# Department of Health and Human Services

# Centers for Medicare & Medicaid Services

# Center for Program Integrity

# Wyoming Personal Care Services

# Focused Program Integrity Review

# Final Report

# December 2018

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## Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of the Wyoming 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.

## Background

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 found 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.

## Methodology of the Review

In advance of the onsite visit, CMS requested that Wyoming complete a review guide that provided the CMS review team with detailed insight into the operational activities of the areas that were subject to the focused review. In addition, questionnaires and review guide modules were sent to PCS providers and/or provider agencies in order to gain an understanding of their role in program integrity. A three-person review team has reviewed these responses and materials in advance of the onsite visit.

During the week of April 23, 2018, the CMS review team visited the Wyoming Department of Health. 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.

## Results of the Review

The CMS team identified areas of concern with the state'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.

## Section 1: Personal Care Services

### *Overview of the State's PCS*

The Wyoming Department of Health (WDH) is the single state agency designated in accordance with 42 C.F.R. § 431.10 to administer the Medicaid program in the state of Wyoming. The WDH is comprised of five operating divisions, the Division of Administration and Support, Division of Aging, Behavior Health Division (BHD), Division of Health Care Financing (DHCF), and Division of Public Health. The WDH administers the PCS under the 1915(c) Home and Community Based Services (HCBS) waiver authorities. The three waiver programs are the Community Choices Waiver (CCW), Comprehensive Waiver and Supports Waiver.

The CCW PCS benefit is administered through the DHCF. The Comprehensive Waiver PCS benefit and the Supports Waiver PCS benefit is administered through the Division of Behavior Health. The PCS benefit is administered to eligible beneficiaries under a traditional fee-for-service (FFS) methodology for those enrolled in HCBS waiver programs, to include those enrolled within the self-directed PCS benefit. The PCS self-directed benefit utilizes both the agency directed and participant directed delivery models. The state does not provide PCS under their state plan authority. During the interview with staff from the DHCF and BHD it was disclosed that there was a letter of agreement between the two divisions, however when asked about agreements between the Community Based Services Unit (CBSU) and Long-Term Care Financial Unit (LTCFU), the review team was advised that an agreement and/or a policy detailing oversight responsibilities did not exist. The CBSU enrolls and LTCFU processes the applications for beneficiaries and checks financial eligibility.

### *Summary Information of the PCS Waivers Reviewed*

Wyoming administers Medicaid PCS to eligible beneficiaries under the 1915(c) waiver authorities. 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.

**Table 1.**

| Program Name/ Year Implemented | State Plan or Waiver Type | Service or Program | Administered By |
|---|---|---|---|
| **HCBS (WY.0236.R05.00) Implemented 07/01/1993** | **Section 1915(c)** | **Community Choices Waiver** | **Wyoming Department of Health, Division of Healthcare Financing** |
| **HCBS (WY.1061.R00.05) Implemented 04/01/2014** | **Section 1915(c)** | **Comprehensive Waiver** | **Wyoming Department of Health, Behavioral Health Division** |
| **HCBS (WY.1060.R00.04) Implemented 04/01/2014** | **Section 1915(c)** | **Supports Waiver** | **Wyoming Department of Health, Behavioral Health Division** |

As previously mentioned, the state currently has three Medicaid waivers that administers service funding and individualized supports to eligible members. The CCW program is authorized under 1915(c) of the Social Security Act. The CCW program was implemented on July 1, 1993, and allows a state to provide supports and services to individuals in their home or community setting, rather than in an institutional setting. Each state has sufficient discretion to develop a waiver program that addresses the needs of the state's target population, is cost-effective, and involves a variety of service delivery methods including participant-directed services. Applicants must be 19 years of age or older and must meet nursing home level-of-care. If the applicant chooses the participant-directed option, applicants must demonstrate that they are capable of directing their own care.

The Comprehensive Waiver program is authorized under 1915(c) of the Social Security Act. The Comprehensive Waiver program was implemented on April 1, 2014, and administers services to eligible persons of all ages with an intellectual or developmental disability or an acquired brain injury with a level of service need score of four or higher and a need greater than the Supports Waiver. The Comprehensive Waiver services help an individual actively participate in the community with friends and family, be competitively employed, and live as healthy, safe, and independently as possible in the least restrictive setting. Services and supports are person-centered and honor one's own choices and preferences. A person is determined eligible for the Comprehensive Waiver, if they meet legal citizenship, residentiary requirements of Wyoming, meets ICF/ID level of care, financial eligibility, qualifies on the Inventory for Client and Agency Planning (ICAP) assessment, meets a clinical eligibility diagnosis, and has a level of service need score of four or higher and assessed service needs in excess of the Supports Waiver or meets emergency criteria or meets one of the Comprehensive Waiver reserved capacity slots.

The Supports Waiver program is authorized under 1915(c) of the Social Security Act. The Supports Waiver program was implemented on April 1, 2014, and administers supportive services to eligible persons of all ages with an intellectual or developmental disability or an acquired brain injury so they can actively participate in the community with friends and family, be competitively employed, and live as healthy, safe, and independently as possible according to their own choices and preferences. A person is determined eligible for the Supports Waiver if, they meet legal citizenship, residentiary requirements of Wyoming, meets ICF/ID level of care, financial eligibility, qualifies on the Inventory for Client and Agency Planning (ICAP) assessment and either have an acquired brain injury or a qualifying diagnosis.

### *Medicaid and PCS Expenditure Information*

Wyoming's total Medicaid expenditures in federal fiscal year (FFY) 2017 were approximately $555 million and covered almost 84,785 beneficiaries. Wyoming's total Medicaid expenditures for PCS in FFY 2017 was approximately $10.07 million. The unduplicated number of beneficiaries who received PCS in FFY 2017 was 1,718. Total unduplicated beneficiaries represents the count of unique individuals receiving PCS during a specified time period. The number of PCS providers enrolled in FFY 2017 was 180 Wyoming does not participate in Medicaid expansion. The Federal Medical Assistance Percentage for Wyoming for FFY 2017 was 50 percent.

