Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Wyoming Comprehensive Program Integrity Review

Final Report

April 2012

Reviewers:
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Introduction

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

This review focused on the activities of the Department of Healthcare Financing (DHCF) within WDH which is primarily responsible for Medicaid program integrity oversight. The report describes one noteworthy and two effective practices, six regulatory compliance issues, and one vulnerability 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 DHCF administers the Wyoming Medicaid program through a fee-for-service (FFS) program. As of January 1, 2011, the program served 67,790 beneficiaries and had 9,228 participating providers. Medicaid expenditures in Wyoming for the State fiscal year (SFY) ending June 30, 2010 totaled $569,768,747.

Program Integrity Section

In Wyoming, the organizational component dedicated to fraud and abuse detection activities is the DHCF, and primary program oversight is conducted by the Program Integrity (PI) Section. At the time of the review, the PI Section had 9.5 full-time equivalent positions dedicated to identifying provider fraud, abuse, and inappropriate payments. In the 2008 MIG program integrity review, Wyoming's program integrity staff were dispersed among sister State agencies and did not directly report to the PI Section manager. Wyoming has since made organizational changes and centralized program integrity functions so that all program integrity staff now report to the PI Section manager. The table below presents the total number of investigations, administrative sanctions, and overpayment amounts identified and collected for the last four SFYs as a result of program integrity activities.

Table 1

SFY	Number of Preliminary Investigations *	Number of Full Investigations**	Number of State Administrative Actions	Amount of Overpayments Identified	Amount of Overpayments Collected
2007	220	15	44	not available	$274,673
2008	243	15	46	not available	$384,093
2009	323	7	70	$438,760	$435,822
2010	344	7	140	$599,967	$485,973

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation. The increase in preliminary investigations in 2009 was attributed to increased staffing.
**Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU or administrative or legal disposition. The State indicated that the decrease in full investigations in 2009 was due to the MFCU becoming more selective regarding referrals.

Methodology of the Review

In advance of the onsite visit, the review team requested that Wyoming complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment and disclosures, and the MFCU. A four-person review team reviewed the responses and documents that the State provided in advance of the onsite visit.

During the week of July 11, 2011, the MIG review team visited the DHCF offices. The team conducted interviews with numerous DHCF officials, as well as with staff from the MFCU. In addition, the team reviewed a sample of provider enrollment applications, case files, and other primary data to validate the State's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the DHCF, but also considered the work of other components and contractors responsible for a range of program integrity functions including provider enrollment. The Children's Health Insurance Program in Wyoming operates as a stand-alone program under Title XXI of the Social Security Act and was, therefore, excluded from the review.

Unless otherwise noted, DHCF 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 or financial information that DHCF provided.

Results of the Review

Noteworthy Practices

As part of its comprehensive review process, the CMS review team has identified one practice that merits consideration as a noteworthy or "best" practice. The CMS recommends that other States consider emulating this activity.

Onsite field representatives for provider education

The State's contract with its fiscal agent includes two dedicated field representatives who conduct provider education and training as requested by DHCF. The field representatives will work with any provider who requests assistance. At a minimum, the field representatives conduct visits with the following provider types each year:

- all in-state hospitals,
- all in-state nursing facilities,
- top 25 paid dentists, pharmacies, and physicians,
- newly enrolled, in-state, pay-to providers,
- providers identified by DHCF as having an abnormally high denial rate, and
- categorized providers as determined in an annual meeting.

The training includes, but is not limited to, a review of provider manuals, claim submission policies and procedures, and systems training for the Medicaid Management Information System. The State reported that the field representatives visit approximately 500 providers each year. This dedicated provider education and training program which targets high-paying providers and high-risk providers on a consistent basis provides a strong preventative tool in minimizing fraud, waste, and abuse.

Effective Practices

As part of its comprehensive review process, CMS also invites each State to self-report practices that it believes are effective and demonstrate its commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. Wyoming reported an updated fraud and abuse detection system and a comprehensive process for verifying services with beneficiaries.

