

Provider Training Series

Chapter 45, Sections 21, 29, and 30

Complaints, CAPs, and Adverse Actions (Module #9)

Wyoming Department of Health

Division of Healthcare Financing

DD Waiver Provider Training Series



Welcome to Module #9 of the Wyoming Department of Health, Division of Healthcare Financing (Division), Provider Training Series for Chapter 45 of the Department of Health's Medicaid Rules (Rules). These rules govern the home and community based Comprehensive and Supports Waivers, hereinafter referred to as the DD Waivers.

Chapter 45, Section 15(d) states that all persons qualified to provide waiver services shall complete training in specific areas prior to delivering services. Although some provider organizations may choose to develop their own training modules, individuals who complete all of the Series training modules and associated training summaries will be in compliance with this specific requirement. Please note that there are provider training requirements established throughout Chapter 45, and it is the responsibility of providers to ensure they meet **all** training requirements prior to delivering waiver services.

This module covers Sections 21, 29, and 30, which address complaints, corrective action plans (CAPs), and adverse actions, formerly referred to as sanctions.

Purpose of This Training



The purpose of this training is to explain the complaint and corrective action process, to familiarize providers with requirements of corrective action plans, and provide information on adverse actions that could be imposed in the event that providers do not comply with federal regulations and Department of Health Medicaid Rules.

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Training Agenda

- ▶ The purpose of the complaint process
- ▶ The importance of corrective action, and how to write and implement a CAP.
- ▶ The types of adverse actions that can be imposed on a provider, and when.
- ▶ Timelines associated with complaints, CAPs, and adverse actions.

By the end of the module addressing complaints, CAPs, and adverse actions, the following topics will have been introduced and explained.

- The purpose of the complaint process, including how and when to file a complaint.
- The importance of corrective action, when the Division will impose corrective action, and how to write and implement a CAP.
- The types of adverse actions that can be imposed on a provider, and when. For this discussion, we will venture into Chapter 16 of the Department of Health's Medicaid Rules, which is related to program integrity and specifically outlines Wyoming Medicaid rules related to adverse actions.
- Finally, throughout the training, we will discuss the established timelines that providers and the Division must meet within each of these processes.

Please note that, for the purpose of these trainings, providers include provider staff and case managers, unless there is a specific need to make a distinction.

Choice



Freedom to make choices is a human right. When the participant's choice isn't respected, a complaint may be warranted, and if the provider or case manager is found to have violated established rules, corrective or adverse actions may be imposed.

As we have mentioned in each of the previous training modules, home and community-based waiver services are based on the tenet that people have the freedom to make choices that impact their lives. It is the responsibility of all DD Waiver providers to offer and respect participant choice. When the participant's choice isn't respected, a complaint may be warranted, and if the provider or case manager is found to have violated established rules, corrective action or adverse actions may be imposed.

Complaints



Com·plaint *noun*

A statement that a situation is unsatisfactory or unacceptable.

So, what is a complaint? A complaint is a statement that a situation is unsatisfactory or unacceptable. People who file a complaint with the Division are referred to as a complainant.

Purpose of a Complaint

- ▶ Participants and stakeholders may formally present why they are unhappy, concerns they have seen, and what they want changed.
- ▶ Community members may address concerns related to participant treatment and quality of life.
- ▶ Providers have the opportunity to improve their services.

Complaints present an opportunity for participants and stakeholders to formally present why they are unhappy, concerns they have seen, and what they want changed. The Division's complaint process is a mechanism for other stakeholders to address concerns related to participant treatment and quality of life. The process serves as a safeguard, and provides the Division with assurance that, if someone sees, hears, or experiences something that is concerning, there is a formal way for the concern to be addressed. A complaint can serve to identify services that are not in alignment with Medicaid Rules.

Finally, since a complaint highlights a concern, whether the concern is a problem with an employee, a violation of a participant's choice or rights, or potential abuse, the provider has the opportunity to review their services and processes and make improvement when possible in order to increase participant and stakeholder satisfaction.