**Table 2.**

| **1915(c) Waiver Authority Service/Program** | **FFY 2015** | **FFY 2016** | **FFY 2017** |
|---|---|---|---|
| Community Choices Waiver | $6,741,150 | $8,005,311 | $8,786,077 |
| Comprehensive Waiver | $795,460 | $1,052,384 | $1,095,563 |
| Supports Waiver | $2,659 | $35,538 | $188,322 |
| **Total Expenditures** | **$7,539,269** | **$9,093,233** | **$10,069,962** |

The PCS expenditures overall remained consistent with some gradual increase demonstrated during the three FFYs reviewed. However, the Supports Waiver experienced an almost 70 percent increase in expenditures from FFY 2015 to FFY 2017. This was attributed to growth in beneficiaries requesting and receiving self-directed PCS under this waiver. Beneficiary enrollment under the Supports Waiver increased from two (2) in FFY15 to twenty-seven (27) in FFY 17.

**Table 3.**

| | **FFY 2015** | **FFY 2016** | **FFY 2017** |
|---|---|---|---|
| Total PCS Expenditures | $7,539,269 | $9,093,233 | $10,069,962 |
| % Agency-Directed PCS Expenditures | 27.85% | 31.67% | 40.1% |
| % Self-Directed PCS Expenditures | 72.15% | 68.33% | 59.9% |

A larger portion of PCS expenditures were allocated to self-directed services in Wyoming during the three FFYs reviewed. Self-directed PCS expenditures were more for the three FFYs than the funds expended on agency-directed PCS. Overall, the percentage of expenditures attributed to each of the PCS delivery models demonstrated a noticeable variance during the time periods reviewed. As previously mentioned, beneficiaries are afforded the decision-making authority to recruit, hire, train, and supervise the individuals who furnish their services under self-directed care models. Beneficiaries may also have decision-making authority over how the Medicaid funds in their service budget are spent.

**Table 4-A.**

| **Example:**<br>**1915(c) Waiver Authority Service/Program** | **FFY 2015** | **FFY 2016** | **FFY 2017** |
|---|---|---|---|
| Community Choices Waiver | 904 | 882 | 927 |
| Comprehensive Waiver | 78 | 81 | 88 |
| Supports Waiver | 2 | 13 | 27 |
| **Total Agency-directed Unduplicated Beneficiaries** | **984** | **976** | **1,042** |

*Unduplicated beneficiary count is the number of individuals receiving services, not units of service. Growth within the waivers occurred as more beneficiaries moved into assistive living.

**Table 4-B.**

| **Example:**<br>**1915(c) Waiver Authority Service/Program** | **FFY 2015** | **FFY 2016** | **FFY 2017** |
|---|---|---|---|
| Community Choices Waiver | 637 | 717 | 640 |
| Comprehensive Waiver | 46 | 48 | 33 |
| Supports Waiver | 0 | 0 | 3 |
| **Total Self-directed Unduplicated Beneficiaries** | **683** | **765** | **676** |

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

Overall, PCS expenditures and the number of unduplicated beneficiaries receiving PCS services remained constant with some gradual changes during the three FFYs reviewed. The CMS review team noted that the Community Choices Waiver had the largest number of unduplicated beneficiaries receiving services and the highest overall expenditures. The Community Choices Waiver requires that an applicant(s) be 19 years of age or older and meet nursing home level-of-care to qualify for services. The other two HCBS waivers require the beneficiaries meet a higher level of need, in addition to other medical diagnoses to qualify for services, thus causing a lower number of beneficiaries to be enrolled in the Comprehensive and Supports Waiver because of these additional requirements. Additionally, changes occurred with-in self-directed waiver programs due to a change in the Fiscal Management Service (FMS) vendor and the new requirement for CPR and First Aid certification.

***State Oversight of PCS Program Integrity Activities and Expenditures***

The DHCF is the Medical Assistance Unit within the single state agency. The state Medicaid Agent serves as the Senior Administrator and directs DHCF operations. The state Medicaid

Agent and her designee, the Waivers and Programs Coordinator, retain the ultimate responsibility for oversight of PCS delivered under the three HCBS waiver programs.

The Waivers and Programs Coordinator manages the Community Based Services Unit (CBSU) and oversees day-to-day operations of the PCS delivered under the Community Choices Waiver program supporting seniors and adults with physical disabilities and works in conjunction with the Long-Term Care Financial Eligibility Unit (LTCFEU). The LTCFEU is responsible for confirming that beneficiaries are financially eligible and CBSU is responsible for assessing the beneficiaries' level of care for eligibility, and citizenship. The citizenship is verified as a part of the recipient application process. During the interview with state staff it was determined that there was no standard operating procedure between CBSU and LTCFEU outlining roles and responsibilities between the two units.

The Waivers and Programs Coordinator, on behalf of the state Medicaid Agent, also oversees administration of and approval of official correspondence related to the two HCBS waiver programs operated by the BHD, Developmental Disabilities Section. The Developmental Disabilities Section Administrator oversees the day-to-day operations of the PCS delivered under the Comprehensive and Supports Waiver programs supporting individuals with intellectual and developmental disabilities. Providers are enrolled using the Information Management for Providers (IMPROV) System. The IMPROV system is used to collect all required certification information from the provider before the provider is allowed to be enrolled with WHD. The IMPROV system also allows providers to report complaints and critical incidents, however this system is not connected to the state's MMIS. The IMPROV system is connected to the Electronic Waiver Management System (EMWS). The EMWS stores the Plan of Cares (POC) amendments and approvals. The EMWS is connected to the MMIS. The WDH stated they are in the process of combining the IMPROV and the current MMIS systems into a new MMIS system.

State staff also advised that all PCS must be prior authorized and be included on the participant's service plan created in the EMWS. The PCS are included in the participant's service plan in accordance with the participant's assessed needs and within the limits established by the HCBS waiver application. The EMWS edits service plans to ensure PCS are authorized within those established limits and submits a prior authorization request to the Medicaid Management Information System (MMIS). The MMIS validates the participant's Medicaid eligibility and verifies enrollment in the particular waiver program for which the prior authorization request is submitted. Five out of the six providers interviewed stated that there were issues with the Prior Authorization (PA) process. For example, providers indicated that there is a significant amount of time between when they are notified to provide services for a beneficiary and when they actually received the PA to begin services. Claims cannot be submitted until the PA is received. The state contracts with vendor Qualis Health to determine a recipient eligibility for skilled nursing based on physician orders. Additionally, the state contracts with vendor Optum to process all PAs for home health services within the state program.

