Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Wyoming Focused Program Integrity Review

Oversight of Medicaid Personal Care Services

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Final Report

Table of Contents

I. Executive Summary **1**
II. Background **3**
III. Results of the Review **6**
A. State Oversight of PCS Program Integrity Activities and Expenditures 6
B. Electronic Visit Verification (EVV) for PCS 7
C. Provider Enrollment and Screening 8
D. State Oversight of Self-Directed Services 10
E. State Oversight of Agency-Based PCS Providers 12
F. PCS Agency Oversight of Staff and Attendants 13
IV. Conclusion **15**
V. Appendices **16**
Appendix A: Results of the Prior Review 16
Appendix B: Technical Resources 19
Appendix C: Program Information 21
Appendix D: State Response 23

I. Executive Summary

Objectives

The Centers for Medicare & Medicaid Services (CMS) conducted a focused program integrity review of Wyoming's Medicaid Personal Care Services (PCS) program to assess the state's program integrity oversight efforts for the Fiscal Years (FY) 2020 – 2022. This focused review specifically assessed the state's compliance with CMS regulatory PCS requirements within 42 CFR Parts 440 and 441. A secondary objective of this review was to provide the state with feedback, technical assistance, and educational resources that may be used to enhance program integrity in the delivery of these services.

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

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

Findings and Recommendations

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

State Oversight of Self-Directed Services

> **Recommendation #1:** To come into compliance with § 455.20, Wyoming should develop and implement a process including written policies and procedures to conduct beneficiary verifications for self-directed care.

Observations

Observations represent operational or policy suggestions that may be useful to the state in the oversight of its Medicaid PCS program. CMS identified **seven** observations related to Wyoming's PCS program integrity oversight. While observations do not represent areas of non-compliance with federal and/or state requirements, observations identify areas that may pose a vulnerability or could be improved by the implementation of leading practices. The observations identified during this review include the following:

State Oversight of PCS Program Integrity Activities and Expenditures

Observation #1: CMS encourages Wyoming to consider strategies to enhance program integrity activities and recoveries related to PCS, which is a program that is historically prone to vulnerabilities. Specifically, Wyoming could focus efforts on increasing fraud referrals to the MFCU, payment suspensions, or overpayment recoveries.

Electronic Visit Verification (EVV) for PCS

Observation #2: CMS encourages Wyoming to work with PCS providers to determine the extent and possible solutions for issues (e.g., inability to correct pending claims, claims data not uploading from third-party EVV to Carebridge) related to providers using the state's EVV system, Carebridge, in conjunction with the provider's agency-owned preexisting EVV system.

Provider Enrollment and Screening

Observation #3: CMS encourages Wyoming to ensure that its new BMS includes the IMPROV component in 2026 to ensure all providers are tracked for compliance within its databases.

State Oversight of Agency-Based PCS Providers

Observation #4: CMS encourages Wyoming to consider assigning a unique identifier or NPI for PCS aides, consistent with CMS guidance.

PCS Agency Oversight of Staff and Attendants

Observation #5: CMS encourages Wyoming to ensure that providers are in compliance with their provider agreement, particularly in regard to the requirements for audits and access to records. When they are not, consider implementing additional procedures to ensure appropriate oversight of the quality and integrity of services billed by the agency.

Observation #6: CMS encourages Wyoming to provide additional training and support to ensure that all PCS providers understand background screening requirements and to ensure PCS employees are checked against the required federal and state databases before hiring and every five years thereafter.

Observation #7: CMS encourages Wyoming to develop policies and procedures and provide additional guidance to ensure PCS providers are reporting instances of possible fraud, waste, or abuse of PCAs, especially terminated PCAs, to WDH to ensure the PCAs do not subsequently go to work for another PCS agency.

II. Background

Focused Program Integrity Reviews

In the Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, CMS set forth its strategy to safeguard the integrity of the Medicaid program.[1] This plan encompasses efforts to ensure that states are adhering to key program integrity principles, including the requirement that state Medicaid programs have effective oversight and monitoring strategies that meet federal standards.

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

Medicaid Personal Care Services

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

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

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

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

The Wyoming Department of Health (WDH) is the single-state Medicaid agency (SMA) responsible for the administration of the Wyoming Medicaid program. Within the WDH, the Division of Healthcare Financing (DHCF) is the Medical Assistance Unit and state-appointed entity to administer Wyoming Medicaid. The State Medicaid Agent serves as the Senior Administrator and directs DHCF operations. In addition, the State Medicaid Agent and the Home and Community-Based Services (HCBS) Administrator retain the ultimate responsibility for oversight of PCS delivered under HCBS waiver programs. Within DHCF, the Medicaid Program Integrity Unit (MPIU) is the organizational unit tasked with facilitating oversight of program integrity-related functions, including those related to PCS.

