HOME AND COMMUNITY-BASED SERVICES

WYOMING MEDICAID
DIVISION OF HEALTHCARE FINANCING

Comprehensive and Supports Waiver

Provider Agreement & Chapter 3

Wyoming Department of Health
Division of Healthcare Financing
Home and Community-Based Services Section
April 29, 2024

Wyoming Department of Health

Welcome to today's Training. I am Shirley Lueders, and I am a Provider Credentialing Specialist with the Home and Community-Based Services Section.

HOME AND COMMUNITY-BASED SERVICES

Ensuring providers understand rules & standards they agreed to when they enrolled in Wyoming Medicaid

The purpose of today's training is to ensure that providers of the Comprehensive and Supports Waiver programs, collectively referred to as the DD Waiver program, understand some of the specific rules and standards they agreed to when they enrolled as Wyoming Medicaid providers

Training Agenda

- ➔ Provider Agreement
- ➔ How the Provider Agreement supports Chapter 3

In today's training session, we will provide a comprehensive overview of the Provider Agreement, and discuss how Chapter 3 supports the provisions set forth in the Agreement.

HOME AND COMMUNITY-BASED SERVICES

Participant choice is a fundamental principle within home and community-based waiver services

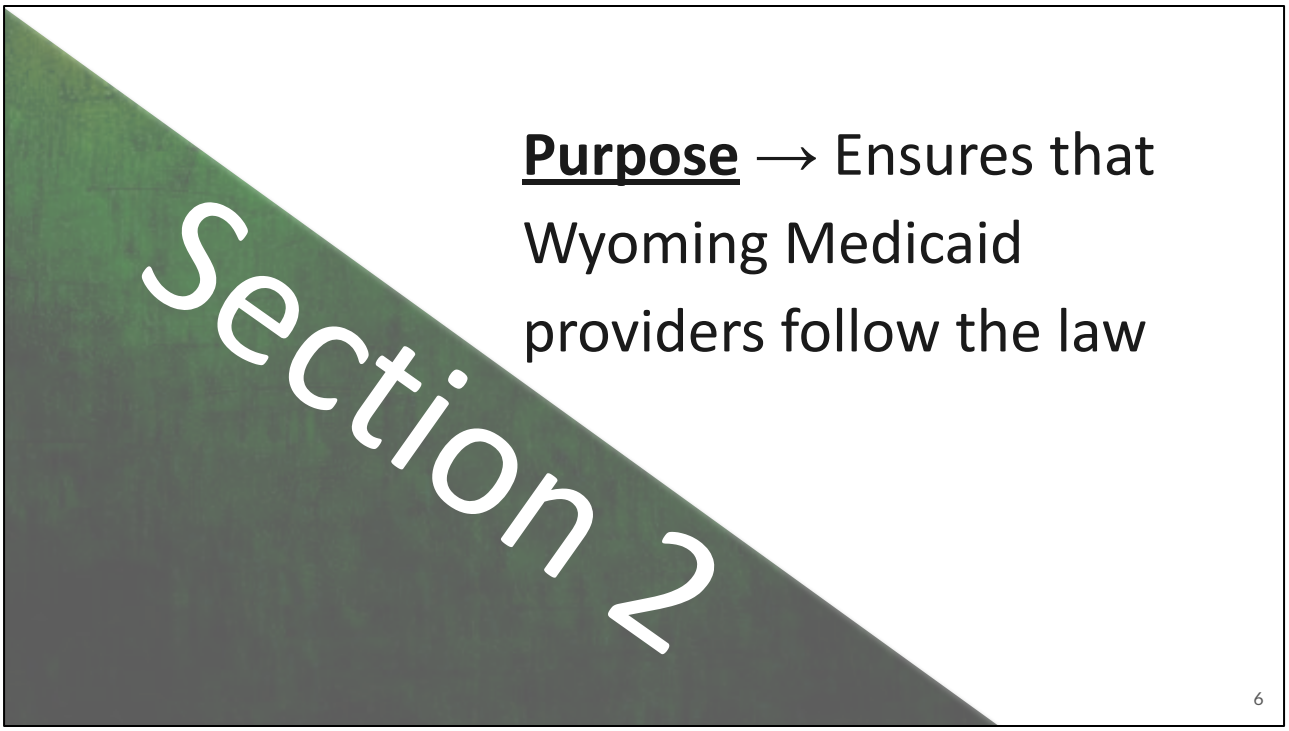
When a provider signs a Wyoming Healthcare Provider Agreement, or what we simply refer to as the Provider Agreement, they are promising to meet established standards and comply with program requirements that guarantee the participant's right to make choices that impact their lives. Whether the choices are related to big decisions or small preferences, having choice is paramount to human dignity.

Provider Agreement

- ➔ Enroll with HHS Technologies
- ➔ Mandatory enrollment

https://health.wyo.gov/healthcarefin/medicaid/for-healthcare-providers/

Before any provider, including physicians, dentists, therapists, and DD Waiver providers, can deliver a Medicaid service, they must be enrolled as a Wyoming Medicaid provider. This enrollment process is administered by HHS Technologies, and includes the execution of the Provider Agreement. This enrollment is separate from the DD Waiver provider certification process that is required by the HCBS Section.



Section 2 of the Provider Agreement outlines its purpose. The purpose is to ensure that every Wyoming Medicaid provider bills and receives payment for services in accordance with applicable law. In short, this agreement is in place to ensure that you, as a Wyoming Medicaid provider, follow the law.