**Table 5.**

| Agency-Directed and Self-Directed Combined | FFY 2015 | FFY 2016 | FFY 2017 |
|---|---|---|---|
| Identified Overpayments | $3,482.72 | $23,425.41 | $6,705.45 |
| Recovered Overpayments | $6,209.28 | $23,425.41 | $3,484.72 |
| Terminated Providers | 0 | 0 | 0 |
| Suspected Fraud Referrals | 0 | 0 | 0 |
| # of Fraud Referrals Made to MFCU | 0 | 0 | 1 |

*Overpayments identified and recovered in FFY 2015, FFY 2016, and FFY 2017 include fraud, waste, and abuse.

Overall, Wyoming's activity regarding post payment actions taken seem low, when compared to expenditures. There was one fraud referral in FFY17 made to the Medicaid Fraud Control Unit and there were no provider terminations related to PCS in FFY17. The referred case is currently going through the adjudication process. During FFYs 15 and 16, there were no findings, provider terminations, or suspected fraud referrals made to the Medicaid Fraud Control Unit (MFCU) related to PCS. There were overpayments identified and recovered for all three FFYs. In FFY15 recovered overpayments were more than the identified amount due to collections received from the previous FFY14 identified overpayments. The FFY17 identified overpayments were more than the recovered amount. This figure only reflects money received by the state at the time of the review. 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.

## Section 2: Self-Directed / Participant-Directed Care Services

### *Overview of Self-Directed Care Services*

42 CFR § 441.450 provides participants, or their representatives, the opportunity to exercise choice and control over services. Beneficiaries are afforded the decision-making authority to recruit, hire, train and supervise the individuals who furnish their services under self-directed care models. Beneficiaries may also have decision-making authority over how the Medicaid funds in their service budget are spent.

Wyoming has authority to operate a self-directed program for personal care services and does so under the three HCBS waiver authorities previously described in this report. The FMS for self-directed services is responsible for the management and disbursement of funds contained in the participant's budget, facilitating the employment of the employees providing participant-directed services such as processing payroll, and withholding taxes, and also performs fiscal accounting and submitting expenditure reports to the participant and state authorities. The beneficiaries under the self-directed program can choose between enrolling in either the participant-directed and the agency-directed programs. If the beneficiary elect the participant directed program they must demonstrate that they are capable of directing their own care. They must have the capability to direct care and must be able and willing to accept and perform the roles and responsibilities of an employer.

If the beneficiary wants to participate in the self-directed program, but can't demonstrate that they are capable of directing their own care, they can choose an agency-directed program in which a Support Broker is utilized. This option is limited to the Comprehensive and Supports waiver. It is the Support Brokers responsibility for training all of the participant's employees. Support Brokers must review employee time sheets and monthly FMS reports to ensure that the individualized budget is being spent in accordance with the approved Individual Plan and Budget, and coordinate follow-up on concerns with the participant's case manager. The Support Brokerage is a waiver service that is funded through the participant's individual budget.

***State Oversight of Self-Directed Services***

The Senior Contracts Manager with CBSU monitors the performance of the FMS agency. The primary function of the FMS in relation to participant-directed services, as outlined in the waivers, is to address federal, state, and local employment tax, labor, and workers compensation insurance rules and other requirements that apply when the participant functions as the employer of workers.

The WDH contract with the FMS vendor outlines the requirements of the FMS to act as agent for the employer/participant in gathering and maintaining relevant employee information; maintaining employer and employee files with necessary tax, IRS, and payroll information; and provide a system for payment of services rendered that takes into account any Department of Employment and waiver specific restrictions as applicable and verifies submitted timesheets against these expectations. Any timesheet submitted that violates a system validation is kicked out of the system and will not be paid without manual review and changes.

These system validations are reviewed annually and as needed, and adjusted as amendments to the waiver(s) are made and ensure that employees are being paid appropriately. The validations are tested before being moved into production by the FMS Information Technology team and are verified routinely via ongoing submission of timesheets.

In addition, if anomalies or inappropriate entries are identified on incoming submitted timesheets either by the system or by FMS staff processing incoming timesheets the FMS contacts the WDH to alert the agency to the possibility of fraudulent or questionable activity. The Senior Contracts Manager and the FMS Office Manager meet weekly to discuss any items of concern or identified issues that need to be addressed, and review contract deliverables and requirements annually or more often as necessary.

The WDH had one referred case within the self–directed program. During the Program Integrity Review several of the PCS providers stated that WDH does not conduct on-site reviews of their agency or self-directed participants. Several of the providers interviewed suggested additional oversight by the state would be beneficial within the self-directed program.

## Section 3: PCS Provider Enrollment

***Overview of PCS Provider Enrollment***

Identifying and recovering overpayments may be resource intensive and take considerable time. Preventing ineligible entities and individuals from initially enrolling as providers allows the program to avoid the necessity to identify and recover overpayments. Provider screening enables states to identify such parties before they are able to enroll and begin billing and is the first line of defense against potential fraud, waste and abuse.

The PCS provider agencies must enroll as a Medicaid provider through the Department's Fiscal Agent. Additionally, PCS provider agencies must be approved by the respective waiver program in order to serve waiver participants. The PCS providers must meet both the general Medicaid provider and the respective HCBS waiver program's provider criteria in order to enroll.

In Wyoming, only after the PCS agency has been determined to have met the general and program specific provider qualification criteria is that agency activated by the Fiscal Agent and able to be reimbursed for waiver PCS. The state does not issue numerical identifiers for PCA/PCS providers. Individuals employed by an agency serving the Community Choices Waiver program must maintain Certified Nurse Assistant (CNA) certification.

The state has implemented the mandatory risk based screening requirements outlined in 42 CFR 455.434. Individual personal care attendants are not enrolled in Wyoming Medicaid. Attendants providing PCS under the participant-directed service delivery model are employed by the participant/authorized representative and are enrolled by the FMS agency. The FMS utilizes an enrollment packet that collects information about the prospective caregiver and outlines the rules/regulations of the self-directed program.

***State Oversight of PCS Provider Enrollment***

As required by 42 CFR 455.450, the state has implemented the screening level provisions, including fingerprinting, based on the assigned level of risk for directly enrolled PCS providers. In addition, the state has implemented the federal database checks on any person with an ownership interest or who is an agent or managing employee of the provider as required. Also, the state does check all parties against the List of Excluded Individuals/Entities (LEIE) and System for Award Management (SAM) monthly after enrollment/reenrollment as required at 42 CFR 455.436(c)(2).

All PCS agencies must submit an application with the Department's Fiscal Agent and are screened against the databases. Additionally, PCS provider agencies must meet the qualifications detailed in each of the Department's HCBS waiver applications.

