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Montana Focused Program Integrity Review

Final Report

February 2020

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Executive Summary

The Centers for Medicare & Medicaid Services (CMS) is committed to performing program integrity reviews with states in order to identify risks and vulnerabilities to the Medicaid program and assist states with strengthening program integrity operations. The significance/value of performing onsite program integrity reviews include: (1) assess the effectiveness of the state's PI efforts, including compliance with certain Federal statutory and regulatory requirements, (2) identify risks and vulnerabilities to the Medicaid program and assist states to strengthen PI operations, (3) help inform CMS in developing future guidance to states and (4) help prepare states with the tools to improve PI operations and performance.

The CMS conducted a focused review of the Montana Medicaid personal care services (PCS). The objective of the review was to assess the level of program integrity oversight of Medicaid PCS at the state level. A secondary objective of the review was to provide the state with useful feedback, discussions and technical assistance resources that may be used to enhance program integrity in the delivery of these services. The review also included a follow up on the state's progress in implementing corrective actions related to CMS's previous program integrity review conducted in calendar year 2012.

Medicaid PCS (sometimes referred to as personal attendant or personal assistance services) includes a range of assistance services provided to beneficiaries with disabilities and chronic conditions, of all ages. Provision of these services in the beneficiary's home is intended to serve as an alternative to institutionalization. Assistance may either be in the form of direct provision of a task by the personal care attendant (PCA) or cuing/prompting by the PCA so that the beneficiary may perform the task. Such assistance most often involves activities of daily living (ADLs) such as eating, drinking, bathing, dressing, grooming, toileting, transferring, and mobility. Services offered under Medicaid PCS are an optional benefit, except when they are medically necessary for children who are eligible for the Early and Periodic Screening, Diagnostic, and Treatment benefit that provides comprehensive and preventive health care services.

Pursuant to the regulations at 42 C.F.R. § 440.167, PCS is a Medicaid benefit furnished to eligible beneficiaries according to an approved Medicaid State Plan, waiver, or section 1115 demonstration. States administer their Medicaid programs within broad federal rules and according to requirements of the specific authority approved by CMS. Services must be approved by a physician, or some other authority recognized by the state. Personal care beneficiaries 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, as designated by each state.

During the week of June 3, 2019, the CMS review team visited Montana's Department of Public Health and Human Services (DPHHS). They conducted interviews with numerous state staff involved in program integrity and administration of PCS to validate the state's program integrity practices with regard to PCS.

Summary of Recommendations

The CMS review team identified a total of 9 recommendations based upon the completed focused review modules and supporting documentation, as well as discussions and/or interviews with key

stakeholders. The recommendations were in the following areas: Overview of the State's PCS, State Oversight of PCS Program Integrity Activities and Expenditures in regards to written policies and procedures, Personal Care Services Provider Enrollment, Oversight of Personal Care Services Providers, Program Integrity Post Payment Actions Taken – PCS Providers, and Electronic Visit Verification (EVV). The recommendations will be detailed further in the next section of the report.

Overview of Montana's Medicaid Personal Care Services

- In FFY18, Montana's Medicaid expenditures totaled approximately $1.8 billion, while the number of beneficiaries served via Medicaid totaled approximately 276,717.
- In FFY18, Montana's Medicaid personal care services expenditures totaled approximately $48,309,958, while the number of beneficiaries receiving personal care services, community first choice or home and community-based personal care services, totaled approximately 5,381.
- PCS are a covered benefit under Montana's State Plan which includes the Community First Choice (CFC) and School Based Health Services. Montana also has CMS approval to provide personal care services under three 1915 (c) HCBS Waivers: Big Sky Waiver (BSW), Serious Disabling Mental Illness (SDMI), and HCBS for Individuals with Developmental Disabilities (HCBS-IDD).
- Conduent is contracted as Montana's fiscal intermediary to enroll PCS Providers. The PCS provider enrollment business rules require that all PCS provider enrollment go through an additional layer of review and receive the Community Services Bureau (CSB) Community First Choice (CFC)/PCS Program Manager approval and sign-off.
- PCS services are reimbursed on fee-for-service basis.
- The state offers both agency-based (AB) and self-directed (SD) PCS options.