HOME AND COMMUNITY-BASED SERVICES

- All providers must sign a Provider Agreement
- All providers will re-sign every 5 years as part of re-enrollment

Section 3 of the Provider Agreement outlines its terms. The agreement will remain in effect for no longer than 5 years from the date of the final execution. This is, in part, why providers are required to re-enroll in Wyoming Medicaid…to reestablish the agreement between Wyoming Medicaid and its providers, and ensure that providers are reminded of the various requirements to which they have agreed.

Section 5 of the Provider Agreement establishes a fairly lengthy list of responsibilities each Wyoming Medicaid provider must uphold. You have agreed to comply with state and federal law, as well as Department rules and policies that apply to the DD Waiver program. To take that responsibility one step further, you have agreed to comply with Wyoming Medicaid provider manuals, which provide additional guidance and requirements for the respective programs, including the DD Waivers. Guidance documents such as the Comprehensive and Supports Waiver Service Index and IPC Guide serve as DD Waiver program manuals.

Providers must maintain documentation and records needed to justify the claims they submit

Providers must keep the documentation and records that are needed to fully explain the services that are provided to a participant, and justify the claims that they submit for those services. If a provider fails to maintain the records and make them available upon request, they may be required to undergo an audit. Findings of this audit may be considered under the False Claims Act and other state and federal laws, and may subject the provider to prosecution.

HOME AND COMMUNITY-BASED SERVICES

Wyoming providers must safeguard health information, ensuring HIPAA compliance and confidentiality

Providers must safeguard information that they create, collect, transmit, or maintain and that relates to a participant's past, present, or future health status. Wyoming is a rural state with a low population, and individuals can be individually identified more easily than in states with higher populations. Providers are responsible for reviewing the requirements outlined in the Health Insurance Portability and Accountability Act, or HIPAA, understanding what is considered protected health information, and ensuring that this information is kept confidential.

Change In Ownership

- ➔ DD Waiver providers must inform Medicaid of ownership changes
- ➔ Non-compliance may lead to adverse actions, including payment recovery

One of the biggest issues that the HCBS Section has experienced is the changes in ownership that seem to continually occur throughout the DD Waiver provider network. We understand that changes happen, and changing ownership is a business decision that every provider has the right to make. However, the provider has a responsibility to notify Medicaid before they make these changes. In fact, the provider must provide advance notice of any change or proposed change to the provider's name; ownership; licensure, certification or registration status; type of service or area specialty; additions, deletions, or replacements in group membership; mailing address; and participation in the program. If there is a change in ownership, the new owner must enroll as a Medicaid provider, and meet specific requirements to obtain certification as a DD provider. However, they will be held to the obligations of the Provider Agreement even if they don't. Failure to do so may subject the provider to adverse action, including the recovery of payments that have been made.

As a reminder, if there is a change in ownership, each participant must be given a choice in staying with the new owner, or selecting a different provider.

Providers must maintain all required documents for individualized plans of care. These requirements are not specified in the Provider Agreement, but are established by the DD Waiver program. While delivering services to participants, providers must be aware of the participant's support needs, must know what is in the participant's IPC, and how the participant wants their services delivered.

Section 6 establishes special provisions. When a provider signs the Provider Agreement, they are stating that they explicitly understand the information in this Section.

- Providers must supply clear, accurate, and up to date information
- Providers must not submit false or fraudulent claims for payment
- Providers are responsible for the actions of their employees
- Providers should have employee policies and procedures that address documenting and billing for services

The first provision is an obvious one. Any falsification of claims, statements, or documents, or any concealment of material fact is a violation of state and federal laws, and any person who falsifies or conceals a material fact may be subject to criminal prosecution. As a provider, you must supply clear, accurate, and up-to-date information. Providing false statements or withholding information is a crime and could be prosecuted as such. As an example, if you are aware of a situation that meets the criteria for a critical incident that must be submitted to the HCBS Section, and do not report that incident, you are withholding information and will be subject to adverse action. Providers must not submit false or fraudulent claims for payment and must not submit claims with deliberate ignorance or reckless disregard of their truth or falsity. Providers are responsible for the actions of their employees, and are ultimately accountable for false claims or information submitted by their employees. Providers should have employee policies and procedures related to documenting and billing for services, and should ensure that employees understand and adhere to these policies.

Individuals who are sanctioned, barred, suspended, or excluded by a Medicare or Medicaid program cannot provide DD Waiver services.

If an individual practitioner, owner, director, officer, employee or subcontractor is subject to sanctions, or has been barred, suspended, or excluded by any federal or state Medicare or Medicaid program, they cannot provide DD Waiver services. Providers must attest that individuals acting in these capacities are not in this situation.

- ➔ Providers must use their assigned Wyoming Medicaid number to submit claims.
- ➔ Sharing or using another provider's number is **prohibited**
- ➔ Overpayment may result in recovery by Medicaid