Wyoming administers Medicaid PCS to eligible beneficiaries under Section 1905(a) State Plan authority and Section 1915(c) Home and Community-Based Services (HCBS) waiver authority. HCBS are a type of person-centered care delivered in the home and community, including PCS. Detailed descriptions of the Wyoming Medicaid PCS Programs and their applications can be found in Appendix C.

In State Fiscal Year (SFY) 2022, Wyoming's total Medicaid expenditures were approximately $580.5 million, providing coverage to approximately 87,953 beneficiaries. Wyoming's Medicaid expenditures for PCS totaled approximately $150 million, and 5,534 beneficiaries received PCS. The WDH offers both agency-based and self-directed PCS options. Appendix C provides enrollment and expenditure data for the PCS population in Wyoming.

In May 2023, CMS conducted a virtual focused program integrity review of Wyoming's PCS program. This focused review assessed the state's compliance with regulatory requirements at 42 CFR Parts 440, 441, 455, and 456, as well as Sections 1905(a), 1915(c), and 1915(j) of the Social Security Act (the Act). As a part of this review, CMS conducted interviews with SMA staff involved in program integrity and the administration of PCS to validate the state's program integrity practices, as well as with key personnel within three[2] PCS agencies. CMS also evaluated the status of Wyoming's previous corrective action plan, which was developed by the state in response to a PCS-focused review conducted by CMS in 2018, the results of which can be found in Appendix A.

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

[2] Four PCS Agencies were originally selected by CMS to participate in the review; however, one agency, Humble Horizon Home Health, declined to participate.

This review encompasses the six following areas:

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

B. **Electronic Visit Verification (EVV) for PCS** – Pursuant to Section 12006(a) of the 21st Century Cures Act, all states were required to implement an EVV system for PCS by January 1, 2020. Failure to meet this requirement results in incremental Federal Medical Assistance Percentage (FMAP) reductions of up to 1 percent unless the state has both made a "good faith effort" to comply and has encountered "unavoidable delays."

C. **Provider Enrollment and Screening** – CMS regulations at § 455.436 require that the SMA check the exclusion status of the provider or persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the Department of Health and Human Services Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE); the System for Award Management (SAM); the Social Security Administration's Death Master File (SSA-DMF); and the National Plan and Provider Enumeration System (NPPES) upon enrollment and re-enrollment, and check the LEIE and SAM no less frequently than monthly. In accordance with § 455.434, PCS agencies or attendants that enroll in Medicaid as providers are also subject to federal screening requirements found at § 455.410.

D. **State Oversight of Self-Directed Services** –States may elect to cover self-directed PCS under a Section 1915(j) waiver, which allows participants or their representatives to exercise choice and control over the budget, planning, and purchase of self-directed PCS. CMS regulations at 42 CFR 441 Subpart J govern the use of this option.

E. **State Oversight of Agency-Based PCS Providers** – Beneficiaries may receive services through a personal care agency that oversees, manages, and supervises their care. Agency-based PCS are available under state plan or waiver authority. In accordance with §§ 441.302 and 441.570, the SMA must ensure that certain necessary safeguards have been taken to protect the health and welfare of individuals furnished services under the program and assure the financial accountability for funds expended for PCS provided through wavier or state plan authority.

F. **PCS Agency Oversight of Staff and Attendants** – As defined by § 440.167, PCS services must be provided by an individual who is qualified to provide such services unless defined differently by a state agency for purposes of a waiver granted under part 441, subpart G. The conditions of participation for home health aides participating in personal care services programs are further detailed at § 484.80. In accordance with these standards, state law often requires PCS agency staff and attendants to be subject to

enhanced screening and credentialing procedures at the date of hire and annually thereafter. As part of this review, CMS interviewed several PCS agencies to determine if they are exercising appropriate oversight of the quality and integrity of services provided to beneficiaries under the care of their agency, in accordance with state standards.

III. Results of the Review

A. State Oversight of PCS Program Integrity Activities and Expenditures

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

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

In Wyoming, the MPIU is primarily responsible for facilitating Medicaid Program Integrity activities. Within the MPIU, the Business Operations Unit is dedicated to waiver service reviews and investigations and the management of the MPIU's fiscal accountability for recoveries. The Audits and Investigations Unit is dedicated to State Plan Service reviews, audits, and investigations. The Eligibility Review Unit is dedicated to reviews and investigations into beneficiary fraud and ongoing quality assurance reviews of beneficiary eligibility determinations. The MPIU identifies fraud and abuse within the Medicaid program through reviewing paid claims history and conducting reviews and investigations to determine provider abuse, deliberate misuse, and suspicion of fraud.