Fraud and abuse detection system

In 2009, the State contracted with a vendor to implement a new fraud and abuse detection system. This new system includes a case tracking component which allows the user to subsequently open a case and document all activities of the case until it is resolved. The new system is web-based and provides querying capabilities for surveillance and utilization review, along with the ability to run customized fraud analytics. The State and the contractor have developed 34 various analytics that staff may use. The case tracking function, which is the newest component of the system, allows the State to track all activities associated with opening and processing a case. This includes, but is not limited to, the ability to attach actual surveillance and utilization review reports, the parameters on which those reports are based, any notes about the case, e-mails, documents such as notices to the provider, and any referral information to the MFCU, to that case. In addition, the MFCU has access and can conduct its own research within the system. The comprehensive and collaborative integration of the query and case tracking functions provides the State with a much more efficient system for tracking a case in its entirety. This technological advance allows the State to eliminate paper versions of files and provides immediate access to information for the MFCU.

Comprehensive processes for beneficiary verification of services
The State has implemented a comprehensive program for verifying services with beneficiaries. Each month the State requires that the fiscal agent conduct a random verification of services with beneficiaries based on paid claims. The overall sample includes specific durable medical equipment products or services (wheelchairs and high-dollar supply claims, respectively) along with an additional sample from all other categories of service, except pharmacy which is handled by another contractor. The State reported that it receives a response from approximately 30 percent of beneficiaries. The fiscal agent reviews all returned Explanations of Medical Benefits (EOMBs) for reporting of any discrepancies, which are subsequently turned over to a multi-disciplinary team chaired by the PI Section for review and any necessary action. The State indicated that over 14,000 beneficiaries had been surveyed for SFY 2009-2010. It further reported recoveries from the EOMB process totaling $61,466 in SFY 2006-2007.

Regulatory Compliance Issues

The State is not in compliance with six Federal regulations related to payment suspension requirements, disclosure requirements, exclusion searches, and notification requirements.

The State does not maintain proper documentation on suspensions of payments and is not conforming to the CMS referral performance standards.
The Federal regulation at 42 CFR § 455.23(a) requires that upon the State Medicaid agency determining that an allegation of fraud is credible, the State Medicaid agency must suspend all Medicaid payments to a provider, unless the agency has good cause to not suspend payments or to suspend payment only in part. Under 42 CFR § 455.23(d) the State Medicaid agency must make a fraud referral to either a MFCU or to an appropriate law enforcement agency in States with no certified MFCU. The referral to the MFCU must be made in writing and conform to the fraud referral performance standards issued by the Secretary. Under the Federal regulation at 42 CFR § 455.23(g), State Medicaid agencies must maintain for a minimum of five years from the date of issuance all materials documenting the life cycle of a payment suspension that was imposed in whole or part; and all materials documenting each instance where a payment suspension was not imposed, imposed only in part, or discontinued for good cause. State Medicaid agencies must also annually report to the Secretary summary information on suspensions of payments, including the nature of the suspected fraud, the basis for suspension, and the outcome of the suspension; and situations in which the State determined good cause existed to not suspend payments, to suspend payments only in part, or to discontinue a payment suspension as described in this section, including describing the nature of the suspected fraud and the nature of the good cause.

The CMS released an Informational Bulletin and Frequently Asked Questions to States on March 25, 2011. In addition, CMS has provided States numerous opportunities, including national teleconferences and sessions during two Medicaid Integrity Institute courses, to learn more about the payment suspension regulation since it became effective on March 25.

At the time of the onsite review, the team requested a list of all MFCU referrals made since March 25, 2011 to determine compliance with the new regulations. The State provided the

names of two entities that had been referred to the MFCU. The MIG review team found that the State suspended payments in only one of these cases. For the case in which no payment suspension had been initiated, the State had opened the case on March 31, 2011 and referred it to the MFCU on April 11, 2011. The State had not suspended payments on this individual based on an oral agreement with the MFCU that the State would not initiate a payment suspension on any referral for 90 days while the MFCU initially reviewed the case. The agreement further included that if the State did not hear back from the MFCU after 90 days requesting to exercise the law enforcement good cause exception, the State would then initiate the payment suspension. However, the State was unable to provide any documentation for the initial law enforcement exception, and follow-up with the State on July 21, 2011 and August 8, 2011 revealed that the State still had not implemented the payment suspension and still did not document the good cause exception. The State has been working with the MIG to update its policy to come into compliance with the regulation.