Overview of Montana's Administration of Personal Care Services

- The DPHHS is the single State Medicaid Agency (SMA). The DPHHS includes the Medicaid and Health Services Branch (MHSB) and within the MHSB is the Senior and Long-Term Care (SLTC) Division, Addictive and Mental Disorders Division (AMDD), Developmental Services Division (DSD), and Health Resources Division (HRD).
- The SLTC is responsible for the daily administration and supervision of the State Plan which includes the CFC and PCS programs and the 1915(c) BSW, as well as issues, policies, rules and regulations related to the CFC, PCS and BSW waiver. The CSB located within SLTC, provides direct oversight of the programs.
- The AMDD is responsible for the daily administration of the SDMI waiver, the DSD is responsible for administration of the HCBS-IDD waiver, and the HRD is responsible for administering the School Based Health Services program.
- The DPHHS contracts with a Quality Improvement Organization (QIO), Mountain Pacific Quality Health (MPQH), to conduct medical necessity reviews for PCS and level of care for State Plan services.
- The DPHHS contracts with Benefits Spectrum Medical and Partners in Health Care (BSMPHC) to provide case management services, which includes prior authorization of PCS for the BSW and SDMI waivers.
- The DPHHS has regional program offices in Billings, Bozeman, Glendive, Missoula, Great Falls, Kalispell, and Butte/Helena.

Summary of PCS in Montana

The Montana DPHHS administers Medicaid PCS to eligible beneficiaries under the State Plan and 1915 (c) HCBS waiver authority. The provision of PCS in the beneficiaries' homes or community settings is intended to serve as an alternative for individuals who would otherwise require institutional care. The Table 1 below provides details of the programs.

Table1.

Program Name/Federal Authority	Administered By	Description of the Program
State Plan PCS Implemented 1987	Montana Department Public Health and Human Services: Senior Long-Term Care Division	• Personal Assistance Services (PAS). • Under the PAS program there is additional time for limited grocery shopping, housekeeping, and laundry.
Section 1915(c) Big Sky Waiver (MT.0148.R06.00) HCBS -Elderly/Physically Disabled. Implemented 1982	Montana Department Public Health and Human Services: Senior Long-Term Care Division	• The BSW program provides HCBS services for the elderly (65 or older) and to individuals with a qualifying physical disability of any age. • Big Sky Bonanza is a participant-directed option under BSW. • To qualify for the BSW, a recipient must be financially eligible for Medicaid and meet the minimum level of care requirements for nursing facility placement. • Individuals must have an unmet need that can only be resolved through the BSW program to qualify for the program.

Program Name/Federal Authority	Administered By	Description of the Program
Section 1915(c) HCBS – Adults with Severe Disabling Mental Illness. (MT. 0455.R02.00) Implemented 2006	Montana Department Public Health and Human Services: Addictive Mental Disorder Division	• The SDMI waiver requires beneficiaries to be financially eligible for Medicaid. • Have a Severe and Disabling Mental Illness; • Be determined appropriate for the HCBS Program via SDMI determination and/or Preadmission Screening and Resident Review (PASRR) screen; • Require the level of care of a nursing facility or hospital; • Be 18 years of age or older; • Not receive case management services through another Medicaid program; • Not receive services through the Developmentally Disabled waiver program; • Live in the area covered by the waiver or willing to move to the area.

Program Name/Federal Authority	Administered By	Description of the Program
Section 1915(c) HCBS for Individuals with Developmental Disabilities (MT.0208.R06.00). Implemented 1990	Montana Department Public Health and Human Services: Developmental Disability Division	• HCBS-IDD 0208 waiver provides support options for beneficiaries with a developmental disability. • Must have a developmental disability. • No age requirement. • Developmental Disabilities Program (DDP) staff is responsible for establishing eligibility for all services for children aged eight and older (and verifying eligibility for children younger than age eight), completing annual Level of Care (LOC) activities, conducting screenings for service openings, processing invoices, contracting, attending planning meetings as needed and generally ensuring service provider compliance with the rules, policies and laws governing DDP waiver funded services.