The Community Choices Waiver requires that all PCS agencies be licensed as a Home Health Agency by the Wyoming Department of Health, Division of Aging, Healthcare Licensing and Surveys Section. Individual providers of agency-based PCS must maintain good status as a CNA. Agency licensure status and expiration date are included in the Department's information systems to ensure continued compliance with provider qualification standards. Only those PCS agencies with a current Home Health Agency license may provide and be reimbursed for PCS.

Agencies maintain personnel files for individual employees which are reviewed as part of the regular licensing surveys. Licensure survey schedules and interim agency actions, such as complaint surveys, are managed by the Healthcare Licensing and Surveys Section. The CBSU meets with the Healthcare Licensing and Surveys Section on a monthly basis for updates to the licensure status for all Community Choices Waiver provider types, survey outcomes, and to discuss any potential actions against a provider's licensure.

The BHD has established a PCS category for an agency certified by the BHD to provide personal care on the Comprehensive and Supports Waivers. An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45. Requirements for providers and provider direct care staff include, but are not limited to: a successful criminal history background screening (FBI, State DCI, DFS, OIG); a current CPR and First Aid certification; a current Medication Assistance certification for direct care staff assisting participants with medications; a current crisis intervention and restraint usage certification, if applicable; and a current driver's license, if providing transportation. Direct care staff shall complete participant specific training prior to providing services to the participant. In addition to Chapter 45 requirements, providers shall adhere to the standards and requirements of all applicable Medicaid rules and regulations specified in the Provider Manual and Provider Agreement. Provider direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, participant rights and rights restrictions, implementing the participant's objectives, and HIPAA and confidentiality requirements.

Provider staff compliance with these requirements must be documented in provider files and available to the BHD for review. The BHD shall conduct a certification renewal each year, during which time staff qualifications shall be reviewed. A sampling of staff files may be utilized. While certification is required, licensure is not. Provider shortages continue to be a challenge in Wyoming, which is a rural state, and the requirement of a license will exacerbate this problem. Personal care services providers are not required to be licensed in Wyoming. All providers under this waiver must be certified by the BHD in order to provide services and bill Medicaid. If a provider loses their State Certification, they are no longer able to bill Medicaid for those services. The BHD, therefore, would discontinue monitoring activities for those providers.

In the event a provider becomes de-certified they may not apply to become certified for a period of two (2) years from the date the provider was de-certified. They also need to ensure that all corrective actions and/or sanctions imposed on them in their previous term as a certified provider are resolved to the satisfaction of the BHD. Upon re-enrollment and certification, they would be subject to a one year certification along with all other requirements of newly certified providers.

All persons providing waiver services including managers, supervisors, direct care staff, participant employees hired through self-direction, and any other person who may have unsupervised access to participants shall complete and pass a background screening pursuant to Chapter 45, Section 14 of Wyoming Medicaid Rules. A successful background screening includes a Wyoming Department of Family Services Central Registry Screening, a United States

Department of Health and Human Services, Office of Inspector General Exclusions Database screening, and a state and national fingerprinted criminal history record check which shows that the individual has not been convicted, plead guilty, no contest to, or does not have a pending deferred prosecution for an offense against a person, or an offense against morals, decency, and family. Individual PCS providers are not licensed. Individuals employed by an agency serving the Community Choices Waiver program must maintain CNA certification.

Individuals employed by agencies supporting the Comprehensive and Supports Waivers, as well as those directly employed by the participant/authorized representative to deliver PCS under the participant-directed service model for all waivers, are not required to maintain CNA certification.

All individual PCS providers must receive first aid and CPR training. Wyoming's rural and frontier nature poses a unique challenge in attracting a sufficient workforce of PCS providers. Licensure and/or certification, and the agency employment and supervision requirements that accompany those credentials, would limit the Department's ability to serve HCBS waiver participants and enable them to live in the least restrictive setting.

Agency license effective dates for Community Choices Waiver PCS agencies are loaded in the Department's information systems. Agencies with an expired license are not reimbursed for PCS. The CBSU and the Wyoming Department of Health, Aging Division, Healthcare Licensing and Surveys Section meet on a monthly basis. Issues identified as part of a licensing or complaint survey are shared in this meeting. Should a PCS provider agency lose its license subsequent to Medicaid enrollment, the Healthcare Licensing and Survey Section notifies CBSU and the agency is removed as an approved provider of PCS available under the Community Choices Waiver. Individuals employed by a PCS provider agency serving the Community Choices Waiver program must be screened against the Department of Family Services Central Registry in accordance with Home Health Agency Licensure standards. In order to maintain CNA certification, individuals must pass a fingerprint-based criminal history background check and must not have committed any act for which disciplinary action was reviewed by the state Board of Nursing that resulted in loss of certification.

The BHD provider certification process for the Comprehensive and Supports Waivers requires all persons providing waiver services including managers, supervisors, direct care staff, participant employees hired through self-direction, and any other person who may have unsupervised access to participants shall complete and pass a background screening pursuant to Chapter 45, Section 14 of Wyoming Medicaid Rules. A successful background screening includes a Wyoming Department of Family Services Central Registry Screening, a United States Department of Health and Human Services, Office of Inspector General Exclusions Database screening, and a state and national fingerprinted criminal history record check which shows that the individual has not been convicted, plead guilty, no contest to, or does not have a pending deferred prosecution for an offense against a person, or an offense against morals, decency, and family.

## Section 4: Personal Care Service Providers

### *Overview of the State's Personal Care Service 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 six provider agencies to be interviewed. Those agencies were Interim Healthcare, Quality Home Health Care, Best Home Health and Hospice, Sharon's Home Health, Continue Care of Cheyenne Inc., and Hands 2 Help LLC.

According to state personnel there were 180 PCS providers, but they were unable to separate them into the number of providers in the agency directed option and the number of providers in the self-directed care because they are included in the general taxonomies and cannot be reported separately from the other provider types providing services under the Community Choices Waiver, Comprehensive Waiver, and Supports Waiver programs. As such, the number of providers in the agency directed option and the number of providers in the self-directed option contracted directly with the state are not available. Wyoming does not participate in managed care and does not provide unique numerical identifiers to PCAs. Additionally, the state does not conduct onsite visits to the PCS agencies to monitor PCAs or agency activities.