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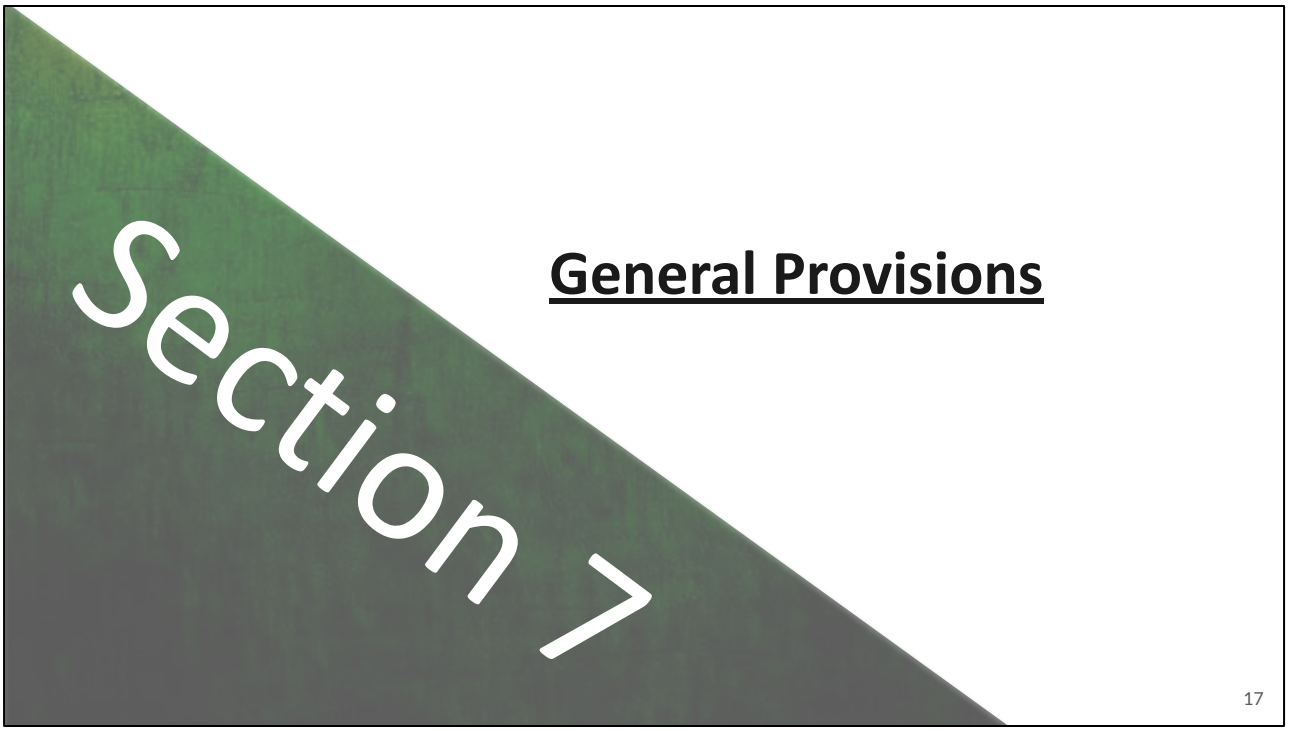
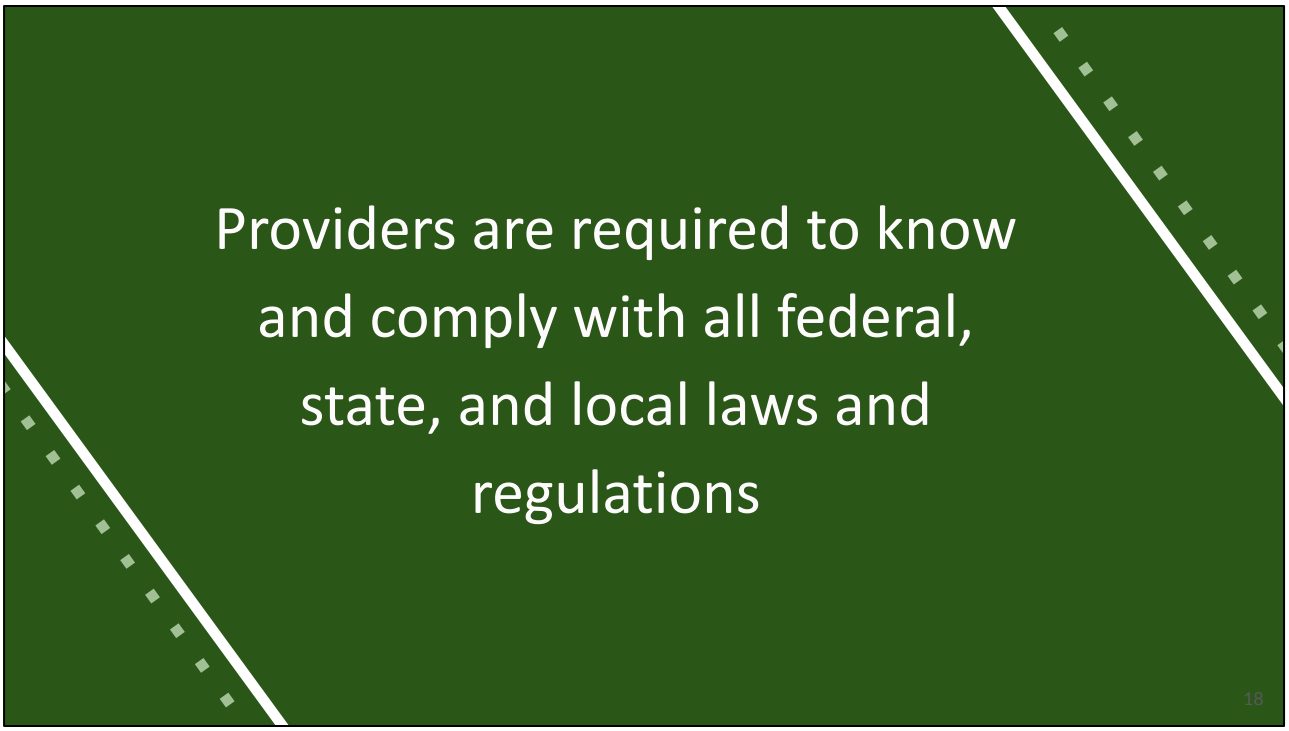
Providers must use their assigned Medicaid number when submitting claims for services, and cannot share that number with other providers, or allow other providers to use their number. In no instance can a provider use another provider's assigned number to bill for services. Overpayment of services is defined by Program Integrity as payment for a service that was not delivered in accordance with rules and regulations. If the provider receives an overpayment for services, Medicaid will recover that payment.