Program Name/Federal Authority	Administered By	Description of the Program
State Plan 1915(k) Community First Choice. Implemented 2013	Montana Department Public Health and Human Services: Senior Long-Term Care Division	• The CFC and PAS programs are designed to provide long-term supportive care in a home setting. These programs enable thousands of elderly and disabled citizens to remain in their homes. The type of care authorized is tailored to each individual in a person-centered manner and dependent upon their needs, living situation, and availability of caregivers. • Services available through the CFC/PAS Program include the ADLs and limited IADLs. • There are two options under which CFC/PAS eligible individuals can choose to receive their services: Agency Based CFC/PAS (AB-CFC/PAS) or Self-Direct CFC/PAS (SD-CFC/PAS). • Eligibility requirements for both AB-CFC/PAS and SD-

Program Name/Federal Authority	Administered By	Description of the Program
		CFC/PAS include: must have a health condition that limits member's ability to perform activities of daily living, participate in the screening process, and be eligible for Medicaid. • Self-Direct Only: Must obtain authorization from their health care professional. • Self-Direct Only: Consumer or their personal representative must also meet capacity, which means they can demonstrate a thorough understanding of the program requirements. • Self-Directed Only: Montana State Law requires a health care professional to certify, on an annual basis, that the individual is capable of managing their own care, which may include skilled services delivered by non-licensed personnel.

Program Name/Federal Authority	Administered By	Description of the Program
State Plan School Based Health Service (PCS) Implemented 2003	Montana Department of Public Health and Human Services: Health Resource Division	• School Based Health Services covers the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program and is a comprehensive approach to health care for Medicaid members ages 20 and under. It is designed to prevent, identify, and then treat health problems before they become disabling. Under EPSDT, Medicaid eligible children may receive any medically necessary covered service, including all school-based services. All applicable prior authorization requirements apply. • Medicaid covers health-related services provided to children in a school setting when all of the following are met: • The child qualifies for Individuals with Disabilities

Program Name/Federal Authority	Administered By	Description of the Program
		Education Act (IDEA). • The services are written into an Individual Education Plan (IEP). • For the Comprehensive School & Community Treatment (CSCT) program, children must have a serious emotional disturbance diagnosis as specified under Administrative Rules of Montana (ARM) 37.87.303 • Personal care paraprofessional services are medically necessary in-school services provided to members whose health conditions cause them to be limited in performing activities of daily living.

Summary of PCS Expenditures and Beneficiary Data

Table 2.

Program Name /Federal Authority	FFY 2016	FFY 2017	FFY 2018
State Plan PCS	$1,832,519.53	$1,574,958.09	$863,425.38
1915 (c) BSW - Physical Disabilities/Elderly	$7,216,457.94	$7,603,016.87	$6,828,981.98
1915(c) HCBS - IDD	$38,038.89	$38,907.93	$38,302.92
1915 (c) SDMI	$531,483.08	$694,309.89	$658,595.96
1915(k) CFC	$ 36,529,773.94	$ 39,553,798.70	$ 36,367,855.48
State Plan School Based PCS	$2,751,750.00	$3,187,509.00	$3,552,797.00
Total Expenditures	**$48,900,023.38**	**$52,652,500.48**	**$48,309,958.72**

The PCS system in Montana has experienced overall growth in the past few years. This is due in part to the implementation of two new programs. The Community First Choice (CFC) was implemented October 1, 2013 and Medicaid Expansion was implemented January 1, 2016. Through these programs there was growth in PCS enrollment and service access to an expanded population. In addition, general education and awareness about the PCS program options across disability populations has continued to improve and generate an increase in referrals. The slight increase in expenditures from FFY16 to FFY17 captures this population growth. The slight decline of PCS expenditures in FFY18 was the result of the implementation of the CFC State Plan program option and the transition of members from PCS to CFC. The majority of Medicaid members who qualify for PCS continue to have the option to enroll and/or transition to the CFC State Plan. Additionally, this decline in FFY2018 was the result of rate and service reductions that occurred January 1, 2018, in the PCS and other Medicaid programs; which decreased Medicaid reimbursement. Service utilization and member enrollment gradually decreased during this time period, as well.

Table 3.