Remember...Mandatory Reporting

A provider or provider staff member who has a reasonable suspicion that a participant's health or safety is in jeopardy shall immediately contact the Division, Protection & Advocacy Systems, Inc., and other governmental agencies, such as law enforcement or DFS, to report incidents or concerns.

As a reminder, according to Wyoming law, everyone must report the suspected abuse, neglect, or exploitation of children or vulnerable adults if they have reasonable cause to believe that it may be occurring. A provider or provider staff member who has a reasonable suspicion that a participant's health or safety is in jeopardy must immediately contact DFS or law enforcement to ensure the safety of participants. The Division, Protection & Advocacy, and other entities must be contacted as required in the Division's incident reporting process.

Provider Policies and Procedures

- ▶ How it will attempt to resolve the complaint;
- ▶ How it will document actions, follow-up, and resolution of the complaint;
- ▶ How and when information will be shared with the complainant, legally authorized representative, and the case manager; and
- ▶ How the complainant will be informed of the process to file a formal complaint with the Division.

Both the provider and the Division are required to have a complaint process. As established in Section 21, providers must have policies and procedures that address how they will handle complaints. The policies and procedures must include:

- How it will attempt to resolve the complaint;
- How it will document actions, follow-up, and resolution of the complaint;
- How and when information will be shared with the complainant, legally authorized representative, and the case manager; and
- How the complainant will be informed of the process to file a formal complaint with the Division.

Providers that are required to obtain national accreditation must ensure that they adhere to the accrediting agency's requirements for complaints or grievances.

Filing a Complaint

DD Critical Incidents and Complaints

To report a Developmental Disabilities Waiver critical incident, click [here](#).

To report a Developmental Disabilities Waiver complaint, click [here](#).

The Division accepts complaints from participants, legally authorized representatives and family members, case managers, providers, and other stakeholders and community members. Complaints may be filed with the Division either verbally or in writing. If a *provider* files a complaint, the complaint must be submitted in writing. If a participant's health and safety is in immediate jeopardy, the provider must notify the proper authorities to address the health and safety concern before a complaint is filed.

Division staff members are only able to follow-up and address issues that are in violation of rules that apply to DD Waiver programs. If the Division receives a complaint that does not identify a rule violation, the complaint may be forwarded on to the appropriate investigative authority, or may be closed.

The complaint portal can be found on the homepage of the Division website. Simply click on the "File a Complaint" link to be directed to the complaint portal. You can also access the portal directly at <https://wyoimprov.com/complaintreport.aspx>.

Waiver Provider On-Line Complaint Form

Complaint Date: 11/27/2020

Participant Information

Participant's Name	<input type="text"/>
Select The Waiver The Participant Is Served By (if known):	<input type="text" value="ABI"/> ▾
Select The Provider That The Complaint Will Be Filed Against:	<input type="text"/> ▾
Your Relationship with the Participant:	<input type="text"/> ▾

Your Contact Information (Please Enter Your Information So We May Contact You)

Name	<input type="text"/>	Address	<input type="text"/>
City	<input type="text"/>	State	<input type="text" value="WY"/> ▾
Phone	<input type="text"/>	Zip	<input type="text"/>
		Email	<input type="text"/>

Complaint Summary

* Note: After you select "Submit" you will go to a Confirmation page where you will be able to Print your Complaint.

The complaint form itself is fairly simple to navigate. The complainant will need to enter the participant's name, the waiver, and the provider the complaint is being filed against. They will then select their relationship with the participant from the drop-down box, and enter their contact information. Finally, they will need to give a detailed account of their complaint so the Division is able to understand the problem and complete appropriate follow-up.

Once the complaint form is completed, the complainant will need to select *Submit*. They will be directed to a confirmation page and will need to *Submit the Final Report*.

The Division receives complaints that address many issues, such as concerns with family members or school situations. However, the Division is responsible for assuring provider compliance with Medicaid Rules while the participant is in services, so these are the only complaints the Division has the authority to investigate. If there are concerns related to a participant's life that are outside of waiver services, providers should submit these to the appropriate authorities.