The DHCF facilitates robust programmatic audits to ensure compliance with established program guidelines. Oversight and monitoring requirements are met through coordinated efforts within WDH using a memorandum of understanding (MOU). Specifically, DHCF holds an MOU with the WDH Division of Aging regarding provider licensing activities for programmatic oversight purposes. The DHCF also holds an MOU with the Wyoming Department of Family Services regarding provider concerns related to programmatic oversight purposes. These MOUs allow for cooperation and information sharing on an as-needed basis. In addition, the HCBS Section verifies requirements on a regular cycle for all providers in a one-to-three-year time frame.

The DHCF also holds an MOU with the Wyoming Attorney General's Office, Wyoming Medicaid Fraud Control Unit (MFCU). According to section 6(D)(ii) of the MOU, pursuant to 42 C.F.R. § 455 .15 and Wyoming Statute § 42-4-405, if the DHCF suspects, after a preliminary investigation, that a Medicaid provider has committed or is committing fraud or abuse, the DHCF is to refer the matter to the MFCU for a full investigation. The parties are to adopt the referral standards identified in the September 2008 CMS report entitled *Best Practices for Medicaid Program Integrity Units' Interactions with Medicaid Fraud Control Units*. The MPIU meets with the Wyoming MFCU monthly, at a minimum. The MPIU did not refer any cases of suspected PCS fraud to the MFCU during the review period; however, the state encourages Medicaid program personnel to collaborate directly with the MFCU. The HCBS Section referred two cases to the MFCU, of which MPIU was made aware.

The WDH indicated the MPIU does not implement corrective action plans, but rather imposes adverse actions (i.e., overpayment recovery or payment suspension) if programmatic deficiencies are discovered during an audit. However, CMS noted the MPIU only made two payment suspensions during the review period. Only one of the three agencies interviewed, Bear Country Home Healthcare, referred suspected fraud to the DHCF during the review period.

The WDH has established PCS program participation and reporting requirements through state policy and on Wyoming's HCBS Section website, which includes participant handbook(s) and provider and case manager manuals.

> **Observation #1:** CMS encourages Wyoming to consider strategies to enhance program integrity activities and recoveries related to PCS, which is a program that is historically prone to vulnerabilities. Specifically, Wyoming could focus efforts on increasing fraud referrals to the MFCU, payment suspensions, or overpayment recoveries.

B. Electronic Visit Verification (EVV) for PCS

EVV is a technology used to verify that PCS visits occurred, and systems include telephonic verification, verification through a fixed or mobile device in the home, verification through a GPS-enabled mobile application, or a combination of these. Pursuant to Section 12006(a) of the 21st Century Cures Act, all states were required to implement an EVV system for PCS by January 1, 2020. Failure to meet this requirement results in incremental FMAP reductions of up to 1 percent unless the state has both made a "good faith effort" to comply and has encountered "unavoidable delays."

Wyoming does utilize an EVV system for in-home scheduling, tracking, and billing for agency-directed PCS providers. Wyoming implemented its current EVV in February 2022 and is in compliance with Section 12006(a) of the 21st Century Cures Act. While the WDH contracts with Carebridge to conduct EVV activities, a provider may use a third-party system as long as it fulfills the requirements of the 21st Century Cures Act and can transfer information to Carebridge through system integration. Even if the provider elects to use a third-party system, all provider claims must be submitted to the Benefits Management System (BMS) through Carebridge for billing. CMS noted that all PCS agencies interviewed reported the use of

Carebridge. Two of the three PCS agencies are also using their own pre-existing EVV system in addition to Carebridge.

The Financial Management Services Agency (FMSA), ACES$, contracts with CellTrak, a third-party EVV solution vendor for self-directed services. The FMSA utilizes the EVV information to confirm visit information to process payroll on behalf of self-directed employers. This EVV system was online and operational for use by all self-directed service providers on December 1, 2020. The WDH has a good faith effort exemption for the future implementation of the State Plan EVV, which should be implemented in the fall of 2023.

During the review, one PCS agency, Bear Country Home Healthcare, indicated issues using their third-party EVV in conjunction with the state's EVV, including the agency's inability to correct a claim in a timely manner until the claim has been processed and paid. This provider also indicated the state's EVV system is not extracting all PCS claims data from the provider's third-party EVV system, resulting in some services being provided but never processed or paid.

Observation #2: CMS encourages Wyoming to work with PCS providers to determine the extent and possible solutions for issues (e.g., inability to correct pending claims, claims data not uploading from third-party EVV to Carebridge) related to providers using the state's EVV system, Carebridge, in conjunction with the provider's agency-owned preexisting EVV system.

C. Provider Enrollment and Screening

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

CMS confirmed that the WDH has a state policy in place addressing this requirement, which can be found in Chapter 45, Section 14 of Wyoming Medicaid Rules. For agency-directed services available under the State Plan and Section 1915(c) waiver authorities, the WDH reported that responsibility for compliance with § 455.436 is delegated to the Wyoming Medicaid's Provider Enrollment, Screening, and Monitoring (PRESM) contractor, HHS Technology Group, LLC. CMS confirmed that the HHS Technology Group is contractually required to verify provider enrollment and eligibility based on federal requirements contained in § 455.436. In addition, the contractor has procedures in place to suspend or restrict the enrollment of providers debarred by state or federal agencies, listed in registries (e.g., child abuse, elder/adult abuse, sex offender), or who do not meet requirements specified by the state. For self-directed services available under the Section 1915(c) waiver authority, responsibility for provider screening is currently delegated to the Wyoming Administration and Information, Human Resources Division.