Section 7 establishes general provisions that you will often find in any contract or agreement. These are easy to overlook, and may appear to be nothing more than legalese. However, there are some extremely important provisions in this section…provisions that you have agreed to and will be held accountable to.



Providers are required to know and comply with all federal, state, and local laws and regulations. The HCBS Section strives to keep providers informed and supply pertinent information; however it is ultimately the provider's responsibility to stay informed regardless of the information that the HCBS Section provides.

The HCBS Section will send notices and correspondence to the provider in writing. It is imperative that providers keep their email and mailing addresses current and accurate. If a provider does not receive an important notification due to an inaccurate mailing or email address, they are still responsible for any required action required in the notification. If mail is returned to HHS Technologies, they will deactivate the provider, which will delay the provider's claim processing. To ensure this doesn't happen, providers must ensure that they update their address and other contact information with HHS Technologies and the HCBS Section.

Providers are independent contractors

The Provider Agreement cannot be used as a guarantee of income, nor is it a guarantee that a provider will be providing DD Waiver program services. The Provider Agreement is only the first step in becoming eligible to support participants. A signed Provider Agreement means a provider is eligible to be ***selected*** by participants, but in no way entitles the provider to be selected. The HCBS Section has had new providers call to ask when they will be assigned participants. Participants have a choice in which providers they choose to serve their needs; providers are not assigned. Once selected, providers must still receive a prior authorization number before being reimbursed for services.

Every provider is responsible for knowing, understanding, and complying with every provision of the agreement that they have signed

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https://www.wyomingmedicaid.com/portal

Again, we did not review every section of the Provider Agreement, but we wanted to bring your attention to some of the points that the HCBS Section has seen providers struggle with in the past. Regardless of what we covered in today's training, every provider is responsible for knowing, understanding, and complying with every provision of the agreement that they have signed. You can find a copy of your current Provider Agreement in the Files and Documents section of your provider profile in the Medicaid portal.

Provider Agreement

- The provider agreement has been updated, with the changes taking effect in **February 2024**. Please access your HHS account to review the latest version.
- Here are some highlights of the updates:
  - Payments (Section 4)
  - Responsibilities of the Providers (Section 5R)

In February 2024, the Department of Health made some key changes to the Provider Agreement. Providers will be required to sign the new version of the Provider Agreement when they re-enroll, and new Medicaid providers will be subject to this new version as well. Here are some key changes:

HCBS waiver providers cannot be retroactively certified as waiver providers. This is now clearly stated in Section 4 of the Provider Agreement.

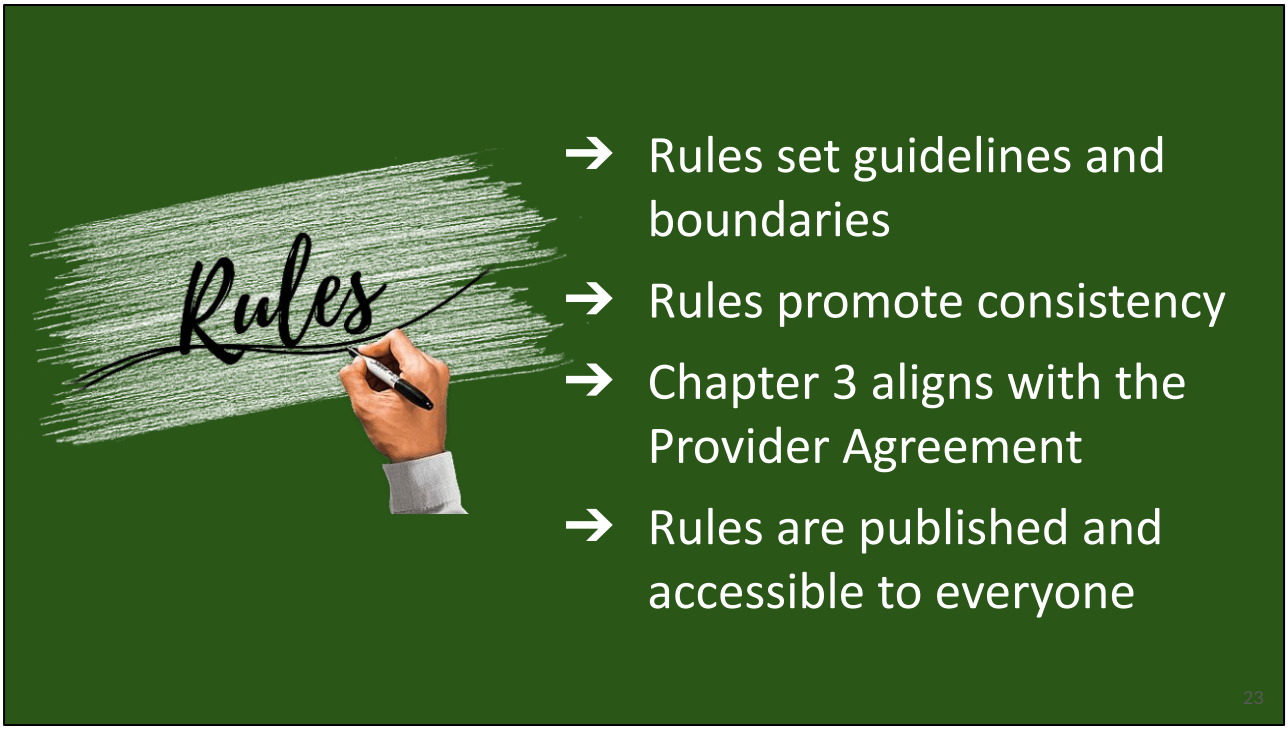
Participants, provider staff members, and HCBS Section personnel have been subject to offensive language and threats during their work. We understand that the jobs we do at the HCBS Section related to holding providers accountable to federal, state, and program rules can cause frustration, but this type of unprofessional behavior cannot be tolerated. Section 5(R) specifically requires providers to refrain from acts of physical workplace violence against Department of Health clients, providers, employees, staff, and contractor personnel. Providers are required to refrain from the use of abusive language, threats of violence, the use of obscenities or other non-verbal expression of aggression, and behavior that a reasonable person would find to be demeaning, humiliating or bullying.