	FFY 2016	FFY 2017	FFY 2018
Total PCS Expenditures	$48,900,023.38	$52,652,500.48	$48,309,958.72
% Agency-Directed PCS Expenditures	35%	35%	36%
% Self-Directed PCS Expenditures	65%	65%	64%

The SD and AB State Plan PCS program expenditures have been relatively stable. The expenditures in the SD program are higher because there is a higher member count and also because the members who typically choose the SD option have a higher acuity and a corresponding higher PCS service authorization. The SD option also has a higher service utilization rate, due to the fact the members are hiring their workers directly and can often staff their shifts more consistently than in the AB option. The AB option, has a lower service utilization due to current workforce shortages, challenges with scheduling and filling PCS shifts, and lower retention rates.

Table 4-A.

Program Name /Authority	FFY 2016	FFY 2017	FFY 2018
State Plan PCS	338	256	241
1915(k) CFC	1,610	1,690	1,688

Program Name /Authority	FFY 2016	FFY 2017	FFY 2018
1915(c) HCBS - IDD	1	1	1
State Plan School Based PCS	399	456	474
1915 (c) BSW - Physical Disabilities/Elderly	1,331	1,297	1,284
1915 (c) SDMI	159	192	203
Total Agency-directed Unduplicated Beneficiaries	3,838	3,892	3,891

*Unduplicated beneficiary count is the number of individuals receiving services, not units of service. Individuals can be receiving more than one service.

Table 4-B.

Program Name /Authority	FFY 2016	FFY 2017	FFY 2018
State Plan PCS	276	213	171
1915(k) CFC	1,850	1,907	2,203
1915(c)BSW – Big Sky Bonanza	33	30	28
Total Self-directed Unduplicated Beneficiaries	2,159	2,150	2,408

*Unduplicated beneficiary count is the number of individuals receiving services, not units of service

The SD and AB State Plan PCS program participation of beneficiaries have seen relative stability for the last three FFYs. Service utilization and member enrollment gradually decreased and increased during this time period, as well. The change in PCS expenditures is the result of the implementation of the CFC State Plan program option and the transition of members from PCS to CFC. The majority of Medicaid members who qualify for PCS continue to opt to enroll and/or transition to the CFC State Plan option.

Results of the Review

The CMS team identified areas of concern with Montana's PCS program integrity oversight, thereby creating risk to the Medicaid program. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible. These issues and CMS's recommendations for improvement are described in detail in this report. In addition, CMS has included technical assistance resources for the state to consider utilizing in its provision of PCS.

Overview of the State's PCS

The DPHHS is the SMA. The DPHHS includes the MHSB and within the MHSB is the SLTC Division, AMDD, DSD, and HRD. The State Plan and 1915(c) HCBS waiver is administered by MHSB. Under this authority, the PCS benefit is administered to eligible beneficiaries under a traditional fee-for-service methodology for those enrolled in the State Plan and HCBS waiver program PCS benefit. The PCS program include a consumer-directed benefit that allows the recipient to choose both agency and self-directed PCS. During the review process, it was disclosed that there was no intra-agency agreement or standard operating procedure between the divisions within MHSB, detailing program integrity oversight responsibilities.

Recommendation #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.

State Oversight of PCS Program Integrity Activities and Expenditures

The SLTC division, which includes the Community Services Bureau (CSB), is responsible for direct program oversight of the CFC, PCS, and Big Sky Waiver programs. The CSB employs three program managers and nine regional program officers (RPO) assigned to enroll PCS provider agencies, provide direct oversight, technical assistance, and conduct provider agency quality assurance reviews. The SLTC contracts with QIO, MPQH to conduct functional assessments, authorization, and utilization review of State Plan PCS. The QIO provides monthly reports on member counts and service authorizations. Additionally, the QIO contract lead and CFC/PCS Program Manager conduct regular meetings to update policies, review individual cases, discuss program compliance issues, training objectives and process fair hearing request. The meetings are scheduled on an as needed basis and occur every few weeks. During the Program Integrity review it was disclosed that these meetings are not documented, however program staff with PCS oversight responsibilities informed the team that all meetings within the waiver program are documented.

The AMDD is responsible for oversight of PCS within the SDMI waiver, the DSD is responsible for the oversight of the PCS services delivered through the HCBS-IDD waiver and the HRD is responsible for administering the School Based Health Services program. The DPHHS utilizes a contract with Conduent, the state's fiscal agent to manage provider enrollment, verifications, and claims processing. The DPHHS requires Conduent to submit a monthly report card that summarizes internal monitoring. The DPHHS utilizes a contract with QIO, MPQH to conduct medical necessity reviews for state plan PCS and level of care for BSW and SDMI waivers.