Division Complaint Timelines - Upon Receipt of a Complaint

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- ▶ Division notice to complainant - within 15 business days
- ▶ Division notice to provider - within 15 business days



It is important that complaints be filed in a timely fashion. A provider or case manager should not wait several months to submit a complaint. If a concern is important enough to file a complaint, then the complaint should be filed as soon as the person is aware of the problem.

The Division will review a complaint within three business days of it being received to determine if there is a violation of Rule, and therefore within the Division's authority to investigate. The Division will send a letter to the complainant that acknowledges the receipt of the complaint within fifteen business days. If the complaint is within the Division's authority, the Division will also send notification within fifteen days to the provider that is the subject of the complaint to inform them that a complaint has been filed.

Division Investigation of a Complaint

- ▶ Review of documentation;
- ▶ Discussions with the participant, provider staff members, and others that have knowledge of the concern; and
- ▶ Site investigation, if determined necessary.

The Division has an internal process that all staff members follow when investigating a complaint. The internal process includes methods for reviewing documentation, talking with people who have knowledge of the concern, and when necessary, conducting a site investigation.

The Division may request documents such as provider policies and procedures; service documentation and billing information; individual plans of care (IPCs), positive behavior support plans (PBSPs), and protocols; employee training records and time cards; and documentation of provider incident reviews and responses.

When investigating a complaint, the Division will speak with the complainant. If a participant is the focus of the complaint, the Division may speak with the participant and any legally authorized representatives as well. There may also be other witnesses, as well as provider staff members and the case manager.

Finally, if there is a significant and immediate health or safety concern addressed in the complaint, or if the complaint is related to a service setting, the Division will conduct a site investigation.

Division Complaint Timelines - Upon Resolution of a Complaint

- ▶ Division notice to complainant - within 15 business days of resolution
- ▶ Division notice to provider - within 15 business days of resolution
- ▶ Division notice to participant - within 15 business days of resolution

Once the complaint investigation is complete, the Division will follow-up with all of the involved parties within 15 business days of the complaint resolution. The Division will notify the complainant that the complaint has been resolved, although no specific information regarding the resolution will be provided. The provider that was the subject of the complaint will also be notified. If the complaint was substantiated, the provider will receive additional information on technical assistance, corrective action, or in some cases, adverse action that will be imposed. If the complaint involved a specific participant, the participant or their legally authorized representative will also be notified of the complaint and the results of the investigation.

Corrective Action



When an incident or rule violation occurs, the situation needs to be resolved.

When an incident or rule violation occurs, the situation needs to be resolved. Corrective action may be a result of a complaint against a provider, an incident that identifies a provider's rule violation or inadequate response, or concerns identified during a provider's certification renewal.

As established in Section 29, the Division will, to the extent practicable and consistent with applicable laws, seek the cooperation of providers in obtaining compliance with standards and rules. The Division may provide technical assistance to providers to help them voluntarily comply with rules. However, if the provider does not make changes after technical assistance is given, or if the issue is considered serious enough to warrant immediate action, the Division may issue corrective action and require the provider to submit a corrective action plan.

The Importance of Corrective Action

- ▶ A correction fixes the immediate problem.
- ▶ Corrective action fixes the root cause of the problem.



The purpose of a corrective action plan is not only to ensure the provider complies with rules, but also to assist the provider in making systemic improvements to their practices in order to address underlying issues that decrease the effectiveness or safety of the services they provide.

Making a correction that fixes the immediate problem isn't always enough. For example, if a provider has a fire in a service setting, putting the fire out is a correction. This action eliminates the immediate problem. But what started the fire? That is the root cause the provider needs to address.

In this example, the fire department determines that the fire is due to faulty wiring. Upon further investigation, the provider hasn't met the Division's requirement of a site inspection by an external entity. It can be presumed that, had the site investigation been completed, the faulty wiring would have been identified so the provider could fix it before the fire occurred.