Chapter 3

➔ Key focus on Chapter 3 for all providers:

- Universal application
- Emphasis on addressing key issues
- Providers must comply
- Alignment with Provider Agreement obligations

Once an entity has an executed Provider Agreement, and their enrollment in Medicaid is complete, they are Wyoming Medicaid providers and must adhere to Wyoming Medicaid rules. The rule we want to focus on today is Chapter 3, which addresses provider enrollment and participation, pre-authorization, payments, and claims submissions of every Wyoming Medicaid provider, regardless of the type of service they provide. As with the Provider Agreement, we are not going to go through each section of this rule, but just focus on some of the more problematic areas. Again, providers have a responsibility to know and comply with the rules that govern their program.



Before we jump in this Chapter, let's take a step back and talk about rules. A common definition of the word rule is "One of a set of explicit or understood regulations or principles governing conduct within a particular activity or sphere." Almost every activity, be it a game, a meeting, or providing a Medicaid funded service, has rules.

At times it can feel like rules are cumbersome. After all, people should know right from wrong without them. The reality is that most people want to do the right thing, but sometimes they don't have the knowledge or self-awareness to do so, until rules are established. And rules go far beyond right and wrong.

- Rules set guidelines and boundaries for participants and providers. They provide the framework for the program, and clearly state what is allowed and not allowed.
- Rules promote consistency. Everyone is expected to comply with the rules, regardless of who you work for or where you live. Rules also help HCBS Section staff members to apply expectations the same way for everyone.
- Chapter 3 in particular is written to align with the Provider Agreement that is signed by every Medicaid provider, and strengthens the requirements outlined in that agreement.
- Finally, because the Rules are published and accessible to everyone, everyone has the same opportunity to be knowledgeable of the program's expectations.

Chapter 3, Section 4 addresses provider qualifications. This section gives the Department the authority to establish provider qualifications. Because each Medicaid service requires different provider qualifications, this section gives authority for other Wyoming statutes and rules to further define these qualifications.

The qualifications for DD Waiver providers are outlined in the Comprehensive and Supports Waiver agreement with the Centers for Medicare and Medicaid Services. Additional qualifications are outlined in Chapter 45 of Wyoming Medicaid Rules. In addition to being enrolled as a Medicaid provider, provider organizations must meet all requirements to be certified as a DD Waiver provider. Finally, providers are required to ensure that every employee, whether directly hired or contracted, meets the specific qualifications required for the service they are providing.

Provider Enrollment & Participation

Section 5 addresses provider enrollment and participation. This section clarifies that a Provider Agreement is only in effect for five years, and that enrollment must be renewed. This Section also states that the Department may retroactively enroll a provider. While this retroactive enrollment applies to Medicaid enrollment, it is important to note that the HCBS Section does not retroactively certify providers. If a provider's certification lapses, we will not backdate certification dates or service lines on a participant's IPC. This clarification was added the Provider Agreement version that went live in February.

Section 5(e)(iv) provides further guidance to providers who employ personnel or contract with other entities. In short, the provider's employees and contractors must operate within their professional licensure or certification, and must meet applicable program rules and standards.

Section 5(f) addresses specific reasons the Department may terminate a provider's enrollment. First on the list is if a provider loses, or fails to provide documentation of required licensure or certification. If a provider fails to recertify as a DD Waiver provider, their Medicaid provider enrollment will be terminated. Provider termination under these circumstances is not considered an adverse action, so if this occurs, the provider does not have a right to reconsideration or a fair hearing.

Chapter 3 → Change in Ownership

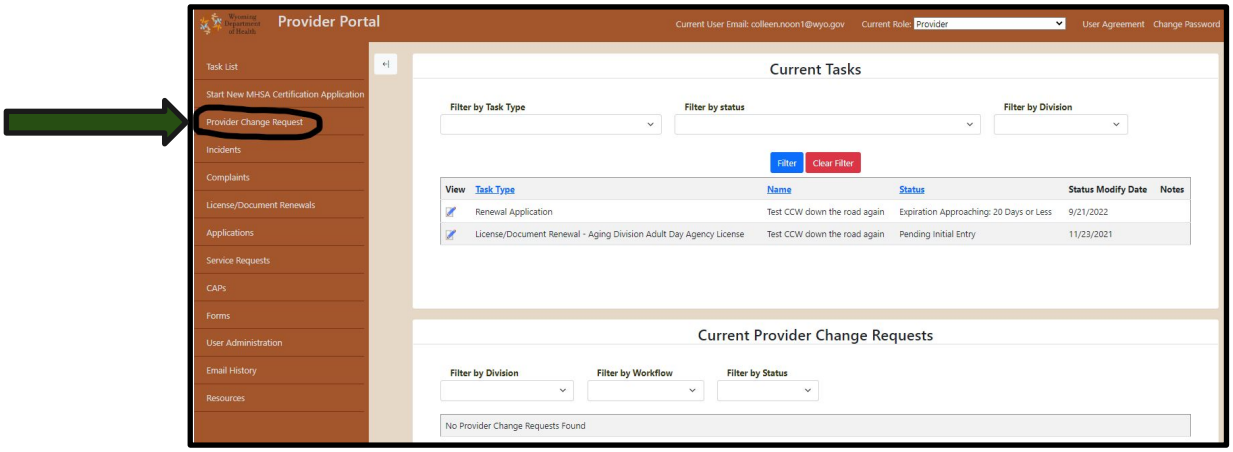
Notify the Department 60 days before ownership changes…ideally 90-120 days in advance

Although we talked about changes in ownership during our presentation on the Provider Agreement, Chapter 3 has an entire section dedicated to the topic. The first sentence in this section is very clear…A provider's Medicaid enrollment and any associated billing privileges are not transferable and cannot be transferred at the time an individual provider's practice or provider entity is sold or transferred.