Initially, every PCS agency must submit an application with the PRESM contractor and meet the general provider enrollment requirements to be a Medicaid enrolled provider, along with an executed provider agreement. In addition to this requirement, waiver providers must be enrolled

in the waiver program for which they intend to provide services and meet the qualifications detailed in each of the HCBS waiver applications. The Comprehensive and Supports Waivers have an online electronic application process. The Community Choices Waiver (CCW) has a separate online application process. The waiver programs have established baseline standards for providers. These are outlined by service type in Wyoming Medicaid Rule Chapter 45, the Comprehensive and Supports Waiver Service Index, Community Choices Waiver Service Index, and applicable waiver agreements. All PCS agencies must be licensed by the Wyoming Department of Health, Division of Aging pursuant to Wyoming Statues 35-2-901(a)(xi). The individuals providing the service must meet the training requirements established by the Aging Division's rules and regulations. Compliance with these requirements must be documented initially and on an ongoing basis. The HCBS Section is responsible for reviewing the waiver provider applications and coordinating with Medicaid Enrollment to ensure that providers have completed the Medicaid enrollment process and the waiver enrollment process prior to activating the provider. The HCBS Section will verify requirements on a regular cycle for all providers in a one-to-three-year time frame.

The DHCF maintains an MOU with the WDH Aging Division to conduct initial and periodic reviews to verify that waiver service providers maintain compliance with applicable provider qualification standards. This includes onsite inspections and complaint investigations for providers of certain waiver services. In addition, the HCBS Section monitors the certification and licensure of all qualified providers in the state data system, Information Management for Providers (IMPROV). If providers lose their required licensure or are decertified by the HCBS Section, that action is documented in the provider profile in IMPROV. Providers are then prohibited from reenrolling. Initial enrollment is monitored by the same HCBS Section, ensuring there are no attempts to reenroll from a previously decertified entity. Providers must understand and ensure ongoing compliance with requirements, the general provider participation standards detailed in Chapter 3 of the Wyoming Medicaid Rules, and the terms and conditions detailed in the provider agreement. One of the primary ways that providers demonstrate ongoing qualifications is through the recertification process.

The HCBS Section provides regular support and training to providers on updated rules and regulations. Informal support and training include bi-monthly provider and case manager support calls, including both updates to rules and regulations, and a training component with each call.

In accordance with § 455.434, PCS agencies or attendants that enroll in Medicaid as providers are subject to federal screening requirements found at § 455.410. SMAs must require providers, as a condition of enrollment in Medicaid, to consent to Fingerprint-based Criminal Background Checks (FCBCs) when required to do so under state law, or by the level of screening based on fraud, waste, and abuse risk as determined for that category of provider, in accordance with § 455.450. High-risk and moderate-risk providers are subject to enhanced screening.

The WDH has implemented the mandatory risk-based screening requirements as outlined in 42 CFR 455.434 which assigns risk and follows the guidance and requirements found within CMS' Medicaid Provider Enrollment Compendium. The WDH categorizes newly enrolled home health agencies as high-risk. Individual PCAs are not enrolled in Wyoming Medicaid as provider

entities.

CMS determined that the WDH has met federal screening requirements. However, the IMPROV system is not yet connected to the state's new BMS, which processes Medicaid claims. This is a repeat finding from the previous review in 2018. The IMPROV system is not expected to be fully integrated into this new system until the new Care Case Management System goes online in 2026. This creates a risk that the WDH may pay claims for providers who have been terminated or failed to maintain the required professional licensure.

> **Observation #3:** CMS encourages Wyoming to ensure that its new BMS includes the IMPROV component in 2026 to ensure all providers are tracked for compliance within its databases.

D. State Oversight of Self-Directed Services

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

Wyoming ensures these requirements are met through the utilization of the FMSA, which is responsible for providing each beneficiary receiving self-directed PCS with a case manager to monitor the beneficiary's expenditures. This case manager is tasked with advising the beneficiary on care choices, reviewing the utilization of waiver services, and reporting significant budget variances that may indicate potential fraud or program abuse to the WDH. In addition, case managers are required to ensure that participants who express an interest are informed of the potential benefits, liabilities, risks, and responsibilities associated with this service delivery option. Participants who are unable to, or uncomfortable with, directing their own services may choose to designate another individual to act as the employer of record and manage the self-directed activities and responsibilities on their behalf.