This is when corrective action is necessary. This violation of Rule potentially threatened the lives of the participants who receive services in the setting that caught on fire. The provider must be able to assure the Division that this won't happen in the future. Although a provider can't guarantee that a fire won't break out for an unexpected reason, the provider does need to have a plan to ensure that the safety standards, such as external inspections, are met.

Division Expectation When Developing A Corrective Action Plan

- ▶ Address the area of non-compliance;
- ▶ Explain detailed action steps;
- ▶ Identify the person responsible;
- ▶ Establish the due date; and
- ▶ Document the completion date.

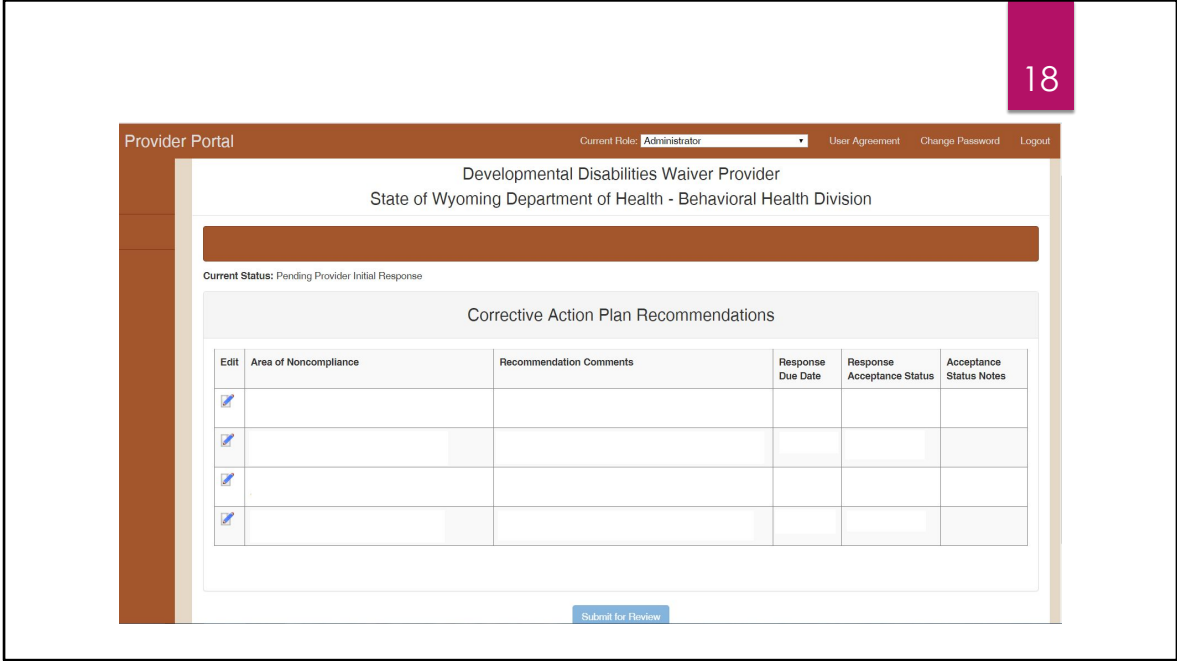
When the Division imposes corrective action on a provider, the provider must develop and submit a plan that explains the steps they will take to make the necessary corrections. This corrective action plan (CAP) must adequately address the area of non-compliance, and include detailed action steps the provider will take to ensure the correction is made now and in the future, the person responsible for ensuring the correction is made, the date by which the correction will be made, and the actual date of completion.

So let's go back to the fire. The Division's corrective action may address a couple of areas. First, the Division may require the provider to ensure the rule related to outside inspections is followed. Second, the Division may require a larger scale inspection of wiring in other service settings. The Division expects the provider to fix any identified deficiencies.

The provider should submit a comprehensive corrective action plan that explains what it will do to ensure the safety of the participants it serves.