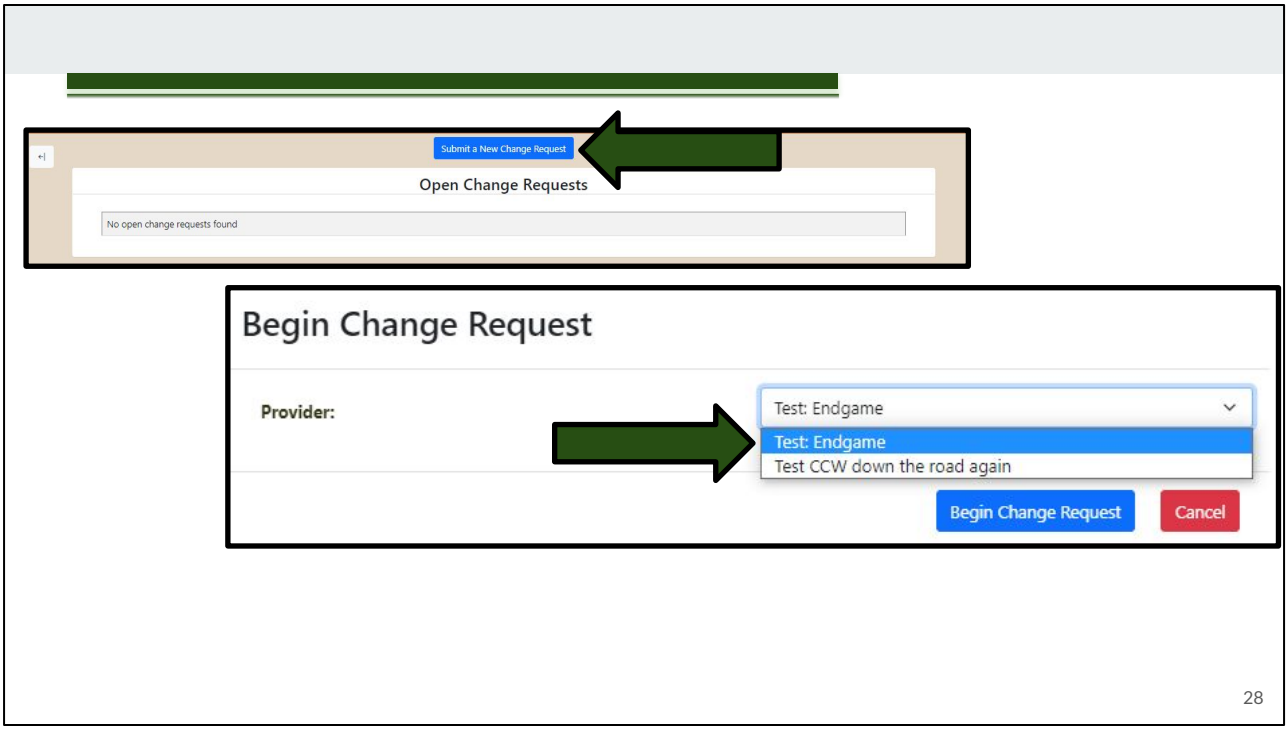
As mentioned in previous trainings, Chapter 3 requires you to provide written notice to the Department 60 days before any ownership changes. However, a change in ownership will affect the many systems that are used in the DD Waiver program, including the Wyoming Health Provider portal, the Electronic Medicaid Waiver System, and Carebridge. If you want to avoid future billing delays and additional administrative hassle, it is imperative that you notify us 90-120 days before a change in ownership occurs.

Please keep in mind that the new owner cannot bill for claims until the sale has been completed and the owner has been enrolled as a Medicaid AND DD Waiver provider. Once a provider changes ownership, they cannot be reimbursed for services that occurred after the effective date under the old provider number. Medicaid is not responsible for, and will not pay, for services that are provided during gaps in provider eligibility that occur as a result of a change in ownership, so please work with the Credentialing Team when these changes are on the horizon.

How providers update demographics



Any time a provider needs to add or update their address, phone number, email, staff, and/or services, they can use the 'Provider Change Request' link on the left hand navigation menu in the WHP portal You can submit more than one change on the same request; however, once the request has been submitted for approval, you cannot change it or submit another report until it has been approved. Only requests with a status of 'pending provider entry' or 'requesting additional information' can be edited.