### *Oversight of Personal Care Services Providers*

#### Interim Healthcare

Interim Healthcare was selected to participate in this Wyoming Program Integrity Review, but elected not to provide any of the requested documents and did not show-up for the scheduled interview session. Additionally, they did not disclose to the state nor to the review team a valid reason why they chose not to comply. This lack of response was in clear violation of the states' provider agreement under General Provisions section D. Specifically, "under the Audit/Access to Records section Medicaid, the MFCU, HHS, and any of their representatives shall have access to any books, documents, papers, and records of the Provider which are pertinent to this Agreement. The Provider shall, immediately upon receiving written instruction from Medicaid, provide to independent auditor, accountant, or accounting firm, all books, documents, papers and records of the Provider which are pertinent to this Agreement. The Provider shall cooperate fully with any such independent auditor, accountant, or accounting firm, during the entire course of any audit authorized by Medicaid, the MFCU, or HHS." The state should ensure that providers are in compliance with their provider agreement.

#### Quality Home Health Care

Quality Home Health Care (hereinafter referred to as QHHC) offers a full range of services including help with daily activities, personal care, and respite. The QHHC is a locally owned

corporation providing personal care services in Albany County with headquarters in Laramie Wyoming. The QHHC has been providing personal care services since 2001. The agency currently provides these services under the Community Choices and the Comprehensive/Supports 1915(c) Waivers. Personal care services are provided by an aide who may assist with daily activities, including grooming, meal prep, and transportation. The QHHC provides in-home care to allow clients to maintain their independence at home instead of going into a nursing home. The QHHC currently provides personal care services to 2 Medicaid recipients, 3 Comprehensive/Supports Waiver recipients, and 47 Community Choices recipients, and currently employs approximately 18 PCA staff and 5 supervisory staff. All employees who work for QHHC must be licensed to work in the state of Wyoming and have completed the 16 hour Home Health Course required by the state.

The agency has established a Compliance Program that provides guidance to various internal anti-fraud and abuse controls. The Compliance Plan is reviewed and approved at least annually by the Compliance Officer and the Governing Board/Compliance Committee. The QHHC Governing Board has designated the Administrator/co-owner as the Compliance Officer. The Governing Board fulfills the role of Compliance Committee and consists of the President, Vice President, Secretary, and Treasurer. The Compliance Officer reports monthly on compliance activities to the Compliance Committee. The Compliance Committee is responsible for approving the compliance program and providing direction relative to all audits and findings. Billing documents including activity sheets and aide notes are reviewed weekly by the Director of Nursing prior to the agency billing Medicaid for services rendered and any issues noted are documented on an electronic incident report. Any incidences noted in the past 3 FFYs have been reported to the Compliance Committee but the state was not notified of any of these incidences. The agency seemed unsure of who at the state level to report instances of fraud, waste, and/or abuse.

Training is provided and documented via a sign-in sheet. A quiz is given after training is completed and the results are maintained in a file. Training topics are determined based on identified issues. Training is also provided as part of the agency's orientation process. All employees must pass a background check which includes a criminal check, motor vehicle records check, National Sex Offender (NSO) Registry check, and an OIG/EPLS check. The vendor Higher Right conducts background checks for the agency. These checks are completed upon hiring and do include felony and abuse registry checks; however database checks at intervals subsequent to hiring are not performed. In addition, the agency relies on the state to notify them of license suspensions instead of periodically checking the licensing database. Supervisory visits are conducted every 14 days to ensure appropriateness of home health aide (HHA) services and to maintain quality of care. In addition, all supervisory visits are unannounced.

The agency does have an electronic visit verification (EVV) system in place, however, this system is not used for PCS and is used by the nurses only, not the PCAs. The agency does not have plans at the present time to add a PCA component to the EVV system. The agency still uses a paper system for documenting all PCA activities. The PCA's aide notes are used to track the aides' activities, which is then signed by the client.

**Best Home Health and Hospice**

Best Home Health and Hospice (hereinafter referred to as BHH) opened in Evanston Wyoming on October 1, 2004, and expanded to Rock Springs to provide quality home health and hospice services. The BHH began providing personal care services on October 1, 2004. The agency is a locally owned and operated S-Corporation that provides services in Lincoln, Sweetwater, and Uinta Counties in Southwest Wyoming. The BHH employs staff for skilled nursing, certified nursing aides, physical therapists, occupational therapists, speech therapists, chaplain services, and social workers. The BHH accepts Medicare, Medicaid, and private insurance clients. The BHH offers a full range of services including home health, home care, hospice, physical therapy, occupational therapy, speech therapy, social work, chaplain, transportation, senior companion, and home delivered meals. The agency currently provides personal care services under the Comprehensive Waiver. Personal care services are provided by an aide who may assist with daily activities, including but not limited to grooming, meal prep, and transportation. The agency is aware PCS are only to be provided to the client, not other household members. The BHH provides in-home care to allow clients to maintain their independence at home instead of going into a nursing home. During FFY 2017 BHH provided personal care services to approximately 170 waiver participants, and employed approximately 58 to 65 PCA staff and 42 supervisory staff.

The agency has established a Compliance Program, Compliance Officer, and a Compliance Committee that provides guidance to various internal anti-fraud and abuse controls. The agency's Compliance Program is based on CMS guidance for a Quality Assurance and Performance Improvement (QAPI) program. The Director of Nursing serves as the Compliance Officer. The Compliance Committee consists of the owners, RN administrator, billing manager, several RNs, Lead CNA, and a therapist. The Compliance Officer will track outcome measures by OASIS assessments, patient characteristics report within the Certification and Survey Provider Enhanced Reports (CASPER), discharge summaries, and monitoring potentially avoidable events on a consistent basis. The Governing Board is responsible for the QAPI program. The QAPI team will meet at least quarterly to discuss measures needing improvement. Improvement ideas may come from supervisors, field staff, and clerical employees. A Utilization Review Committee reviews case charts from the prior quarter. Case charts are reviewed for appropriateness of services provided. This committee may have any combination of clinicians reviewing charts. All disciplines will be represented in the audit, and at least 10 percent of cases should undergo review including closed cases from the past quarter. Quarterly the QAPI coordinator reports to the Board of Directors the overall results, including addressing each issue, an analysis of each issue, prevention and control activities, and the numerical outcome or results of each issue. The QAPI program is re-evaluated annually to ensure it is relevant.