Area of Non-Compliance	Action Step	Responsible Party	Due Date
Chapter 45, Section 13(e) - Provider service setting inspections - the service setting is free of any other significant health or safety concerns, including...wiring problems...	ABC Services will ensure inspections from an outside entity, including wiring inspections, are completed on all settings owned or operated by ABC Services.	Firestorm, Maintenance Technician	June 2021
Ongoing inspections	ABC Services will use Google tasks to ensure ongoing inspections in accordance with Medicaid Rules.	Ghost Rider, Safety Coordinator	April 2021

In this example, the provider plans to schedule an external inspection for all of the settings it owns or operates. Additionally, the provider is addressing the fact that the inspection didn't happen as required, and has identified how it will ensure that external inspections are conducted in the future.



The CAP process is administered through the Provider Portal. The portal contains links to guidance documents that will walk you through the process.

CAP Timelines - Immediate Concerns

Suspected non-compliance that relates to the immediate health, safety, welfare, or rights of participants shall be addressed immediately after the situation is discovered.

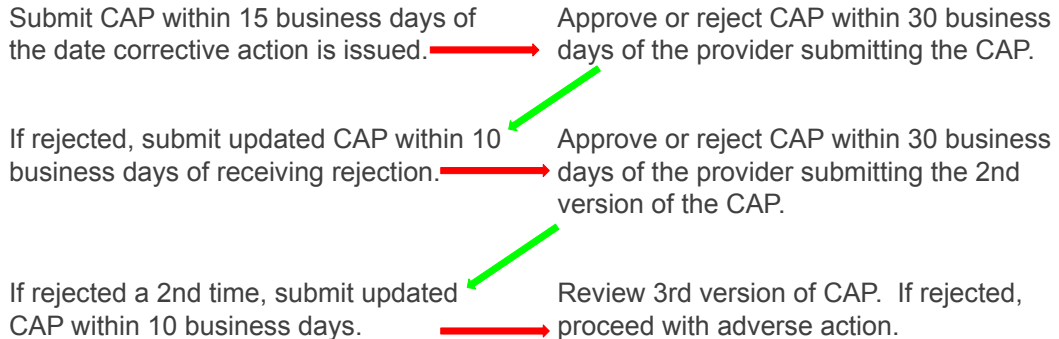


Although the CAP is an important and necessary part of the corrective action process, it goes without saying that immediate health, safety, and welfare concerns must be addressed immediately. A CAP may still be required in order to address the underlying cause of the health concern, but the concern itself will need to be addressed immediately.

CAP Timelines

Provider

Division



The Division will approve or reject CAPs that are submitted by the provider. A CAP will be rejected if it doesn't adequately address the area(s) of non-compliance, or doesn't contain the other elements that are required.

The timelines for the provider's submission and the Division's response to a CAP are included in Section 29. As mentioned previously, issues of health, safety, welfare, and rights must be addressed immediately.

The provider has fifteen (15) business days from date corrective action is issued to submit a CAP to the Division, using the Provider Portal. The Division has thirty (30) business days to approve or reject the CAP. If the CAP is approved, the provider must follow its action items in order to fulfill the terms of the CAP as it was submitted. If the CAP is rejected, the Division will provide information on the reason for the rejection. The provider has ten (10) business days to revise and resubmit the CAP. The Division then has thirty (30) more business days to approve or reject the second version of the CAP. If the Division rejects the CAP a second time, the provider has a final ten (10) business days to revise and resubmit the CAP. If the Division still rejects the CAP, the Division will proceed with adverse action.

Ensuring Provider Compliance with the CAP

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- ▶ Provider is responsible for ensuring actions have been completed within specified timeframes.
- ▶ Provider may be required to submit monthly status reports.
- ▶ Division may review the provider's compliance with the CAP during the certification period, or during the provider's certification renewal.

As established in Section 29, the provider is responsible for completing appropriate follow-up monitoring to assure that the actions identified in their CAP have been completed within the specified time frames. In some cases an action may be ongoing. In our example, the provider planned to have inspections completed on all of the service settings they owned or operated. Due to the scheduling of the inspector, this was anticipated to take several months, so the due date was set for June 2021.

