the requirements of § 455.20, Conduent, the state's fiscal agent, sends out a random sample of explanation of benefits statements per month across all Medicaid services. However, DPHHS does not track the service types that are being verified. Therefore, the state has no record of how many PCS have been verified through this process. The DPHHS is unable to calculate return on investment because the explanation of benefits statements sent out are random and DPHHS will only know it is PCS if a response is received.

In Montana, these oversight and monitoring requirements are not met. The SURS has a basic program integrity process but no formal written policies and procedures for monitoring PCS. The state has minimal staff for program integrity functions and no formal policy for reporting credible allegations of fraud to the MFCU. The state indicated they start with data analytics looking for anomalies, however, CMS noted the state does not have adequate software to perform data analytics. If potential fraud, waste, or abuse is detected, SURS will move forward with a preliminary review. If a credible fraud risk is indicated, their process is to refer to the MFCU. The DPHHS SURS meets monthly with the MFCU to discuss cases and issues. The critical incident policy details the specific incidents to be reported.

States are also required to implement an EVV system to help oversee PCS providers. EVV is used to verify that PCS visits occurred and can be performed through a number of methods, including telephonic or GPS-enabled mobile applications. Pursuant to Section 12006(a) of the

[5] Excluding claims for dates when beneficiaries were admitted to an inpatient facility and the date they were discharged.

21st Century Cures Act, all states were required to implement an EVV system for PCS by January 1, 2020. Failure to meet this requirement results in incremental FMAP reductions of up to 1 percent, unless the state has both made a "good faith effort" to comply and has encountered "unavoidable delays." During the review period, Montana did not utilize an EVV system for in-home scheduling, tracking and billing for PCS providers. Montana implemented their current EVV on July 1, 2024, and is currently in compliance with Section 12006(a) of the 21st Century Cures Act. Montana paid a penalty for not having the EVV in place by the CMS required deadline.

In summary, PCS program integrity activities are limited in Montana due to lack of adequate program integrity resources to effectively prevent, detect, investigate, and refer PCS provider fraud, including a lack of program integrity data analytics and software tools, investigative staff, and poorly developed policies and procedures.

Recommendation #1: CMS recommends Montana ensure state regulations and rules align with federal regulations at § 455.14 (Preliminary Investigation) and § 455.15 (Full Investigation). The state should also require PCS providers to coordinate any fraud referrals with the Surveillance and Utilization Review Section (SURS), which should in turn coordinate with the Medicaid Fraud Control Unit (MFCU) on any necessary administrative actions.

Observation #1: CMS encourages Montana to allocate sufficient resources to the prevention, detection, investigation, and referral of suspected provider fraud. Detailed policies and procedures should be in place to guide the referral process. CMS also encourages Montana to enhance its data analytics capabilities and improve post-payment review procedures to increase the identification of improper payments and suspected fraud referrals to the MFCU. Montana should focus efforts on increasing fraud referrals to the MFCU, payment suspensions, and overpayment recoveries.

Observation #2: CMS encourages Montana to implement edits in the Medicaid Management Information System (MMIS) that can prevent Medicaid fraud, waste, and abuse, including safeguards against improper billing for institutional stays and services rendered after a beneficiary's date of death.

Observation #3: CMS encourages Montana to review and update the beneficiary verification process to enhance its return on investment from a PCS program integrity perspective.

Observation #4: CMS encourages Montana to provide audit education and training for providers in accordance with Montana Code 53-6-1407. CMS also encourages Montana to provide regular training opportunities for PCS providers related to topics including but not limited to PCS program rules and/or guidance, billing requirements, fraud, waste, and abuse identification, referral, and reporting requirements. CMS further encourages Montana to establish policies and procedures and provide additional training and/or guidance to ensure PCS providers are appropriately returning overpayments and reporting and referring suspected fraud, waste, or abuse to the DPHHS.

Observation #5: CMS encourages Montana and the MFCU to consider providing periodic training for DPHHS staff on Medicaid fraud, waste, and abuse. This training would improve communication, provide guidance, and support enhanced program integrity activities, ultimately increasing the number of PCS fraud, waste, and abuse referrals.

B. Provider Enrollment and Screening

CMS regulations at § 455.436 require that the SMA conduct database checks to verify the exclusion status of the provider, persons with an ownership or control interest, and agents and managing employees on the HHS-OIG's LEIE, SAM, SSA-DMF, and NPPES upon enrollment and reenrollment, and check the LEIE and SAM no less frequently than monthly.