Initially, when the participant selects this option, they exercise decision-making authority and accept the responsibility for taking the direct role in managing the service. To be considered for enrollment in the self-directed option, the individual must complete a participant profile assessment as the first step in the service planning process. The case manager is then responsible for developing a comprehensive and accurate service plan using the Electronic Medicaid Waiver System (EMWS). The frequency and duration of the services authorized on a participant's service plan must correspond with their needs. It is the case manager's responsibility to ensure that waiver services are authorized in accordance with the service definition established in the CCW or Developmental Disabilities (DD) Waiver Service Index. Case managers must also ensure that the services authorized do not exceed service caps or limitations for the specific

service and that services are authorized within the scope of the service. Service plans are screened through a system review process and may be subject to a manual review by HCBS Section staff.

The FMSA contractor, ACES$, provides fiscal payroll support for the employer of record. This includes EVV and visit verification/management as it relates to authorizing and monitoring payroll for self-directed PCS providers, conducting the CCW program-required background screenings, monitoring self-directed PCS provider compliance with HCBS required certifications and training, and verifying employer-set wages and service provisions fall within agency specified limitations. The FMSA requires prior authorizations for CCW self-directed services. For services provided through the DD waivers, the DHCF provides an approved self-directed budget, which is allowed to be used toward any self-directed services specified in the plan of care. The FMSA maintains edits within their electronic systems to ensure that an individual's self-directed PCS budget cannot be overspent and adheres to the participant's employer's set wage for payment to their PCS employee.

The FMSA has not been delegated authority to investigate or audit self-directed employers and does not manage oversight or monitor self-directed PCS employees. In addition, the WDH is not monitoring self-directed PCS providers and has not delegated this to any external entities. Further, the FMSA does not conduct data mining for PCS claims. Alternatively, the beneficiary, their representative, or the self-directed employer is solely responsible for hiring, training, monitoring, disciplinary action, and termination of their employed individual PCS providers.

The FMSA does monitor EVV submissions for inappropriate or excessive use of EVV edits within the submissions as defined in their exception policy, which is collaboratively reviewed for appropriateness by the DHFC and the FMSA. In addition, FMSA has internal edits in place for EVV submissions that require the employer's signature that the service was received as reflected. These edits verify the submitted time prior to them going to payroll for processing. During the quarterly contractual audit conducted by DHCF staff, a review is conducted on a random sample of files that includes verifying alignment between the service delivery/visit information, the employer-specified wage, and the payroll advice. The WDH can further reconcile FMSA submitted reimbursement claims against payroll advice information. The FMSA is audited by the DHCF every fiscal quarter to verify compliance with all contractual requirements and deliverables, including reconciliation of FMSA reimbursement claims to self-directed employee advice, and employer wage verification documents.

The WDH instructs concerns of possible fraudulent activities, complaints, or incidents raised as they relate to a self-directed PCS provider, be directed to WDH through the HCBS staff, case managers, and/or the MPIU for investigation.

The FMSA is not tasked with performing beneficiary verifications as part of their contractual responsibilities. CMS noted that while the WDH has policies and procedures in place to perform beneficiary verifications for other provider types, this process is not inclusive of self-directed PCS, which is not in compliance with § 455.20.

Recommendation #1: To come into compliance with § 455.20, Wyoming should develop and implement a process including written policies and procedures to conduct beneficiary verifications for self-directed care.

E. State Oversight of Agency-Based PCS Providers

Beneficiaries enrolled to receive services through a personal care agency have their care overseen, managed, and supervised by the agency. Agency-based PCS in Wyoming are available under the State Plan and Section 1915(c) HCBS waiver authorities. In accordance with §§ 441.302 and 441.570, the SMA must assure that certain necessary safeguards have been taken to protect the health and welfare of individuals furnished services under the program and to assure the financial accountability for funds expended for agency-based PCS provided through waiver or state plan authority.

For DD waiver services, the number of personal care service units authorized by the DHCF will be based on individual extraordinary care needs as specified in the individualized plan of care and other assessments. Each service, in combination with other services included in an individualized plan of care (IPC), must fit within the individual budget amount assigned to each participant. The IPC must account for services to cover the entire plan year.