Additionally, under the BSW and SDMI waivers the DPHHS contracts with Benefits Spectrum Medical (BSM) and Partners in Homecare (PHC) to provide case management services, which include approving prior authorizations for PCS. The SDMI Community Program Officers review all waiver members' files. Specifically, the reviews include an examination of case notes, level of care determination and re-evaluation, prior authorization for services and support, monthly expenditures, cost sheets, admittance forms, serious occurrence reports, and training documentation.

The DPHHS processes all PCS claims through its MMIS system, with the exception of claims generated through the Developmental Disability Program (DDP). These payments are processed through the DDP Agency Wide Accounting and Client System (AWACS) payment system. Currently, the MMIS system and the AWACS payment system do not communicate with one another. The DPHHS advised that the AWACS system is currently being integrated into the MMIS system.

The DPHHS provides on-going training on updated rules and regulations for PCS providers. Additionally, newly enrolled providers and providers who need additional support and assistance, as determined through quality assurance reviews are also given training on a monthly basis on PCS topics, however this PCS training is not mandatory. Training is only mandatory when a PCS provider initially enrolls with Medicaid or when a provider is sanctioned through the quality assurance review process. During the Program Integrity review, state personnel advised that although training is not mandatory they typically have 90-95 percent provider participation attendance during the in-person and state-wide Skype training, but acknowledged that they don't capture the number of attendees during the Skype training sessions.

Recommendation #2

The state should consider establishing a process or procedures to document meetings and discussions pertaining to its Medicaid program.

Recommendation #3
The state should continue with integration plans ensuring that its MMIS system includes the components of the AWACS system and implement edits designed to protect against Medicaid fraud, waste, and abuse.

Recommendation #4
The state should consider establishing a process to capture the number of attendees during its Skype training sessions.

State Oversight of Self-Directed Services
When a provider agency enrolls with Medicaid to deliver PCS they must select to deliver services under the agency-based or self-directed option. Recipients are allowed to choose between an agency-based or self-directed option for PCS services. The self-directed provider agency is required to provide ongoing monitoring of self-direct services and member compliance with the self-directed program requirements. The provider agency conducts an in-person intake visit with the member 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 directed and delivered according to the authorization.

In addition to the agency responsibility to provide regular monitoring, every self-direct provider agency submits an annual report to the CSB for review. The CSB staff conduct comprehensive quality assurance reviews of self-directed providers on an on-going basis. The review occurs every one to three years, depending upon the outcome of the prior review. The following are components of every quality assurance compliance review: intake visit, recertification and annual visit, person-centered planning, health and safety, program oversight and plan facilitator staff criteria, services delivered according to service plan, services authorized and billed correctly, services billed with appropriate documentation, and health care professional authorization. The PCS oversight and review process is the same for agency-based and self-directed providers.

The SLTC Division conducts and tracks audits on SD provider agencies by state fiscal year (SFY). In the last three SFYs there were 16 quality assurance reviews (QAR). The results of the quality assurance reviews indicated compliance with the review standards. Specifically, there were 13 of the 16 reviews that met a 90 percent compliance threshold and received a two- or three-year review cycle. The remaining three reviews identified a one-year review cycle. Two of the reviews ended in provider agency sanctions. Standards that received the lowest compliance score included service delivery and service billing. In the review process the provider agency receives a quality assurance communication that documents the area of non-compliance and is required to address the issue in writing. The SLTC Division also developed training on provider service delivery and billing to address the areas of non-compliance on a state-wide basis. Training was provided in-person across the state in spring 2017.

Financial Management Services (FMS) are currently provided by North Central Independent Living Services for the self-directed option of the Big Sky Waiver program, Big Sky Bonanza. The FMS

submit quarterly report cards and utilization reports to CSB. On-site follow up reviews are conducted every three years or more frequently if necessary.