If the issue being addressed is something that is ongoing, such as completing documentation on time or participating in required trainings, the completion date on the CAP may be "*ongoing*".

The Division, at its discretion, may require the provider to submit a monthly status report until all action items have been satisfactorily completed. If the Division does not receive the monthly status report as required, the Division may proceed with imposing adverse actions.

The Division may review the provider's compliance with the CAP at any time during the certification period, or during the provider's certification renewal to assure the provider has fully implemented and evaluated the corrective action plan, and that participants remain safe during the implementation.

Adverse Action



Sanctions may be imposed in accordance with the provisions of Chapter 16 of the Department of Health's Medicaid Rules.

Sanctions, which are now referred to as adverse actions, are addressed in Section 30. As established in this Section, sanctions may be imposed in accordance with the provisions of Chapter 16 of the Department of Health's Medicaid Rules.

Chapter 1 of the Department of Health's Medicaid Rules defines an adverse action on a provider as the termination, suspension, or other sanction of a provider, the denial or withdrawal of admission certification, the determination of a per diem rate, or the denial or reduction of a Medicaid payment to a provider.

Reasons for Adverse Actions

- ▶ Inclusive list is available in Chapter 16, Section 12 of the Department of Health's Medicaid Rules.
- ▶ Of note:
 - ▶ Failure to render requested documentation.
 - ▶ The chronic failure to provide services pursuant to the IPC.
 - ▶ Continuing condition creating serious detriment to the health, safety, or welfare of recipients of home and community-based waiver services.

Chapter 16 establishes rules for Medicaid Program Integrity, and provides an inclusive list of reasons that the Division might impose an adverse action in Section 12. Of particular note are the following reasons:

- The provider's failure to render requested documentation.
- The provider's chronic failure to provide services pursuant to the IPC.
- A continuing condition caused by the provider that creates serious detriment to the participant's health, safety, or welfare.

Adverse Action as a Result of Rule Violations

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Notwithstanding the provisions of Section 29 of this Chapter, the Division may impose sanctions or revoke provider certification for any violation of these rules.

Although there is a specific list of reasons an adverse action can be imposed, Section 30 establishes that the Division may impose adverse actions or revoke provider certifications for **any** violation of Department of Health Medicaid Rules.

Considerations When Making a Decision to Impose Adverse Actions

- ▶ The nature and extent of the provider's violations;
- ▶ The provider's history of previous violations;
- ▶ Actions taken or recommended by other State regulatory agencies; and
- ▶ The steps the provider has taken to reduce the possibility of future violations.

In very few circumstances will the Division jump right to an adverse action. The Division will consider the nature and extent of the rule violations, as well as the provider's history of rule violations. The Division will also consider any actions that have been taken or recommendations that have been made by other State agencies, such as the Department of Family Services. Finally the Division will consider the provider's willingness to come into compliance with Rule. If the provider has failed to address rule violations in the past, this is an indication that adverse action may be warranted in future instances.

Adverse Actions That Can Be Imposed

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- ▶ Educational intervention;
- ▶ Recovery of overpayments;
- ▶ Suspension of payments;
- ▶ Suspension of provider agreement;
- ▶ Termination of provider agreement;
- ▶ Place conditions on a provider;
- ▶ Impose a monitor;
- ▶ Impose civil monetary penalties;
- ▶ Impose an immediate suspension; or
- ▶ Impose an additional appropriate adverse action

There are several adverse actions that can be imposed on a provider, including:

- Educational interventions;
- Recovering overpayments;
- Suspending provider payments;
- Suspending the provider agreement;
- Terminating the provider agreement;
- Placing conditions on a provider;
- Imposing a monitor;
- Imposing civil monetary penalties;
- Immediately suspending a provider's certification; or
- Any other additional and appropriate adverse actions.

These actions are explained in Chapter 16.