Based on the information provided by WDH during the review, there were 28 PCS providers contracted to furnish State Plan PCS and 614 waiver PCS providers in FY 2022. The provider submits claims for services performed under their business name and associated National Provider Identifier (NPI) and/or Wyoming Provider ID Number. Therefore, the provider is responsible for the qualifications and standards of behavior for employees delivering services, billing, and otherwise working for the organization. Providers are responsible for ensuring that all claims submitted under their provider agreement(s) and identification number represent services delivered only by qualified staff members. Individual PCAs are not directly enrolled with or paid by the WDH. Because PCS aides are not identified on claims for services, the WDH is limited in its ability to closely review PCS claims to identify individual aide fraud and aberrant trends from data mining and claims reviews, which are important components of program oversight. Assigning unique identifiers or NPIs to PCS aides would facilitate more efficient and transparent tracking of each PCS service rendered and reimbursed. CMS has released guidance on this practice that Wyoming could review and implement.[3]

Additionally, PCS providers are subject to audits/reviews/data mining conducted by WDH to identify any aberrant billing patterns. Specifically, the MPIU has a dedicated data analytics function to conduct data mining and analytics. Analytics are conducted at the provider agency level only. Monitoring is conducted through receipt of referrals from internal Medicaid programs, the public, law enforcement, other state agencies, telephone hotline, and coordination of efforts with contracted partners and the Statewide Compliance Auditor. CMS confirmed that Wyoming has written policies and procedures in place for suspected fraud referrals that meet

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

federal requirements to assure the financial accountability for funds expended for agency-based PCS provided through waiver or state plan authority.

Observation #4: CMS encourages Wyoming to consider assigning a unique identifier or NPI for PCS aides, consistent with CMS guidance.

F. PCS Agency Oversight of Staff and Attendants

In accordance with state law, PCS agency staff and attendants are subject to enhanced screening and credentialing procedures at the date of hire and annually thereafter. The WDH does not require individual aides or caregivers providing PCS services to be enrolled in Wyoming Medicaid, therefore it is the responsibility of the employing agency to perform the appropriate database checks. Background screenings must be completed upon initial employment. Documentation of background screenings must be maintained by the provider for all staff who qualify for screenings. This information will be requested by WDH as a part of recertification with the CCW program. The Provider Credentialing Team will review subsequent background screenings during provider certification renewals. Providers must present documentation that demonstrates that the screenings have occurred upon request by the HCBS Section.

The WDH provider certification process for the Comprehensive and Supports Waivers requires all providers and provider staff members who deliver direct 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 must 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, HHS-OIG's LEIE database screening, and a state and national fingerprinted criminal history record check that 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. Any individual required to receive an initial background screening is required to undergo subsequent background screenings every five years. In addition, providers and any person with an ownership or control interest or who is an agent or managing employee of the provider are required to undergo subsequent monthly HHS-OIG LEIE database screenings. The WDH provider certification process for the Community Choices Waiver requires a check against the United States Department of Justice, National Sex Offender public website in addition to the background screening list above.

As part of the review, CMS selected four provider agencies to be interviewed: Bear Country Home Healthcare, Best Home Health & Hospice, Cowboy Cares Home Health & Hospice, and Humble Horizon Home Health.

Humble Horizon Home Health was selected to participate in this Wyoming focused program integrity review but elected not to provide all requested documents and did not show up for the scheduled interview session. Additionally, Humble Horizon Home Health did not disclose to the state nor the review team a valid reason why they chose not to comply. This is a repeat finding from the previous review where a different provider did not participate, which indicates an

enhanced risk regarding state oversight. In addition, this lack of response was in violation of the states' provider agreement under General Provisions section D - Audits and Access to Records, which requires Medicaid, other WDH programs, MFCU, HHS, and any of their representatives to have access to any books, documents, papers, and records of the provider that are pertinent to the agreement. The provider must, immediately upon receiving written instruction from the program, provide to any independent auditor or accountant all books, documents, papers, and records of the provider that are pertinent to the agreement. The provider must cooperate fully with any such independent auditor or accountant during the entire course of any audit authorized by Medicaid, other WDH programs, the MFCU, or HHS. The state should ensure that providers are in compliance with their provider agreement.

Two of the three agencies interviewed reported compliance with background screening requirements. One agency, Bear Country Home Healthcare, was not performing an HHS-OIG's LEIE database screening on employees, which is in violation of Chapter 45, Section 14 of Wyoming Medicaid rules and the provider agreement.

In addition, CMS found during the interviews that the agencies find the current reporting process to be confusing when reporting instances of PCA fraud, waste, and abuse. Currently, the agencies are instructed to notify the SMA in addition to other agencies such as the MFCU, the Wyoming Board of Nursing, and/or law enforcement as necessary when fraud exists. One agency terminated an employee for aberrant behavior and reported the employee to the State licensing board but did not notify WDH nor the MFCU because no overpayment was due. Another agency reported numerous PCAs to the Sherriff's Department, and no other agencies, for theft in the participant's home. While WDH does not require individual aides or caregivers providing PCS services to be enrolled in Wyoming Medicaid, policies and procedures should be in place to ensure agencies are making the proper referrals of terminated PCAs when fraudulent behavior exists.

Observation #5: CMS encourages Wyoming to ensure that providers are in compliance with their provider agreement, particularly in regard to the requirements for audits and access to records. When they are not, consider implementing additional procedures to ensure appropriate oversight of the quality and integrity of services billed by the agency.