Personal Care Services Provider Enrollment

The state requires that all enrolling PCS agency providers submit documentation to ensure compliance with the CFC and PCS provider enrollment regulations Administrative Rule: 37.40.1013 Agency-Based and Self-Directed CFC Services: Provider Enrollment. Compliance with these requirements must be documented and verified by the CFC/PCS Program Manager prior to the provider agency's enrollment being approved. Approval is also contingent on an on-site visit verification, which is conducted by the RPO and kept on file with Conduent. The provider agency submits documentation requirements on an annual basis as part of the QAR. However, in order to be a PCA provider in the HCBS-IDD waiver, the provider must first be enrolled in State Plan Medicaid as a PCS provider and have the provider enrollment approved by a DDP regional manager. The DDP reviews agencies annually to ensure the provider is enrolled in Medicaid State Plan services.

Additionally, the state manages provider enrollment through the ongoing screening, rather than conduct licensing requirements. This enables a wide array of provider agencies (independent living centers, local county hospitals, tribal entities etc.) to enroll as providers. Due to the remoteness of areas within the state, the current enrollment process ensures that a diverse group of providers deliver services to meet the unique needs of Montana residents (urban, rural, very rural, reservations). The state does not require an individual PCA to be licensed. Specialty Trained Attendant services under HCBS PAS are provided by attendants who have been specially trained to meet the unique needs of the HCBS member. Areas of special training include knowledge and understanding of serious mental illness and the needs of members with mental illness, as well as physical disabilities. It is the responsibility of the provider agency to ensure that assistants are appropriately trained under agency-based services. The member is responsible under self-direct services. The personal care agency is responsible for conducting OIG federal database checks and conduct other background checks on their individual employees at the provider's discretion. The state does not conduct site visits to determine whether the agencies are in compliance with these checks.

During the Program Integrity review, CMS determined through interviews with DPHHS staff and provider agencies that employee background checks had no uniformity and in some cases were limited in nature. The background checks varied from agency to agency. One agency was manually checking a state web-based site identified as Montana Department of Corrections Offender Network Search, con-web, one was checking all agency based and administrative employees through a state bureau of ID background check, one was utilizing a private agency to conduct seven year criminal felony history checks, national sex offender registry search, motor vehicle, social security verification, Office of Inspector General (OIG) List of Excluded Individuals and System for Award Management checks, and the last agency conducts a seven year criminal history check by county court search for felony and misdemeanor convictions, and only federal database checks on new hires. Additionally, it was disclosed by a provider that they do not have a process to report employees who are found to be disqualified from participation in the Medicaid program due to being listed on the OIG exclusion list.

Recommendation #5

The state should consider establishing minimum standards for conducting criminal background checks and federal database checks for all PCS providers.

Oversight of Personal Care Services Providers

Providers of PCS deliver supports to Medicaid eligible beneficiaries in their own home or communities who would otherwise require care in a medical institution. These non-medical services assist beneficiaries who have limited ability to care for themselves because of physical, developmental, or intellectual disabilities or conditions. These non-medical services assist beneficiaries with ADLs.

As part of the onsite review, CMS's review team selected four provider agencies to be interviewed. Those agencies were A Plus Health Care Inc., Southern Home Care Services, Montana Independent Living Project, and Home Care Services LLC. All four providers disclosed that DPHHS requires that they report all serious incidents into the Quality Assurance Management System (QAMS). The QAMS is a live database administered by the CSB. The QAMS database serves two purposes: Compliance with the Federal Quality Assurance Mandates for both Home and Community Based Services (HCBS) waiver and Community First Choice (CFC). The HCBS staff utilize data from QAMS to respond to CMS questions and performance measures and to streamline, standardize, and simplify quality assurance communication between providers, RPOs, CPOs and Central Office staff in a secure and paperless environment. Data from the QAMS is used to document trends across the state which in turn enables the CSB to identify training needs and assess program policy and procedure. The DPHHS has an established hotline listed on their state website, however it is only utilized for Medicaid member fraud and client fraud. Provider fraud reported directly through the hotline goes directly to the Medicaid Fraud Control Unit (MFCU).

During the interview with all four providers it was disclosed that even though all serious incidents are reported into QAMS, they do not refer cases of suspected fraud to DPHHS, instead they refer directly to the MFCU for investigation. The review team also determined from the interviews that when these incidents are referred to the MFCU, DPHHS is not notified of any investigatory efforts, nor is DPHHS taking any action. All investigatory communication is between the provider agency and the MFCU.