All PCA staff must be a licensed CNA in the state of Wyoming in order to provide PCS services. The agency stated there is a 16 hour requirement in the state of Wyoming to maintain a license. To ensure the agency is meeting this requirement, annually they rent a building for providing state required training and to perform skills training. The HIPPA training and first aid training is required for all PCAs. The BHH determines training through complaints, identified issues, etc. The agency does at least 24 hours of in-service training per year. The initial orientation process

and training can last up to 2 months. All employees must pass a background check which includes a criminal check through the Bureau of Criminal Identification. The prospective employee is then placed in a hold position until the background check comes back clean. They also screen individuals for a history of substantiated abuse or neglect of a disabled or elder adult or a supported finding of severe abuse or neglect of a child from the licensing information system maintained by the Department of Family Services. This also includes felony checks. All employees have central registry checks as well. The central registry checks verify any state exclusion and the background check verifies any federal exclusions. Monthly the agency checks all staff to verify any new exclusions and that current employees are in good standing. The RN must oversee the PCA and develop and implement the Aide Care Plan. Supervisory visits are conducted every 14 days and performance evaluations are completed annually by the supervisor. In-home competence evaluations are completed annually with each PCA by the RN and the PCA is required to pass a skills test annually with the RN management team. Continuous training/in-services are held each month. In addition, supervisory visits are conducted every other week, one visit when the aide is there and one unannounced visit. The case manager also checks once per month with the client when the aide is not there.

The agency has an Electronic Medical Records System (EMRS) in place called Kinnser. They have been using this system since the first quarter of 2015. Electronic visit verification is an additional feature to which the agency subscribes. With EVV they are able to verify with the GPS when the patient is seen and the address in which they were seen. System capabilities are that the patient must sign, date stamp in/out, GPS tracking, ability to review documents, documentation of physicians' orders, etc.

**Sharon's Home Health**

Sharon's Home Health (hereinafter referred to as SHH) is a for-profit C corporation proprietorship home health agency established in 1998. They were certified in Wyoming to provide PCA services on October 10, 1998. The agency provides PCA services under the Community Choice 1915(c) Waiver. The SHH currently has three locations: Casper, Moorcroft and Big Horn, Wyoming. The agency services an area over 8,700 square miles in size with over 40,000 residents. The home health agency offers a variety of services to include: physical therapy, skilled nursing, respite, occupational, speech pathology, hospice and home health aide services (PCS). The SHH is Medicare/Medicaid licensed and the majority of their services are provided to Medicare and Medicaid eligible beneficiaries. During FFY 2017 SHH provided personal care services to approximately 193 waiver participants, and employed approximately 10 PCA staff and 4 supervisory staff.

The SHH has an established Compliance Program in place for Medicare that promotes quality patient care, high standards of ethical conduct, the prevention, and resolution of conduct that does not conform to SHH's standards, policies, applicable law, and health care program requirements. The Governing Body is comprised of the Owner/Director of home health, the Administrator, Director of Nursing, and Compliance Nurse. The compliance plan is normally reviewed and approved by the compliance officer, compliance nurse and the administrator. The Compliance Officer/Compliance Nurse is responsible for ensuring that any findings of fraud, waste or abuse are appropriately addressed. The compliance nurse has direct oversight of PCA

staff. The PCA's are CNAs, as required by the Community Choice Waiver program. According to documents from SHH, the compliance nurse implements, monitors, coordinates, and supervises as necessary to facilitate an effective compliance program and takes appropriate action on matters that raise compliance concerns. This includes reporting of complaints of suspected fraud, waste, and abuse. The compliance nurse reports promptly any apparent intentional violation of any state or federal regulation by any staff or employee to the administrator and performs quality and accuracy checks of PCA notes prior to submission to payroll and their contracted biller, Integrity Billing.

The CNAs must hold a valid license with the state within 3 months of hire and complete 16 hours of training through the Institute for Professional care within the first 2 weeks of employment. The PCAs are not allowed to provide patient care until these 16 hours are completed. The PCAs are then required to be supervised by a registered nurse (RN) for 16 hours and be checked off on competency skills. The SHH also provides training to personnel concerning compliance issues, applicable laws, regulations, third party payer program requirements and SHH policies. The employee must sign a form verifying that they have received training from SHH on the Compliance Program. This Compliance plan training takes place at least once every two years. Once the PCA has completed training and orientation, and their background check has returned stating that applicant meets the criteria for employment under the state statute, they are able to start employment. PCAs are required to obtain 12 hours of CEUs (continuing education units) annually. During the interview with SHH, the Program Integrity review team observed that currently, employees are being trained on Medicare rules and regulations and not applicable Medicaid rules and regulations. The SHH does not have a compliance program in place that complies with Medicaid state rules and regulations. Specifically, written policies and procedures provided by SHH outlined Medicare protocols for reporting, detecting and preventing fraud, waste and abuse. The SHH could not provide compliance protocols for Medicaid rules and regulations.

The SHH did not report any audit findings or fraud, waste, and abuse in the last three FFYs, and they did not have any referrals of suspected PCS fraud. The SHH contracts with Integrity Billing to perform billing functions such as claims processing and pre and post auditing of home health service claims. Integrity Billing submits claims according HHA notes and timesheets which are compared to actual visit notes weekly by payroll/human resources. The HHA notes are also signed off by the RN and reviewed for accuracy and additional signature by the compliance nurse. The SHH contracts with Home Coding Solutions to perform full chart audits, which include the HHA plan of care and applicable HHA notes. The SHH states there have been no overpayments reported in the past three FFY's. The SHH stated that they do not know when overpayments should be reported to the state.

The SHH does not do any performance evaluations or oversight audits, visits or reviews with their billing contractors Integrity or Home Coding Solutions. The SHH does not conduct unannounced visits to ensure services recorded by the PCAs were actually completed, but does conduct announced visits to the recipients' home every two months. The PCA notes are signed off on a daily basis by the non-supervisory RN and supervisory compliance nurse. The SHH does not have an EVV system. Currently, PCAs receive a device known as the EMR Deverro that records HHA notes, times and dates. This device does not capture geographic location.

The SHH has no process in place to perform federal database checks nor do they check all applicable state/federal databases. The SHH does check with the state to verify that there were no PCAs or staffed providers that have been revoked or terminated from Medicare/Medicaid or any other federal programs. As stated by SHH, they have never checked any federal criminal databases initially, monthly or annually for excluded individuals or PCAs. However, they do ensure that PCAs have been fingerprinted through the state Board of Nursing. The SHH states their inter-disciplinary team (IDT) meets every two weeks to review and assess their auditing and monitoring program. This does include review of time sheets, claims and pre-billing audits.

