Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Wyoming Comprehensive Program Integrity Review

Final Report

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INTRODUCTION

The Centers for Medicare and Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Wyoming Medicaid Program. The onsite portion of the review was conducted at the Office of Healthcare Financing (OHCF) within the Wyoming Department of Health (WDH). The MIG review team also visited the offices of the State's Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the OHCF which is primarily responsible for Medicaid program integrity oversight. The report describes three effective practices, three regulatory compliance issues, and four vulnerabilities in the State's program integrity operations.

THE REVIEW

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help Wyoming improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Wyoming's Medicaid Program

The OHCF administers the Wyoming Medicaid Program. As of the State fiscal year (SFY) ending June 30, 2007, the program had Medicaid expenditures totaling $452,437,547, and processed an average of 1.8 million claims annually for the past three SFYs. The Federal medical assistance percentage for Wyoming for Federal fiscal year 2007 was 52.917 percent.

At the time of the review, Wyoming had 12,271 enrolled providers. In SFY 2007, Wyoming's 81,106 recipients received all Medicaid services fee-for-service. Wyoming does not deliver Medicaid services through a managed care program.

Program Integrity Section

In Wyoming, the organizational component dedicated to fraud and abuse detection activities is the OHCF; primary program oversight is conducted by the Program Integrity (PI) Section. At the time of the review, the PI Section had approximately four full-time employees dedicated to identifying provider fraud, abuse and inappropriate payments. In addition, there are six full-time employees involved in program integrity activities who are dispersed among sister State agencies. While these employees do not directly report to the PI Section manager, their activities are coordinated by the PI Section at monthly meetings. The table below presents the total number of audits and overpayment amounts collected for the last three SFYs as a result of program integrity activities.

Table 1

SFY	# of Case Reviews Conducted	Overpayment Recoveries	Average Recovery per Case Review
2005	1193	$ 280,269	$ 1,019
2006	1092	$ 257,397	$ 2,548
2007	1294	$ 183,878	$ 1,803

Methodology of the Review

In advance of an onsite visit, the review team requested that Wyoming complete a comprehensive review guide and supply documentation to support its answers to the review guide. The review guide included such areas as provider enrollment, claims payment and post-payment review, managed care, Surveillance and Utilization Review Subsystem (SURS), and the MFCU. A five-person review team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of March 31, 2008, the MIG review team visited the OHCF offices and the MFCU. The team conducted interviews with numerous OHCF officials as well as the MFCU Director.

Scope and Limitations of the Review

This review focused on the activities of the OHCF PI Section. Wyoming's State Children's Health Insurance Program operates as a stand alone program under Title XXI of the Social Security Act and was, therefore, excluded from this review. Unless otherwise noted, OHCF provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing, financial, or collections information that OHCF provided.

RESULTS OF THE REVIEW

Effective Practices

The State has highlighted a practice that demonstrates its commitment to program integrity. This practice involves providing onsite assistance to various providers.

Onsite provider assistance

The PI Section utilizes a contractor to provide two field provider representatives who offer onsite assistance to all in-state hospitals and nursing facilities; the top 25 paid dentists, physicians and pharmacies; newly-enrolled providers; and providers identified as having abnormally high denial rates (i.e., Representatives provide educational materials to providers and answer questions.). This assistance is provided annually.

Additionally, the CMS review team identified two practices that are particularly noteworthy. CMS recognizes the State's utilization of a contractor's data capabilities and termination of inactive providers and providers with incorrect or outdated information as further evidence of the State's program strengths.

Utilization of contractor's data capabilities
The PI Section compensates for limited staff resources by using data mining services and claims analysis provided by the State's fiscal agent. The contractor maintains a data warehouse and decision support system that is used to rank providers, generate other standard reports, and develop customized reports. Since 1997, the SURS within the Medicaid Management Information System has been supplemented with tools that provide a peer to peer analysis across a provider-specific claim type, advanced data analysis and filtering to analyze the universe of claims for abnormalities, and a query system.

Termination of inactive providers and providers with incorrect or outdated information
The PI Section instructs its fiscal agent to terminate all providers whose mailings have been returned to the contractor, eliminating the ability of those providers to bill Medicaid unless and until the fiscal agent gets the correct mailing address. This enhances the provider enrollment and system maintenance capabilities. The process began approximately two years ago and has resulted in a dramatic decrease in the number of providers with inaccurate addresses. In addition, the fiscal agent terminates providers who have not filed a claim within the past 365 days or providers who have not updated their license.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to required disclosure and notification activities.

OHCF's electronic provider enrollment applications do not capture ownership, control, and relationship information.
Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of five percent or more.

OHCF uses both paper and electronic enrollment processes. While the paper enrollment applications capture the required disclosures, the electronic provider applications do not capture the addresses of individuals who have ownership or control interest in the disclosing entity.

Recommendation: Modify the electronic provider enrollment applications to capture addresses of individuals with ownership or control interest in the disclosing entity.

OHCF's provider enrollment applications do not capture required criminal conviction information for managing employees and agents.
The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request.

While the OHCF electronic provider applications solicit criminal conviction information about owners and managing employees as well as the applicant, the paper enrollment forms only require disclosure of the provider applicant's criminal convictions. With regards to agents, neither the electronic nor paper applications solicit criminal conviction information.