Timelines if Provider Certification is Revoked

- ▶ Provider shall submit a plan that addresses how they will assist with the transition within twenty (20) calendar days.
- ▶ Provider, case manager, and plan of care team shall implement transition plans within ninety (90) calendar days.
- ▶ Provider can continue to bill for services during the transition as long as they meet service definitions and adhere to the IPC.

In the event that a provider's certification is revoked as part of an adverse action, Section 30 establishes timelines to ensure that the participant's who are receiving services from the provider have time to establish services with another provider.

Section 30 requires the provider to submit to the Division a plan that explains how they will support the participant and plan of care team with a transition to a different provider. This plan must be submitted within twenty calendar days. The transition plan must include the items in the transition checklist, which is found on the [HCBS Documents Library](#) of the Division website, under the *DDForms* tab. The plan of care team then has 90 days to implement the transition plans, although the participant may transition to the new provider sooner than the 90 day timeframe. The provider can continue to bill for the services it provides through the transition period as long as they are meeting the service definitions and providing the services in accordance with the participant's IPC.

Certification Revocation

A provider who has had their certification revoked under this Section shall not provide waiver services.

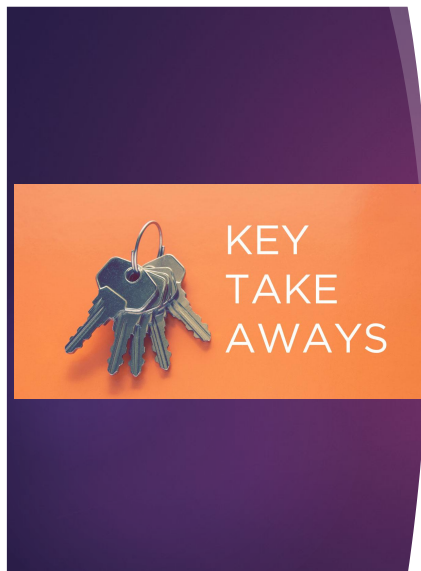
As established in Section 30, a provider that has had its certification revoked as a result of an adverse action will not be approved to provide waiver services in any capacity, including participant-directed services, in the future.

Right to a Fair Hearing

- ▶ Provider may dispute an adverse action pursuant to Chapter 4.
 - ▶ Must be requested within twenty (20) business days after the mailing of the notice of adverse action.



As established in Section 30, providers have the right to dispute an adverse action. To request a hearing, the provider must send the request by certified mail, return receipt requested, or personally deliver the request to the Division offices on the 4th floor, west wing of 122 W. 25th Street in Cheyenne, within twenty business days after the mailing of the notice of adverse action. Other rules related to adverse actions are found in Chapter 4 of the Department of Health's Medicaid Rules.



1. Complaints and CAPs provide an opportunity to improve services.
2. Areas of non-compliance must be corrected.
3. Failure to develop a CAP may result in adverse action.
4. Adverse action may be imposed for any violation of Medicaid Rule.

As we end this training, we'd like to review some of the key takeaways:

1. Providers should view complaints and CAPS as an opportunity to improve their practices and the services they deliver. This will result in a higher level of participant and stakeholder satisfaction, and improve participant outcomes.
2. The provider must correct all areas of non-compliance identified, and must ensure that they will maintain compliance in the future.
3. If a provider fails to develop a comprehensive CAP that addresses all areas of non-compliance that have been identified, the Division may impose adverse actions.
4. As a reminder, the Division may impose adverse action for any violation of Medicaid Rule.

Questions???

Contact your Provider or Benefits and Eligibility Specialist

<https://health.wyo.gov/healthcarefin/hcbs/contacts-and-important-links/>

Thank you for participating in the training on complaints, CAPs, and adverse actions. If you have questions related to the information in this training, please contact your Division representative. Contact information can be found by clicking on the link provided in the slide.

Don't read this section as part of the live presentation

Please be sure to complete a summary of this training so that you can demonstrate that you received training on the rights of participants receiving services.