Observation #6: CMS encourages Wyoming to provide additional training and support to ensure that all PCS providers understand background screening requirements and to ensure PCS employees are checked against the required federal and state databases before hiring and every five years thereafter.

Observation #7: CMS encourages Wyoming to develop policies and procedures and provide additional guidance to ensure PCS providers are reporting instances of possible fraud, waste, or abuse of PCAs, especially terminated PCAs, to WDH to ensure the PCAs do not subsequently go to work for another PCS agency.

IV. Conclusion

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

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

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

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

V. Appendices

Appendix A: Results of the Prior Review
Wyoming's last CMS program integrity review was in April 2018, and the report for that review was issued in December 2018. The report contained 14 recommendations for improvement. During the virtual review in May 2023, CMS conducted a thorough review of the corrective actions taken by Wyoming to address all recommendations reported in the calendar year 2018. The findings from the 2018 Wyoming focused program integrity review report have not all been corrected by the state as noted below.

Findings

1. ***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.***
   Status at the time of the review: Corrected

2. ***State should ensure that its new MMIS system includes the IMPROV component to ensure all providers are tracked within its databases.***
   Status at the time of the review: Not Corrected
   The new BMS is not connected to the IMPROV solution. However, this connection is slated for 2026 when the new Care Case Management system goes online. While the IMPROV is not connected to the BMS there are safeguards integrated within the IMPROV workflow which ensure the component activities performed in the BMS are completed prior to finalizing an individual or entity's eligibility to render PCS services.

3. ***State should develop policies and procedures for the prior authorization process to ensure it's operating in an efficient manner.***
   Status at the time of the review: Corrected

4. ***The state should ensure that they are allocating sufficient resources to the prevention, detection, investigation, and referral of suspected provider fraud.***
   Status at the time of the review: Not Corrected
   Wyoming believes it is allocating sufficient resources to the prevention, detection, investigation, and referral of suspected FWA within PCS services. However, this appears to remain a risk to the Medicaid program given the limited number of suspected fraud cases, referrals to the MFCU, payment suspensions, and recoveries during the current review period.

5. ***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.***

Status at the time of the review: Not Corrected
Wyoming indicated in its response that WDH has initiated numerous audits, reviews, and investigations into PCS services since the 2018 focused review. However, CMS noted during the current review period that the FMSA does not routinely monitor or oversee self-directed PCS providers. The HCBS participant or their delegated employer is solely responsible for hiring, training, monitoring, disciplinary action, and termination of their employed individual PCS provider. Monitoring of self-directed PCS providers is not conducted by WDH or delegated by the agency to any external entities.

6. ***Consider assigning a unique identifier to each PCA to facilitate tracking of each PCA's work.***
   Status at the time of the review: Not Corrected
   According to the WDH, this recommendation was not and continues to remain an unrealistic option at this time. Wyoming continues to dedicate adequate resources on both the program and program integrity side to safeguard against FWA in the area of self-directed services.

7. ***The state should ensure that providers are in compliance with their provider agreement.***
   Status at the time of the review: Not Corrected
   Humble Horizon Home Health was selected to participate in the current Wyoming Program Integrity Review but elected not to provide all requested documents and did not show up for the scheduled interview session. This is a repeat finding from the previous review where a different PCS provider failed to participate in the scheduled Program Integrity Review.

8. ***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.***
   Status at the time of the review: Corrected

9. ***The state should ensure PCS providers are reporting to the state instances where PCAs are terminated for possible fraudulent behaviors.***
   Status at the time of the review: Not Corrected
   The state indicated the Agency Program Integrity Section and Home and Community Based Services Section work in collaboration to ensure education is supplied to providers on the "how to's" of reporting FWA; however, this remains as a finding based on interviews with three PCS provider agencies during the current Program Integrity Review.

10. ***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.***
    Status at the time of the review: Corrected

11. ***Consider providing routine training to PCS providers on updated rules and regulations to ensure appropriate billing.***
    Status at the time of the review: Corrected

12. ***The state should consider conducting onsite visits to the PCS agencies in order to monitor PCAs and/or agency activities.***
    Status at the time of the review: Corrected

13. ***The state must ensure that each PCS provider completes the necessary federal database checks monthly and ensure that they are aware of all policies and procedures.***
    Status at the time of the review: Not Corrected
    The WDH indicated that all PCS providers must perform the necessary OIG federal database checks before they can be certified to provide PCS. Providers are required to demonstrate the results of a successful screening before the provider application is approved. The PCS providers are required to routinely ensure that new hires and current employees are not listed on the HHS-OIG's LEIE. However, this remains a finding as one provider agency we reviewed was unaware, during the review period, that they were required to check providers against the LEIE.