The State acknowledged that it had not created referral procedures according to the CMS performance standards issued in 2008. The State has been utilizing the MFCU's referral form along with its own policy and procedure regarding information to submit when making a referral. A review of the MFCU's form and the State's operating procedure revealed that the State was meeting all of the requirements except for ensuring the inclusion of the date that the issue/complaint was reported to the State. A review of the referrals made after March 25, 2011 revealed that these cases did not include the information.

***Recommendations**:* Ensure required documentation is maintained when invoking a good cause exception for payment suspension under 42 CFR § 455.23. Amend referral procedures to conform to the CMS referral performance standards.

The State does not capture all required ownership and control disclosures from disclosing entities.

Under 42 CFR § 455.104(b)(1), a provider (or "disclosing entity"), fiscal agent, or managed care entity, must disclose to the State Medicaid agency the name, address, date of birth (DOB), and Social Security Number (SSN) of each person or entity 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 5 percent or more. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Additionally, under § 455.104(b)(2), a disclosing entity, fiscal agent, or managed care entity must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or managed care entity as spouse, parent, child, or sibling. Moreover, under § 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or managed care entity in which a person with an ownership or controlling interest in the disclosing entity, fiscal agent, or managed care entity has an ownership or controlling interest. In addition, under § 455.104(b)(4), the disclosing entity must provide the name, address, DOB, and SSN of any managing employee of the disclosing entity, fiscal agent, or managed care entity. As set forth under § 455.104(c), the State agency must collect the disclosures from disclosing entities, fiscal agents, and managed care entities prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or managed care entity.

The DHCF allows FFS providers to enroll electronically or using paper forms. The electronic enrollment form captures most required disclosures. However, as of March 25, 2011, State agencies must capture SSNs and DOBs and enhanced address information for all persons with an ownership or control interest in providers seeking enrollment in a State Medicaid program. The data fields for an applicant's SSN and DOB are not required fields on the electronic form within their system, and the applicant can complete the electronic enrollment without providing that information. Since the implementation of the revised regulation, which occurred on March 25, 2011, applicants have enrolled without submitting their SSNs and DOBs.

The paper enrollment form obtains the name, relationship, SSN and DOB for each person who is a managing employee, has an ownership or control interest of 5 percent or more in the disclosing entity, or has an ownership or control interest of 5 percent or more in any other organization that bills Medicaid. It does not solicit the addresses of each disclosing person as required by the regulation. The paper enrollment form also does not request the name and address of each person with an ownership or controlling interest in any other disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership of 5 percent or more. Consequently, the required relationship disclosure information is not obtained.

The State is not obtaining any of the § 455.104 disclosure information on the paper enrollment form used in its HCBS waiver program or from its fiscal agent.

Recommendations: Develop policies and procedures for the appropriate collection of disclosures from disclosing entities and fiscal agents regarding persons with an ownership or control interest, or who are managing employees of the disclosing entities and fiscal agents. Modify paper and electronic disclosure forms as necessary to capture all disclosures required under the revised regulation at 42 CFR § 455.104. System corrections should be implemented to ensure that applicants cannot enroll without providing all information required by the regulation.

The State does not capture criminal conviction disclosures from providers or contractors. 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. The regulation further requires that the Medicaid agency notify the U.S. Department of Health and Human Services (HHS-OIG) whenever such disclosures are made. In addition, pursuant to 42 CFR § 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

The paper DHCF enrollment provider application does not collect criminal conviction information about FFS non-institutional providers, agents or managing employees and consequently, the State is not able to report such disclosures to HHS-OIG.

Recommendations: Develop and implement policies and procedures for the appropriate collection of disclosures from providers regarding persons with an ownership or control interest, or persons who are agents or managing employees of the providers who have been convicted of a criminal offense related to Medicare, Medicaid or Title XX since the inception of the programs.