**Continue Care of Cheyenne Inc.**

Continue Care of Cheyenne Inc. (hereinafter referred to as CCCI) has been providing PCS services since December 1991. The CCCI provides Medicaid PCS to eligible beneficiaries under the 1915(c) waiver. The CCCI is a licensed, locally owned and operated S-Corporation located in Cheyenne. The CCCI served 16 Medicaid beneficiaries and had approximately 7 PCA staff members during FFY 2017. The CCCI has maintained 6 supervisory personnel for the last three FFYs. All employees who work for CCCI must be licensed to work in the state of Wyoming and have completed the 16 hour Home Health Course required by the state.

The CCCI does have a compliance program, and compliance policies and procedures in place that was reviewed by Wyoming's Program Integrity Director. The CCCI agency's Compliance Program is based on CMS guidance for a Quality Assurance and Performance Improvement (QAPI) program and does not have a compliance committee or compliance officer. The QAPI board takes on the role of the compliance committee and compliance officer. The QAPI board focuses on high risk, high volume or prone areas of service and reports on a monthly basis to the governing body. The QAPI board will also educate staff on an annual basis and conduct performance improvement evaluations. The governing body is responsible for approving the QAPI program and QAPI board members and for approving yearly QAPI reports and education. The CCCI does conduct internal audits of client and personnel files. Audits of patient charts are conducted randomly on a monthly basis and the chart review results are entered into the QAPI book for staff education and reporting.

In the state of Wyoming, in order to provide PCS services, PCA staff must be a licensed CNA, receive 16 hours of practical training with skill verification and 75 hours of orientation in a classroom setting. The CCCI ensures PCA's receive 80 hours of training upon hiring during orientation, with 16 hours of this training devoted to skills evaluation. The Wyoming Division of Criminal Investigation (DCI) is responsible for conducting all background and finger print checks. They also screen individuals for a history of substantiated abuse or neglect of a disabled or elder adult or a supported finding of severe abuse or neglect of a child from the licensing information system maintained by the Department of Family Services (DFS). This also includes felony checks. All employees have central registry checks as well. The central registry checks verify any state exclusion and the background check verifies any federal exclusions. License checks are conducted twice a year. The prospective employee is then placed in a hold position until the background check comes back clean. Employment is contingent upon successful completion of the background investigation process. The LEIE and SAM screenings will be completed by CCCI for all employees on a monthly basis thereafter.

The CCCI nurses perform both announced and unannounced site visits with the PCAs and beneficiaries at 60-day intervals. The CCCI has utilized EVV since 2015. However, it's only for skilled services. The CCCI expects to have PCA services included in its EVV system in the future. Instead, of an EVV system CCCI uses a copy of the client's Daily Activity Report (DAR) sign-off sheet to monitor tasks performed by the PCA, which is then signed by the client. The time sheets are submitted twice a week, where they are reviewed by the office assistant and supervising nurse for accuracy and client's signature. If any discrepancies are discovered during this process then the clinical manager and/or the administrator is notified and an investigation is conducted. The employee will be educated on the errors or terminated. The CCCI does not notify the state when an employee is terminated for submitting questionable documents that could be fraudulent in nature. The CCCI staff stated to the review team that the state has not given guidance on case referral and has not received any training from the WDH on PCS topics.

**Hands 2 Help LLC**

Hands 2 Help LLC (hereinafter referred to as H2H) was founded in June 1999, as a Limited Liability Company in response to a need for regulated private duty services for residents of Big Horn and Park County Wyoming. Initially, H2H developed a holistic philosophy that offered the elderly a cost-effective alternative to facility placement. The H2H provides Medicaid PCS to eligible beneficiaries under the 1915(c) waiver. The H2H served 84 Medicaid beneficiaries and had approximately 29 PCA staff members during FFY 2017. The H2H has maintained approximately five supervisory personnel for the last three FFYs. All employees who work for H2H must be licensed to work in the state of Wyoming and have completed the 16 hour Home Health Course required by the state. In the state of Wyoming in order to provide PCS services, PCA staff must be a licensed CNA, receive 16 hours of practical training with skill verification and 75 hours of orientation in a classroom setting.

The H2H does have a compliance program, however the compliance policies and procedures are very sporadic. The H2H lists the Administrator, Lisa Bellmyer, as the designated Compliance Officer. The Administrator is responsible for the overall direction and organization of the agency in accordance with all federal and state regulations. The Administrator also interprets and enforces agency policies as established by the governing body and is fiscally responsible for an effective budget and accounting system. The Administrator reports to the board of directors. The board is considered the Compliance Committee and consists of the owners.

The Administrator will provide informal coaching and mentoring to new employees as a part of H2H's agency wide performance improvement program. Within the first 90 days of employment the employee skills and competencies will be evaluated to determine fit with the agency. After the 90 day period, the Administrator will then provide the employee with an initial evaluation. Depending on the outcome of the evaluation, the Administrator and the Clinical Supervisor may require the employee to attend additional training. Evaluations will then be conducted on an annual basis. If an employee performs below expectations, violates agency policy, or performs a criminal act the employee could be subject to a corrective action, verbal counseling, probation, suspension without pay and/or termination.

The Wyoming DCI is responsible for conducting all background and finger print checks. They also screen individuals for a history of substantiated abuse or neglect of a disabled or elder adult, or a supported finding of severe abuse or neglect of a child from the licensing information system maintained by the DFS. This also includes felony checks. All employees have central registry checks as well. The central registry checks verify any state exclusion and the background check verifies any federal exclusions. License checks are conducted twice a year. The prospective employee is then placed in a hold position until the background check comes back clean. Employment is contingent upon successful completion of the background investigation process. During the interview with H2H they advised that they do not conduct any federal database checks thereafter because it's not required by the state. The H2H also stated that they don't receive training related to PCS topics from the WDH.

The H2H conducts unannounced and announced site visits every 60 to 90 days and the visits are maintained in a log. During the supervisory visits the nurses will use a checklist to verify which tasks were performed. The EVV system has not been implemented yet, but the agency anticipates being in compliance by January 2020.

## Section 5: Electronic Visit Verification (EVV)

### *Overview of the State's Electronic Visit Verification (EVV) System*

An EVV system is a telephonic and computer-based in-home scheduling, tracking, and billing system. Specifically, EVV documents the precise time and type of care provided by caregivers' right at the point of care. Some of the benefits of utilizing an EVV system include ensuring quality of care and monitoring costs expenditures.