14. ***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.***
    Status at the time of the review: Corrected

Appendix B: Technical Resources

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

- Access COVID-19 Program Integrity educational materials at the following links:
  - Risk Assessment Tool Webinar (PDF) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-tool-webinar.pdf
  - Risk Assessment Template (DOCX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.docx
  - Risk Assessment Template (XLSX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.xlsx
- Access the Resources for State Medicaid Agencies website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs to address techniques for collaborating with MFCUs.
- Access the CMS frequently asked questions document, Allowability of Using National Provider Identifiers (NPIs) for Medicaid Personal Care Attendants (PCAs), at https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforprofs/downloads/faqs-using-npis-for-medicaid-pcas.pdf
- Access Vulnerabilities and Mitigation Strategies in Medicaid Personal Care Services at https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforprofs/downloads/vulnerabilities-mitigation-strategies.pdf
- Access the Preventing Medicaid Improper Payments for Personal Care Services fact sheet and booklet at https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/downloads/pcs-prevent-improperpayment-factsheet.pdf and https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/downloads/pcs-prevent-improperpayment-booklet.pdf
- Access the Medicaid Payment Suspension Toolkit at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf, to address overpayment and recoveries.
- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts. http://www.riss.net/
- Continue to take advantage of courses and training at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.

- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at https://www.cms.gov/hfpp.
- Consult with other states that have Medicaid managed care 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 managed care staff in program integrity issues. Use the Medicaid PI Promising Practices information posted in the RISS as a tool to identify effective program integrity practices.

Appendix C: Program Information

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

Table C-1. Wyoming Medicaid PCS Programs

Program Name/Federal Authority	**Administered By**	**Description of the Program**
Section 1905(a) State Plan Authority	WDH	PCS are available to assist Medicaid eligible members to perform ADLs and Instrumental Activities of Daily Living (IADLs) in the member's home, place of employment or community. State Plan PCS services became a covered service effective April 2021. State Plan PCS services were not a covered service prior to this date.
Section 1915(c) HCBS Waiver Authorities		
Section 1915(c) Community Choices Waiver (CCW)	WDH/DHCF	The CCW program allows the state to provide supports and services to individuals in their home or community setting, rather than in an institutional setting. PCS are available to eligible individuals who are aged 65 and older, or individuals who are aged 19 – 64 who have a disability that is verified as meeting Social Security Administration (SSA) disability determination criteria.
Section 1915(c) Comprehensive Waiver	WDH/DHCF	The Comprehensive Waiver program administers services to eligible individuals of all ages with intellectual and developmental disabilities (ID/DD), or individuals ages 21 and older with an acquired brain injury. The waiver requires a person-centered approach to determine the support needs of participants in the individualized plan of care and to assign the individual budget amount. Individuals must meet emergency criteria, in addition to eligibility criteria, in order to receive services on this waiver.
Section 1915(c) Supports Waiver	WDH/DHCF	The Supports waiver administers supportive services to eligible individuals of all ages with ID/DD, or individuals ages 21 and older with an acquired brain injury. The waiver requires a person-centered approach to determine the support needs of participants in the individualized plan of care and to assign the individual budget amount.

Table C-2. Wyoming PCS Enrollment by Authority*

	FY 2020	FY 2021	FY 2022
1905(a) State Plan Authority	0	0	2
1915(c) HCBS Waiver Authorities	2,494	2,597	2,445

*Enrollment totals do not include beneficiaries participating in PCS self-directed services.

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

	FY 2020	FY 2021	FY 2022
1905(a) State Plan Authority	$0	$0	$35,437
1915(c) HCBS Waiver Authorities	$20,294,230	$22,334,309	$30,541,861

Table C-4. Waiver Authority Expenditures by Type

1915(c) HCBS Waiver Authorities	FY 2020	FY 2021	FY 2022
Community Choices Waiver (CCW)	$6,447,520	$8,391,463	$18,441,818*
Comprehensive Waiver	$11,770,312	$11,371,445	$9,676,676
Supports Waiver	$2,076,398	$2,571,401	$2,423,367

*The increase in CCW expenditures correlated with provider reimbursement rate increases, increase in utilization of home health aide services, and pandemic-related Appendix K flexibilities that allowed many plans to add PCS services, and more provider types given the ability to deliver these services.

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

Agency-Directed and Self-Directed Combined	FY 2020	FY 2021	FY 2022
Identified Overpayments	$0*	$0*	$0*
Recovered Overpayments	$49,670	$38,000	$128,137
Terminated Providers	2	1	2
Suspected Fraud Referrals	35	27	30
Number of Fraud Referrals Made to MFCU	0	1	1

* Identified overpayment totals were not provided during the CMS review.

Appendix D: State Response

State PI Review Response Form

INSTRUCTIONS:

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

Classification	Issue Description	Agree	Disagree
Recommendation #1	To come into compliance with § 455.20, Wyoming should develop and implement a process including written policies and procedures to conduct beneficiary verifications for self-directed care.		

____
[Name], [Title]

____
Date (MM/DD/YYYY)