Modify disclosure forms as necessary to capture all disclosures required under the regulation at 42 CFR § 455.106.

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

The Federal regulation at 42 CFR § 455.436 requires that the State Medicaid agency must check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on HHS-OIG's List of Excluded Individuals/Entities (LEIE) and the General Services Administration's Excluded Parties List System (EPLS) no less frequently than monthly.

Prior to implementation of this new regulation, CMS issued a State Medicaid Director Letter (SMDL) #08-003 dated June 16, 2008 providing guidance to States on checking providers and contractors for excluded individuals. That SMDL recommended that States check either the LEIE or the Medicare Exclusion Database (MED) upon enrollment of providers and monthly thereafter. States should check for providers' exclusions and those of persons with ownership or control interests in the providers. A follow-up SMDL (#09-001) dated January 16, 2009 provided further guidance to States on how to instruct providers and contractors to screen their own employees and subcontractors for excluded parties.

The State does check providers against the MED upon initial enrollment and then monthly thereafter. The State is utilizing the LEIE and the MED, but is not searching the EPLS as required by 42 CFR § 455.436(c)(2) at the time of enrollment or subsequently on a monthly basis.

Furthermore, since the State is not collecting all disclosures as described at 42 CFR § 455.104, the State is not checking monthly the exclusion status of all persons with an ownership or control interest or who is an agent or managing employee through LEIE and EPLS databases.

***Recommendations*:** Develop and implement policies and procedures for appropriate collection and maintenance of disclosure information about the provider, any person with an ownership or control interest, or who is an agent or managing employee of the provider pursuant to 42 CFR § 455.436. Search the LEIE (or the MED) and the EPLS upon enrollment, reenrollment, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities.

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

The regulation at 42 CFR § 1002.3(b)(3) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

The State indicated that it does not notify the HHS-OIG of any adverse actions taken on providers' participation in the Medicaid program.

Recommendation: Develop and implement procedures for reporting to HHS-OIG program

integrity-related adverse actions taken on a provider's participation in the Medicaid program as required by 42 CFR § 1002.3(b)(3).

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

Under the regulation at 42 CFR § 1002.230, the State Medicaid agency must provide notice to HHS-OIG within specified timeframes, unless the MFCU has already provided such notice, when an individual has been convicted of a criminal offense related to the delivery of health care items or services under the Medicaid program. If the State agency was involved in the investigation or prosecution, the State agency must provide notice to HHS-OIG within 15 days after conviction, and if the State agency was not involved in the investigation or prosecution, the State agency must provide notice to HHS-OIG within 15 days after learning about the conviction.

Neither the State nor the MFCU is notifying HHS-OIG of criminal convictions. The State makes no notifications, while the MFCU only notifies the National Practitioner Data Bank. The State-MFCU Memorandum of Understanding (MOU) does not discuss which entity is responsible for reporting to HHS-OIG.

Recommendations: Institute policies and procedures that address reporting criminal convictions to HHS-OIG pursuant to 42 CFR § 1002.230. Modify the MOU with the MFCU to ensure compliance with reporting criminal convictions to HHS-OIG.

Vulnerabilities

The review team identified one area of vulnerability in Wyoming's program integrity practices which involved not using permissive exclusion authority.

Not utilizing its authority to initiate exclusions for any reason for which the HHS-OIG could exclude a provider.

The regulation at 42 CFR § 1002.210 requires that the State institute administrative procedures to exclude a provider for any reason for which the HHS-OIG could exclude a provider under 42 CFR Parts 1001 and 1003.

The Medicaid State Plan reserves the right to exclude problem providers on a discretionary basis, using the permissive exclusion authority permitted under 42 CFR §1002.210 and DHCF does have a policy in place regarding permissive exclusions. However, this program integrity tool is not being utilized by the State. The DHCF has initiated no permissive exclusions in the past four SFYs. Thus, the State is not as proactive in excluding problem providers from its Medicaid program as it has the authority to be.