According to 42 C.F.R. § 455.14, if the SMA receives a complaint of Medicaid fraud or abuse from any source or identifies any questionable practices, it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation and under 42 C.F.R. § 455.15, if the findings of a preliminary investigation give the agency reason to believe that an incident of fraud or abuse has occurred in the Medicaid program, the agency must refer to the MFCU. Currently, the direct referrals from the provider agency to the MFCU without state participations is not in compliance with 42 C.F.R. § 455.14 and § 455.15. The DPHHS was unable to inform the CMS team of the origination of investigations obtained from MFCU and reported by DPHHS. Finally, CMS review team was informed by provider agencies that there was no process in place for reporting terminated employees to DPHHS for possible fraudulent behaviors.

Recommendation #6

The state should ensure that they are in compliance with federal regulations 42 C.F.R. § 455.14 Preliminary Investigations and 42 C.F.R § 455.15 Full Investigations. The state should also ensure providers of PCS are coordinating any fraud referrals with the program integrity unit. The PIU should in turn be coordinating any administrative actions with the MFCU.

Recommendation #7

The state should ensure PCS providers are reporting to the state instances where PCAs are terminated for possible fraudulent behaviors.

Table 5.

Agency-Directed and Self-Directed Combined	**FFY** 2016	**FFY** 2017	**FFY** 2018
Identified Overpayments	$398,778	$575,520	$488,043
Recovered Overpayments	$398,778	$575,520	$488,043
Terminated Providers	0	0	0
Suspected Fraud Referrals	0	0	0
# of Fraud Referrals Made to MFCU	0	0	0

Overpayments identified and recovered in FFY 2016, FFY 2017, and FFY 2018 include fraud, waste, and abuse.

Overall, Montana's activity regarding post payment actions taken seems low, when compared to expenditures. There were no fraud referrals made in the last three FFYs to law enforcement from DPHHS. During FFYs 16, 17, and 18, there were overpayments identified and recovered. During the interview with DPHHS, the review team learned that DPHHS did not have an overpayment policy specific to PCS services. Additionally, all four providers interviewed identified small overpayments during the last three FFYs. Given the limited number of investigations and referrals along with the low number of overpayments and terminations that the PCS agencies reported, the state should ensure that they are allocating sufficient resources to the prevention, detection, investigation, and referral of suspected provider fraud.

Recommendation #8
The state should ensure that they are allocating sufficient resources to the prevention, detection, investigation, and referral of suspected provider fraud.

Electronic Visit Verification (EVV)
An EVV system is a telephonic and computer-based in-home scheduling, tracking, and billing system. Currently, DPHHS does not utilize an EVV system for in-home scheduling, tracking, and billing. Pursuant to Section 12006 of the 21st Century Cures Act, all states are required to implement an EVV system for PCS by January 1, 2020, however the Cures Act includes a provision that allows states to delay implementation of EVV for up to one year if they can demonstrate they have made a good faith effort to comply and have encountered unavoidable delays. The DPHHS is in the process of submitting a good faith effort exemption for personal care services to delay implementing an EVV system for a year.

Recommendation #9
The state should submit a 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 of Corrective Action Plan from Year 2012 Review

Montana's last CMS program integrity review was in October 30, 2012, and the report for that review was issued in February 2014. The report contained three recommendations relative to implementation of core program integrity activities, payment suspensions, and provider enrollment practices. The CMS completed a desk review of the corrective action plan in November 2016. The desk review indicated that the findings from the 2012 review have all been satisfied by the state.

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:

- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute, which can help, address the risk areas identified in this report. Courses that may be helpful to Montana are based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.
- Review the document titled "Vulnerabilities and Mitigation Strategies in Medicaid Personal Care Services". This document can be accessed at the following link https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/MedicaidGuidance.html
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Visit and utilize the information found on the CMS' Medicaid Program Integrity Education site. More information can be found at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html.
- Consult with other states that have PCS programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of staff in program integrity.

Conclusion

The CMS focused review identified areas of concern and instances of non-compliance with federal regulations which should be addressed immediately.

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas 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 take place, and identify which area of the state Medicaid agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the CAP 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 the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the CAP should identify those corrections as well.

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