For agency directed services available under the state plan and Section 1915(c) waiver authorities, responsibility for compliance with § 455.436 is delegated to the agency. Compliance requirements for this regulation apply only to providers who are enrolled in traditional Medicaid and are issued a Medicaid provider ID. CMS confirmed that OMS has a state policy in place addressing this requirement. For PCAs not enrolled with the state, federal database checks (e.g., LEIE or SAM) are not required under federal law for either traditional or managed care Medicaid, though states may impose their own requirements. CMS confirmed that the DPHHS has a state policy in place addressing this requirement. For self-directed services available under the state plan and Section 1915(c) waiver authorities, the Financial Management Services Agency (FMSA) performs provider screenings and provides fiscal intermediary and other support services to beneficiaries who choose to self-direct their service.

In accordance with § 455.410, PCS agencies or attendants that enroll in Medicaid as providers are subject to federal screening requirements found at § 455.450. SMAs must require providers, as a condition of enrollment in Medicaid, to consent to Fingerprint-based Criminal Background Checks (FCBCs) when required to do so under state law, or by the level of screening based on fraud, waste, and abuse risk as determined for that category of provider, in accordance with § 455.434. High risk and moderate risk providers are subject to enhanced screening. The state contracts with Conduent to manage provider enrollment, verification, and claims processing. Conduent submits a monthly report card that summarizes internal monitoring. In accordance with the Administrative Rules of Montana 37.40.1013 and 37.40.1122, PCS agency staff and attendants are subject to these enhanced screening and credentialing procedures at the date of hire and annually thereafter. The DPHHS's enhanced screening and credentialing procedures require PCS providers to enroll as a PCA and comply with on-site visit requirements both before and after enrollment to verify information submitted to DPHHS. All providers must sign a Disclosures, Screening and Enrollment Requirements provider agreement to provide services in Montana which covers enrollment requirements and Conduent performs initial and monthly database checks. State policy requires that all PCS provider enrollment go through an additional layer of review and training by the CFC/PAS Quality Assurance Manager and the CSB Enrollment/Claims Specialist. Montana considers PCS providers to be low to moderate risk. For providers classified as moderate risk, on-site visits occur as part of the enrollment process. The state only requires fingerprinting of a provider or a person with a five percent or more direct or indirect ownership interest in the agency.

As part of this review, CMS interviewed several PCS agencies to determine if they are exercising appropriate oversight of the quality and integrity of services provided to beneficiaries under the care of their agency, in accordance with state standards. CMS selected three provider agencies to be interviewed: Southern Home Care Services, Inc., Montana Independent Living Project, and Consumer Direct Personal Care. In Montana, it is the responsibility of the PCS agencies to do database checks for the individual staff. Each of the agencies reported compliance with these requirements.

CMS determined that DPHHS has met federal screening requirements. However, CMS noted the state does not require individual PCS providers to be licensed or have a National Provider Identifier (NPI). While CMS does not require NPIs to be used to identify PCAs, a unique numeric identifier, such as an NPI, would be an efficient method of electronically recording which individual PCA provided PCS for a particular beneficiary on a particular visit.

> **Observation #6:** Consistent with CMS guidance,[6] CMS encourages Montana to assign a unique identifier or NPI for PCAs. This would facilitate more efficient and transparent tracking of each PCS service rendered or reimbursed.

C. State Oversight of Self-Directed and Agency-Based Services

A self-directed PCS state option allows beneficiaries or their representatives, if applicable, to exercise decision-making authority in identifying, accessing, managing, and purchasing their PCS. A state offering a self-directed option must assure that certain necessary safeguards have been taken to protect the health and welfare of individuals furnishing services under the program and assure the financial accountability for funds expended for self-directed services in accordance with § 441.464. These safeguards must include prevention against the premature depletion of the beneficiary directed budget, as well as identification of potential service delivery problems that might be associated with budget underutilization.