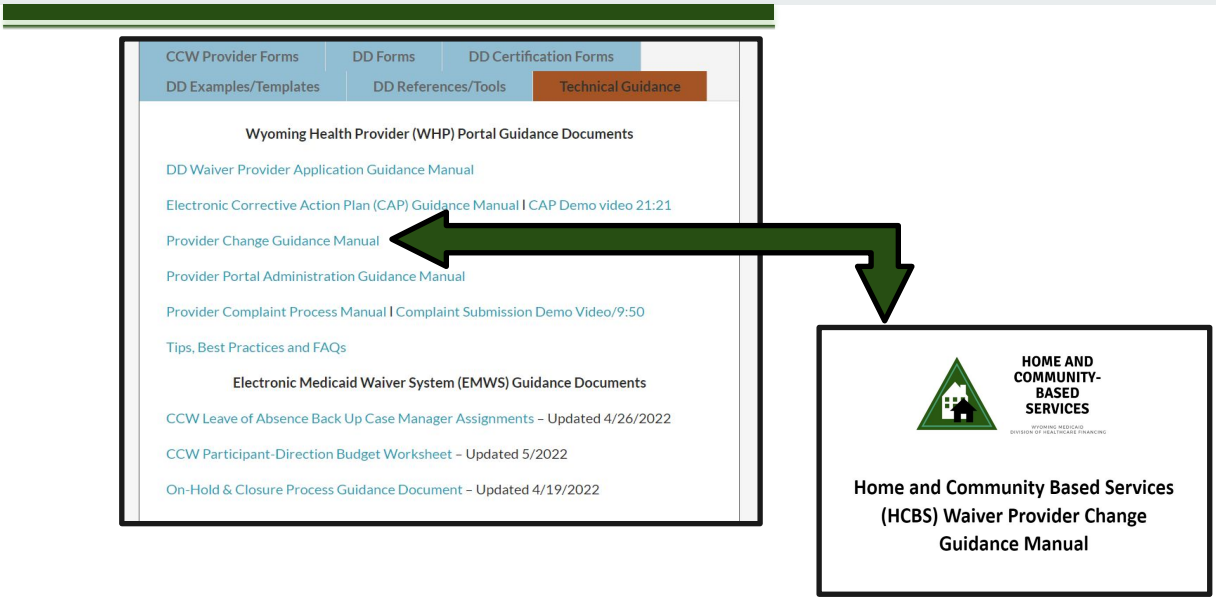


Click on the “Provider Change Request” link in the left hand navigation to open the page and begin any desired change.

Select the provider you wish to change from the drop down menu. If the user only has one provider attached to their user account it will automatically populate the name of the provider. If the user is attached to multiple providers, the user will have the opportunity to choose the provider to which the change needs to be applied. Once the provider has been chosen, click on the ‘Begin Change Request’ button .

After clicking on the button, a ‘Demographics’ page will open. Note that the process is similar to the initial and renewal processes. Don't forget to go to the certification page to submit the request.

https://health.wyo.gov/healthcarefin/hcbs/document-library/



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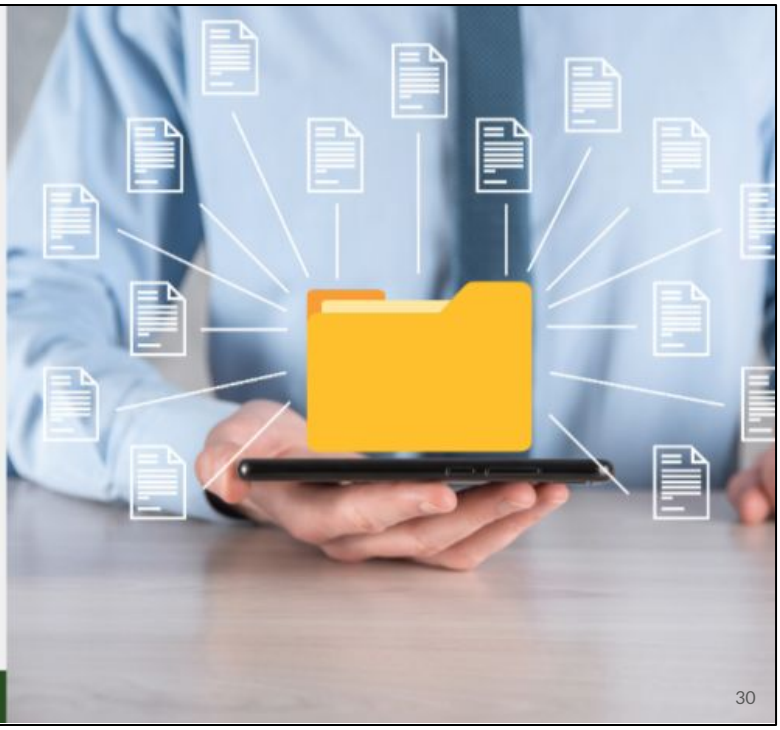
For further step by step information please refer to the HCBS Waiver Provider Change Guidance Manual

Providers are obligated to furnish their financial records and participant medical records upon request