Recommendation: Modify both the electronic and paper application forms to meet the full criminal conviction disclosure requirements of the regulation.

OHCF does not perform required notifications about excluded providers.
The regulation at 42 CFR § 1002.212 requires a State agency that has initiated an exclusion to notify the individual or entity subject to an exclusion, as well as other State agencies, the State medical licensing board, the public, recipients, and other interested parties.

Interview of PI Section staff revealed that OHCF notifies only the individual or entity subject to exclusion. It does not notify the other parties identified in the regulation at 42 CFR § 1002.212.

Recommendation: Develop and implement procedures to provide notification about exclusions to all required parties.

Vulnerabilities
The review team identified four areas of vulnerability in Wyoming's program integrity practices regarding maintaining a centralized program integrity function, verifying provider licenses, limiting provider enrollment, and recipient fraud and abuse investigations.

Not maintaining a centralized program integrity function.
The program integrity function is not centrally organized within the Wyoming Medicaid agency. State oversight of the program integrity function is assigned to OHCF staff, although staff in sister State agencies perform some program integrity functions and the State's fiscal agent maintains a staff that performs SURS functions. Under this decentralized program integrity structure, staff in multiple state agencies conduct program integrity reviews under the direction of their own agency's management.

Without a centralized program integrity function, States may encounter problems involving unreported issues, duplication of effort, jurisdictional conflicts, and poor coordination of program integrity efforts. If reviews are not effective, and problems go unidentified, the overall organization runs the risk of having issues grow to significant levels, which, when discovered, could lead to large overpayments, and even possible allegations of fraud.

Recommendation: Consider centralizing within OHCF the authority for all program integrity activities.

Not verifying provider licenses.
Providers applying to participate in Wyoming Medicaid must mail in a copy of the provider's license. The State's fiscal agent does not undertake to determine if provider licenses have unreported limitations. Therefore, the program may be vulnerable to billings for services that are beyond the limitations imposed on a provider's license.

Recommendation: Perform full verifications of provider licenses before enrolling providers in the Medicaid program.

Not limiting the period during which out-of-state providers may continue to bill Medicaid.
Out-of-state providers may enroll in Wyoming Medicaid once they have provided services to a Wyoming Medicaid recipient and submitted a claim for services. Once Wyoming allows out-of-state providers to enroll, it permits them to remain in the program and continue billing under the same terms as in-state and border area providers. Therefore, the program may be vulnerable to continuous billings for services by out-of-state providers whose activity is difficult to monitor.

Recommendation: Consider limiting the duration in which non-border area, out-of-state providers may remain enrolled in Wyoming Medicaid after the initial out-of-area service they provided has been reimbursed.

Not ensuring that all instances of suspected recipient fraud or abuse are fully investigated.
Under 42 CFR § 455.15(b) and (c), if the State Medicaid agency's preliminary investigation leads to a suspicion that a recipient has defrauded the Medicaid program, the case must be referred to an appropriate law enforcement agency; if the agency believes that a recipient has abused the program, the State Medicaid agency must conduct a full investigation. The regulation at 42 CFR § 455.16 stipulates that a full investigation must continue until appropriate legal action is initiated, the case is closed or dropped due to insufficient evidence, or the case is resolved.

When suspected cases of recipient fraud or abuse come to its attention, OHCF refers them to the Wyoming Department of Family Services (DFS), the agency responsible for investigating recipient fraud and abuse. The review team found that OHCF does not routinely follow up with DFS to ensure that all cases referred by OHCF have been fully investigated or referred to law enforcement where appropriate. According to the PI staff interviewed for the review, DFS does not inform the OHCF PI Section about the results of the cases referred for investigation by OHCF. As a result, the possibility exists where the Federal share of DFS recoveries identified through its investigations of recipient fraud or abuse was not credited to the Federal Government through the CMS-64 quarterly expense report. It was beyond the scope of the review to make that determination.

Recommendation: Develop and implement procedures for tracking the status of suspected recipient fraud and abuse cases referred by OHCF to DFS. Also, OHCF should conduct a review of DFS recoveries to determine whether the appropriate funds have been credited to the Federal Government through the CMS-64 quarterly expense report.

CONCLUSION

The State of Wyoming applies some effective practices that demonstrate program strengths and the State's commitment to program integrity. These effective practices include:

- onsite provider assistance,
- utilization of a contractor's data capabilities, and
- termination of inactive providers and providers with incorrect or outdated information.

CMS encourages the State to continue to look for additional opportunities to improve overall program integrity.

However, the identification of three areas of non-compliance with Federal program integrity regulations is of concern and should be addressed immediately. In addition, four vulnerabilities were identified. CMS encourages OHCF to closely examine the areas of vulnerability identified in the review.

It is important that these issues be rectified as soon as possible. To that end, we will require OHCF to provide a corrective action plan for each area of non-compliance within 30 calendar days of the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of Wyoming will ensure that the deficiencies will not recur. The corrective action plan should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If OHCF has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of Wyoming on building upon effective practices, correcting its regulatory compliance issues, and eliminating its vulnerabilities.