Currently, Wyoming 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. To meet this implementation requirement by 2020 the state is actively working to secure an EVV vendor.

### Recommendations for Improvement

- Consider developing detailed oversight responsibilities of each WDH unit responsible for oversight and administration of PCS. A standard operating procedure that specifies which state unit(s) are responsible for all aspects of PCS monitoring, oversight, and lines of communication between the agencies may be beneficial towards creating a more unified understanding regarding PCS monitoring and oversight responsibilities.
- State should ensure that its new MMIS system includes the IMPROV component to assure all providers are tracked within its databases.
- State should develop policies and procedures for the prior authorization process to ensure it's operating in an efficient manner.
- The state should ensure that they are allocating sufficient resources to the prevention, detection, investigation, and referral of suspected provider fraud.
- Initiate regular audits and investigations of self-directed PCS. Services are not being verified and only one investigation had been conducted. As a result, there is a lack of oversight of this service which creates a vulnerability for the state.
- Consider assigning a unique identifier to each PCA to facilitate tracking of each PCA's work.
- The state should ensure that providers are in compliance with their provider agreement.
- The state should establish guidance on the basic requirements for all PCS providers regarding compliance program structure to ensure continuity within its Medicaid PCS program.
- The state should ensure PCS providers are reporting to the state instances where PCAs are terminated for possible fraudulent behaviors.
- The state should continue to work with the PCS providers to ensure that PCS staff are receiving adequate training in identifying, investigating, and referring potential fraudulent billing practices to the state program integrity unit.
- Consider providing routine training to PCS providers on updated rules and regulations to ensure appropriate billing.
- The state should consider conducting onsite visits to the PCS agencies in order to monitor PCAs and/or agency activities.
- The state must ensure that each PCS provider complete the necessary federal database checks monthly and ensure that they are aware of all policies and procedures.
- The state should 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.

## Section 6: Status of Corrective Action Plan

Wyoming's last CMS program integrity review was in July 2011, and the report for this review was issued in April 2012. The report contained 6 findings and 1 vulnerability. During the onsite review in April 2018, the CMS review team conducted a thorough review of the corrective

actions taken by Wyoming to address all issues reported in calendar year 2012. The findings of this review are described below.

**Findings –**

1. ***The state does not maintain proper documentation on suspensions of payments and is not conforming to the CMS referral performance standards.***

**Status at time of the review:** corrected

- The state concurs that as of July 11, 2011, we were not in compliance with this regulation when invoking a good cause exception. However, as of November 1, 2011, the state maintains required documentation when invoking a good cause exception for payment suspension under 42 CFR § 455.23. The referral procedures have been amended to conform to the CMS referral performance standards.

2. ***The state does not capture all required ownership and control disclosures from disclosing entities.***

**Status at time of the review:** corrected

- The state concurs with this finding. DHCF has been working to meet all provider screening requirements effective March 25, 2011. This is an involved process concerning many program areas and our fiscal agent. It will take until April 1, 2013, to fully comply with all the provider screening requirements. However, the state has modified the paper enrollment to match the web enrollment effective March 1, 2012.

- The state procured services from vendor Digital Harbor in May of 2014. This vendor supplies the fiscal agent with a technology called Know Your Provider and this technology meets all the required screening requirement for provider enrollment. See attached examples of the paper enrollment forms which were utilized between identification of the issue and KYP system implementation.

3. ***The state is not obtaining any of the § 455.104 disclosure information in its HCBS waiver program or from its fiscal agent.***

**Status at time of the review:** corrected

- The state believes this statement is a mistake in the Medicaid Integrity Program Report as the state is and has been obtaining disclosure information in its HCBS waiver programs in exactly the same way as all Medicaid providers.

4. ***The state does not capture criminal conviction disclosures from providers or contractors.***

**Status at time of the review:** corrected

- The state concurs with this finding. The DHCF has been working to meet all provider screening requirements effective March 25, 2011. This is an involved process concerning many program areas and our fiscal agent. It will take until April 1, 2013, to fully comply with all the provider screening requirements. However, the state has modified the paper enrollment to match the web enrollment effective March 1, 2012.

- The state procured services from vendor Digital Harbor in May of 2014. This vendor supplies the fiscal agent with a technology called Know Your Provider and this technology meets all the required screening requirement for provider enrollment. See attached examples of the paper enrollment forms which were utilized between identification of the issue and KYP system implementation.

***5. The state does not conduct complete searches for individuals and entities excluded from participating in Medicaid.***

**Status at time of the review:** corrected

- The state concurs that as of July 11, 2011, we were not completing searches of the EPLS database. The EPLS database had only been made available as a downloadable database three weeks prior to July 11, 2011. As of August 1, 2011, the state has come into compliance with checking the EPLS database upon enrollment and monthly thereafter.

- The DHCF has been working to meet all provider screening requirements effective March 25, 2011. This is an involved process concerning many program areas and our fiscal agent. It will take until April 1, 2013, to fully comply with all the provider screening requirements. However, the state has modified the paper

- The state procured technology services from vendor Digital Harbor in May of 2014. This vendor supplies the fiscal agent with a technology called Know Your Provider and this technology meets all the required screening requirement for provider enrollment. See attached examples of the paper enrollment forms which were utilized between identification of the issue and KYP system implementation.

***6. The state does not report all adverse actions taken on provider participation to the HHS-OIG.***

**Status at time of the review:** corrected

- The state believes this statement is a mistake in the Medicaid Integrity Program Report as the state began reporting to the HHS-OIG as required by 42 CFR § 1002.3(b)(3) immediately upon review by the MIG reviewers.

***7. The state does not report health care-related criminal convictions to HHS-OIG within required timeframes.***

**Status at time of the review:** corrected

- The state believes this statement is a mistake in the Medicaid Integrity Program Report as the state began reporting to the HHS-OIG as required by 42 CFR § 1002.230 immediately upon review by the MIG reviewers.

## Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Wyoming 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 Wyoming 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 issues.

## Conclusion

The CMS supports Wyoming efforts and encourages the state to look for additional opportunities to improve overall program integrity. The CMS focused review identified areas of concern 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 report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the weaknesses 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 plan should identify those corrections as well.

The CMS looks forward to working with Wyoming to enhance and strengthen its program integrity function.