Recommendation: Implement existing policies and procedures to initiate provider exclusions from the Medicaid program pursuant to 42 CFR § 1002.210.

Conclusion

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

- onsite field representatives for provider education,
- a fraud and abuse detection system, and
- comprehensive processes for beneficiary verification of services.

The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of six areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, one area of vulnerability was identified. The CMS encourages Wyoming to closely examine the vulnerability that was identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require DHCF to provide a corrective action plan for each area of non-compliance within 30 calendar days from 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. It 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 Wyoming 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 correcting its areas of non-compliance, eliminating its area of vulnerability, and building on its effective practices.

Wyoming Department of Health
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Thomas O. Forslund, Director **Governor Matthew H. Mead**

May 8, 2012

Ref: TG-2012-131

Robb Miller, Director of the Division of Field Operation
Centers for Medicare and Medicaid Services
Medicaid Integrity Group, Center for Program Integrity
7500 Security Boulevard
Baltimore, MD 21244

Dear Mr. Miller:

I am in receipt of your final report pertaining to the Wyoming Comprehensive Program Integrity Review. This letter constitutes our response in accordance with your request. In regard to the findings of your report I am submitting the following comments:

Pages 4-5: The State does not maintain proper documentation on suspensions of payments and is not conforming to the CMS referral performance standards.

Recommendations: Ensure required documentation is maintained when invoking a good cause exception for payment suspension under 42 CFR § 455.23. Amend referral procedures to conform to the CMS referral performance standards.

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

Pages 5-6: The State does not capture all required ownership and control disclosures from disclosing entities.

Recommendations: Develop policies and procedures for the appropriate collection of disclosures from disclosing entities and fiscal agents regarding persons with an ownership or control interest, or who are managing employees of the disclosing entities and fiscal agents. Modify paper and electronic disclosure forms as necessary to capture all disclosures required under the revised regulation at 42 CFR § 455.104. System corrections should be implemented to ensure that applicants cannot enroll without providing all information required by the regulation.

Official Response from Wyoming
May 2012

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

Page 6: The State is not obtaining any of the § 455.104 disclosure information in its HCBS waiver program or from its fiscal agent.

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

Pages 6-7: The State does not capture criminal conviction disclosures from providers or contractors.

Recommendations: Develop and implement policies and procedures for the appropriate collection of disclosures from providers regarding persons with an ownership or control interest, or persons who are agents or managing employees of the providers who have been convicted of a criminal offense related to Medicare, Medicaid or Title XX since the inception of the programs. Modify disclosure forms as necessary to capture all disclosures required under the regulation at 42 CFR § 455.106.

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

Page 7: The State does not conduct complete searches for individuals and entities excluded from participating in Medicaid.

Recommendations: Develop and implement policies and procedures for appropriate collection and maintenance of disclosure information about the provider, any person with an ownership or control interest, or who is an agent or managing employee of the provider pursuant to 42 CFR § 455.436. Search the LEIE (or the MED) and the EPLS upon enrollment, reenrollment, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities.

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

Official Response from Wyoming
May 2012

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

Pages 7-8: The State does not report all adverse actions taken on provider participation to the HHS-OIG.

Recommendation: Develop and implement procedures for reporting to HHS-OIG program integrity-related adverse actions taken on a provider's participation in the Medicaid program as required by 42 CFR § 1002.3(b)(3).

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

Page 8: The State does not report health care-related criminal convictions to HHS-OIG within required timeframes.

Recommendations: Institute policies and procedures that address reporting criminal convictions to HHS-OIG pursuant to 42 CFR § 1002.230. Modify the MOU with the MFCU to ensure compliance with reporting criminal convictions to HHS-OIG.

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

Should you have any questions regarding this response, please contact me directly or Christine Bates at (307) 777-3594.

Sincerely,

Ms. Teri Green
State Medicaid Agent

TG/RC/ct

c: Richard Allen, DMCHO Associate Regional Administrator
Christine Bates, Program Integrity Manager
Jackie Garner, CMCHO Consortium Administrator
Christine Stickley, MFCU Director