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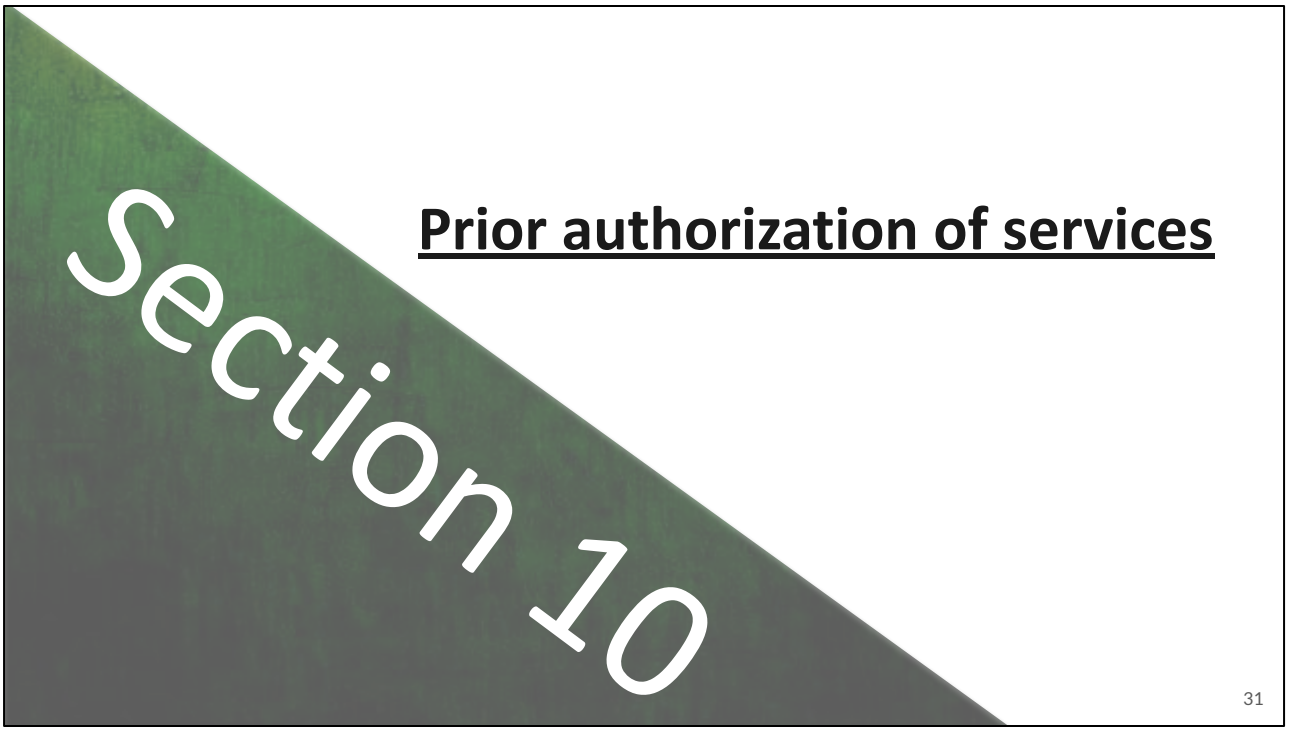
Providers are obligated to furnish their financial and participant's medical records upon request. These records must be accessible to representatives from various state and federal entities, including the Department and its representatives, the United States Department of Health and Human Services, the Wyoming Attorney General, and the Medicaid Fraud Control Unit. The Department holds the authority to duplicate provider records as deemed necessary to fulfill its operational requirements.

If a provider refuses to make financial or medical records available, the Department will immediately suspend the provider’s Medicaid payments for services rendered after the date the records were requested. This suspension will remain in place until the Department verifies that the records have been produced and maintained.

Moreover, the provider is mandated to reimburse the entirety of Medicaid payments received during the period for which supporting records are not produced. This repayment must be completed within ten (10) days upon receiving a written request for restitution.



Section 10 addresses the prior authorization of services. DD Waiver services must be authorized before they can be paid. As a provider, you are required to have a prior authorization number for any service you provide. If you provide a service without this prior authorization, you will not be paid for these services.

Payment of Claims

Section 12 addresses the payment of claims. Since Medicaid is the payer of last resort, a provider cannot seek Medicaid reimbursement until all payments from third parties have been sought and exhausted. That is a very clear cut rule, and is widely known among providers. However, there can be confusion on how covered and non-covered services work.

- If a service is covered under Medicaid, a provider may not request, receive or attempt to collect a payment from the participant or participant's family. The provider must accept the Medicaid allowable payment as the full payment. The provider cannot choose to bill a participant instead of billing Medicaid as an alternative.
- If a provider is providing a non-covered service, they can bill a participant as long as the provider has notified the participant in writing, and the participant has agreed, in writing, to pay for the services before they are furnished.
- If a provider delivers a covered service that is in excess of the service limits, they can seek payment from the participant, again, if the participant is notified and agrees to the charge before the services are furnished.

Submission Of Claims

Section 13 addresses the submission of claims. This is a fairly lengthy section that establishes how claims should be submitted, timelines, and claim denials. Of particular interest is Section 13(g), which states that a provider must complete all required documentation, including signatures, before submitting a claim. If documentation is prepared or completed after the claim is submitted, the claim may be deemed insufficient to substantiate the claim, and payment will be withheld or recovered.

Key Takeaways

HOME AND COMMUNITY-BASED SERVICES

1. **Providers must be enrolled as Medicaid Provider, and have an executed Medicaid Provider Agreement.**
2. **Providers are responsible for reading, understanding, and adhering to the Provider Agreement.**
3. **Providers must comply with all Wyoming Medicaid Rules, including Chapter 3.**
4. **Failure to comply with Medicaid rules could result in revocation of the Provider Agreement or other adverse action.**

Before we end, we'd like to review some of the key takeaways of today's training.

1. As a Comprehensive and Supports Waiver provider, you must also be enrolled as a Wyoming Medicaid provider. As a Wyoming Medicaid provider, you must have a signed, fully executed Provider Agreement on file.
2. When you signed the Provider Agreement, you indicated that you would meet the established standards and requirements; therefore, you are responsible for reading, understanding, and adhering to those standards and requirements.
3. As a Medicaid provider, you must comply with all Wyoming Medicaid Rules. Chapter 3 specifically addresses provider enrollment and participation, and supports the requirements outlined in the Medicaid Provider Agreement.
4. If you fail to comply with the rules and standards outlined in the Medicaid Provider Agreement and Wyoming Medicaid rules, your Provider Agreement could be revoked, and you could be subject to other adverse actions.

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DIVISION OF HEALTHCARE FINANCING

Questions???

Contact your Incident Management or Credentialing Specialist

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

Thank you for participating in today's training. If you have questions related to the information in this training, please contact your area Incident Management or Provider Credentialing Specialist. Contact information can be found by visiting the web address provided in the slide.