Montana ensures these requirements are met through contracts with the FMSA and case management contractors, which provides each beneficiary receiving self-directed PCS with a case manager to monitor the participant's expenditures. The case manager is tasked with advising the beneficiary on care choices and reporting significant budget variances that may indicate potential fraud or abuse to the DPHHS. For state plan and CFC, the Big Sky Waiver (BSW) contracts with Benefis Spectrum Medical, and the Severe and Disabling Mental Illness (SDMI) waiver contracts with Aware. Additionally, the DPHHS contracts with Mountain Pacific Quality Health, a Quality Improvement Organization (QIO), to conduct medical necessity reviews for PCS and level of care to identify any potential outliers, as well as provide monthly reports on beneficiary count and service authorizations. In addition, the QIO contract lead and the CFC/PAS program managers and section supervisors meet monthly to update policy, review individual cases, discuss program compliance issues, identify training objectives, process fair hearing requests, etc. The QIO meets weekly with representatives from CFC/PAS to review and

[6] https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforprofs/downloads/faqs-using-npis-for-medicaid-pcas.pdf

address utilization related issues.

The self-directed beneficiary or their personal representative is responsible for hiring, training, and managing their PCAs. Any time self-directed PCS are chosen, the beneficiary must obtain authorization from their health care professional. The beneficiary or their personal representative must demonstrate a thorough understanding of the program requirements. During orientation, a document outlining how to report fraud is covered with the self-directed beneficiary. The self-directed provider agency is required to provide ongoing monitoring of self-direct services and beneficiary compliance with program requirements. The provider agency conducts an in-person intake visit with the beneficiary and conducts in-person visits every six months to monitor compliance and provide oversight. The six-month visit includes a review of service delivery records to ensure services are being conducted according to the authorization.

Beneficiaries in Montana can also elect to have their care overseen, managed, and supervised by a personal care agency. Agency-based PCS is available under state plan/waiver authority. In accordance with §§ 441.302 and 441.570, the SMA must ensure that certain safeguards are in place to protect the health and welfare of individuals furnishing services under the program and to maintain the financial accountability for agency-based PCS expenditures. Montana meets these requirements through its QIO and case management contractors, which perform case management services, prior authorization, functional assessments, utilization review, and level of care reviews. Case management services include prior authorization of PCS for the BSW and SDMI waiver. The CFC/PAS RPOs review annual provider prepared reports and conduct regular quality assurance reviews, including post payment review of claims. The BSW RPOs complete targeted quarterly reviews, including examination of case notes, service plans, financial accountability, and compliance with prior authorization policies. The SDMI Community Program Officers review one hundred percent of the waiver member files, including examination of case notes, level of care, prior authorization, expenditures, etc.

The Senior Long-Term Care (SLTC) Division, within DPHHS, is responsible for oversight of the CFC/PAS and BSW programs. Within SLTC, the CSB provides direct program operation oversight and conducts comprehensive reviews for compliance of CFC/PAS provider agencies. The compliance reviews are known as Quality Assurance Reviews (QAR). The QAR is conducted for every Medicaid enrolled CFC/PAS provider to ensure compliance with federal assurance standards, collect quality assurance data, and to identify training needs. Corrective action including sanctions, may occur if a provider agency is unable to demonstrate compliance during the review. Each provider agency is required to submit an annual Provider Quality Assurance Report (PQAR) to CSB, which is audited every one to three years based on the outcome of the prior review. This report documents outcomes from the PQAR and provides assurance that the agency is meeting established program parameters, meeting federal assurance standards, and identifies and responds to agency training needs. The PCS agencies are subject to recoupments and corrective actions plans if programmatic deficiencies are discovered during the review.

For the SDMI waiver, an Oversite Committee meets monthly, which includes community program officers, program analysts, program managers, and supervisors. The topics discussed include health and wellness, waitlist monitoring, training, systemic issues, and provider issues.

Community program officers attend monthly meetings with providers hosted by case management teams and meet bi-weekly with case management teams.

CMS did not identify any findings or observations related to these requirements.

IV. Conclusion

CMS supports Montana's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified one recommendation and six observations that require the state's attention.

We require the state to provide a corrective action plan for the recommendation within 30 calendar days from the date of issuance of the final report. The corrective action plan should explain how the state will ensure that the recommendation has been addressed and will not reoccur. The corrective action plan should include the timeframe for the corrective action along with the specific steps the state expects will take place and identify which area of the SMA is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the corrective action plan, such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of issuance of the final report. If the state has already acted to correct compliance deficiencies or vulnerabilities, the corrective action plan should identify those corrections as well.

The state is not required to develop a corrective action plan for any observations included in this report. However, CMS encourages the state to take the observations into account when evaluating its program integrity operations going forward.

CMS looks forward to working with Montana to build an effective and strengthened program integrity function.

V. Appendices

Appendix A: Results of the Prior Review

Montana's last CMS program integrity review was in June 2019, and the report for that review was issued in February 2020. The report contained nine recommendations. During the virtual review in July 2024, CMS conducted a thorough review of the corrective actions taken by Montana to address all recommendations reported in calendar year 2020. The findings from the 2019 Montana focused PI review report have not all been satisfied by the state.

Findings

1. ***The state should consider developing a standard operating procedure that clearly describes the oversight/administrative roles and responsibilities of each division related to PCS.***
   Status at time of the review: Not Corrected

   Montana agrees that developing a standard operating procedure that documents oversight/administrative roles and responsibilities of each division related to PCS will be an important tool to improve communication and coordination of referrals to SURS and MFCU. This operating procedure will be drafted, approved, and distributed to applicable parties by June 30, 2026.

2. ***The state should consider establishing a process or procedures to document meetings and discussions pertaining to its Medicaid program.***
   Status at time of the review: Not Corrected

   Montana will implement a meeting recording or transcription whichever is available, along with retaining a list of the attendees for the meetings held pertaining to PCS. This will strengthen records-keeping and help support reviews. Montana hopes to have this by 06/30/2026.

3. ***The state should continue with integration plans ensuring that its MMIS system includes the components of the Agency Wide Accounting and Client System (AWACS) payment system and implement edits designed to protect against Medicaid fraud, waste, and abuse.***
   Status at time of the review: Corrected

4. ***The state should consider establishing a process to capture the number of attendees during its Skype training sessions.***
   Status at time of the review: Not Corrected

   Montana will implement a PCS meeting recording or transcription, whichever is available, along with retaining a list of the attendees for formal provider meetings related to fraud, waste, and abuse. This will strengthen records-keeping and help support

reviews. The State is exploring technology changes to allow for attendance tracking when training is held, specifically on Medicaid fraud, waste, and abuse. Montana anticipates to implement this by 06/30/2026.

5. ***The state should consider establishing minimum standards for conducting criminal background checks and federal database checks for all PCS providers.***
   Status at time of the review: Corrected

6. ***The state should ensure that they are in compliance with federal regulations 42 CFR § 455.14 Preliminary Investigations and 42 CFR § 455.15 Full Investigations. The state should also ensure providers of PCS are coordinating any fraud referrals with the PIU. The PIU should in turn be coordinating any administrative actions with the MFCU.***
   Status at time of the review: Not Corrected

   Montana DPHHS program staff have amended their Serious Occurrence Reporting (SOR) policy (attached) to ensure suspected fraud, waste, and abuse is reported to SURS. SURS is functionally separate from program staff, which allows for impartial reviews. SURS conducts a review of all referrals received to fulfill both Program Integrity and Utilization Control regulatory requirements (42 CFR 455 and 456). In addition, SURS has routine communications with MFCU to discuss trends, current cases, and upcoming referrals from SURS to MFCU, or referrals from MFCU to SURS. This two-tier approach ensures that suspected or credible allegations of fraud are referred to MFCU.

7. ***The state should ensure PCS providers are reporting to the state instances where PCAs are terminated for possible fraudulent behaviors.***
   Status at time of the review: Corrected

8. ***The state should ensure that they are allocating sufficient resources to the prevention, detection, investigation, and referral of suspected provider fraud.***
   Status at time of the review: Not Corrected

   SURS performs reviews on all Montana Medicaid providers, including PCS reviews. While no suspected PCS referrals to MFCU were initiated during the review period, SURS routinely refers suspected and credible allegations of fraud to MFCU. With the implementation of written protocols, operating procedures and increased training opportunities, the department believes that increased referrals will occur, regardless if additional resources are provided to SURS specific to PCS services. Through the Executive Planning Process, SURS can work with department leadership to determine if additional resources can be requested during the next legislative session.

9. ***The state should submit good faith effort exemption or require the use of an EVV system as a method to verify visit activity for Medicaid-provided PCS as required under Section 12006 of the 21st Century Cures Act. The EVV system should verify the date of service, location of service, individual providing the service, type of service, individual receiving the service, and the time the service begins/ends.***
   Status at time of the review: Corrected

Appendix B: Technical Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance and educational resources for the SMA.

- Access the Resources for State Medicaid Agencies website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs to address techniques for collaborating with MFCUs.
- Access the CMS frequently asked questions document, Allowability of Using National Provider Identifiers (NPIs) for Medicaid Personal Care Attendants (PCAs), at https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforprofs/downloads/faqs-using-npis-for-medicaid-pcas.pdf
- Access Vulnerabilities and Mitigation Strategies in Medicaid Personal Care Services at https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforprofs/downloads/vulnerabilities-mitigation-strategies.pdf
- Access the Preventing Medicaid Improper Payments for Personal Care Services fact sheet and booklet at https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/downloads/pcs-prevent-improperpayment-factsheet.pdf and https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/downloads/pcs-prevent-improperpayment-booklet.pdf
- Access the Medicaid Payment Suspension Toolkit at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf, to address overpayment and recoveries.
- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts. https://www.riss.net/
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at https://www.cms.gov/hfpp.

Appendix C: Program Information

Table C-1 provides detailed information on the PCS programs available in Montana.

Table C-1. Montana Medicaid PCS Programs

Program Name/Federal Authority	Administered By	Description of the Program
State Plan Authorities		
Section 1905(a) State Plan Authority	DPHHS	PCS are available to assist Medicaid eligible beneficiaries to perform ADLs and IADLs in the member's home, place of employment, or community.
State Plan – School Based Health Services	DPHHS	Personal care paraprofessional in-school services are provided to beneficiaries whose health conditions cause them to be limited in performing ADLs.
1915(k) - Community First Choice (CFC) State Plan Option	DPHHS	The CFC option allows states to provide home and community-based attendant services and support to eligible Medicaid enrollees under Section 1915(k) of their state plan, which was established under the Affordable Care Act of 2010. This option enables states to offer person-centered services that beneficiaries can self-direct while receiving additional federal funding.
Section 1915(c) HCBS Waiver Authorities		
Big Sky Waiver (BSW)	DPHHS	Provides personal assistance, specially trained attendant care, and other services to individuals ages 65 or older and individuals with physical disabilities or other disabilities who meet a nursing facility level of care.
Severe and Disabling Mental Illness (SDMI)	DPHHS	Provides personal assistance service and other needed services to individuals with mental illness ages 18 or older who meet a nursing facility level of care.
Individuals with Developmental Disabilities	DPHHS	Provides personal care and other needed services to individuals with intellectual disabilities or developmental disabilities for all ages who meet an intermediate care facility for individuals with intellectual disabilities level of care.

Table C-2. Montana PCS Enrollment by Authority

	FY 2021	FY 2022	FY 2023
State Plan*	3,751	3,717	3,671
1915(c) HCBS Waivers	1,281	1,272	1,069

* State Plan Authority enrollment total includes state plan, School Based Health Services, and CFC.

Table C-3. Summary of Montana PCS Expenditures by Authority

	FY 2021	FY 2022	FY 2023
State Plan**	$42,222,688	$57,523,956	$59,321,679
1915(c) HCBS Waivers	$7,545,074	$7,160,565	$6,060,804

** State Plan Authority expenditures total includes state plan, School Based Health Services, and CFC.

Table C-4. Waiver Authority Expenditures by Type

1915(c) HCBS Waiver Authority	FY 2021	FY 2022	FY 2023
Big Sky	$70,623,718	$59,380,747	$61,763,697
Severe Disabling Mental Illness	Included with Big Sky	$16,465,790	$19,920,247
Individuals with Developmental Disabilities	$123,652,188	$133,307,745	$147,673,261

Table C-5. Program Integrity Post Payment Actions Taken – PCS Providers

Agency-Directed and Self-Directed Combined	FY 2021	FY 2022	FY 2023
Identified Overpayments	$0	$0	$0
Recovered Overpayments	$0	$0	$0
Terminated Providers	0	0	0
Suspected Fraud Referrals	0	0	0
Number of Fraud Referrals Made to MFCU	0	0	0

Appendix D: State Program Integrity Review Response

INSTRUCTIONS:

For each draft recommendation listed below, please indicate your agreement or disagreement by placing an "X" in the appropriate column. For any disagreements, please provide a detailed explanation and supporting documentation.

Classification	Issue Description	Agree	Disagree
Recommendation #1	CMS recommends Montana ensure state regulations and rules align with federal regulations at § 455.14 (Preliminary Investigation) and § 455.15 (Full Investigation). The state should also require PCS providers to coordinate any fraud referrals with the Surveillance and Utilization Review Section (SURS), which should in turn coordinate with the Medicaid Fraud Control Unit (MFCU) on any necessary administrative actions.		

Acknowledged by:

Heather Smith, Program Compliance Bureau Chief

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[Name], [Title]

11/19/2025

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Date (MM/DD/YYYY)