INTRODUCTION

After presentation of the special report Analysis of Selected Data and Transactions - Arkansas Medicaid Program - Mental Health Services to the Legislative Joint Auditing Committee (LJAC) at its June 22, 2012, meeting, the LJAC created a subcommittee to continue study of the special report. The Medicaid Subcommittee of the LJAC met on July 9 and 10, 2012, and authorized the Division of Legislative Audit (DLA) to continue to review and examine issues relating to the Medicaid Program.

This report is issued in response to a legislative request, approved by the Executive Committee of LJAC, for DLA to provide information about the Medicaid Program.

OBJECTIVES

The objectives were to provide to members of the General Assembly:


- Results of DLA procedures relating to Medicaid Program recipient eligibility and provider eligibility and payments.

- Results of other DLA procedures.

- Results disclosed in selected reports issued by other entities.

SCOPE AND METHODOLOGY

The summaries of Medicaid Program findings relating to recipient eligibility and provider eligibility and payments were obtained from State of Arkansas Single Audit Reports for the years ended June 30, 2009, 2010, and 2011. Documents and information reviewed for State Fiscal Year 2012 (SFY12) were primarily provided by the Department of Human Services (DHS) and enrolled Medicaid providers.
The methodology used in conducting this review was developed uniquely to address the stated objectives; therefore, this review was more limited in scope than an audit or attestation engagement performed in accordance with Government Auditing Standards issued by the Comptroller General of the United States.

**BACKGROUND**

Created by Title XIX of the Social Security Act, Medicaid is a joint federal-state program that provides medical assistance to eligible individuals based on financial need and other factors. The Medicaid Program was implemented in Arkansas on January 1, 1970, and is regulated and administered by the Division of Medical Services (DMS), a division of DHS. The Centers for Medicare and Medicaid Services (CMS) administer the Medicaid Program for the U.S. Department of Health and Human Services (HHS).

**Medicaid Program Funding**

Federal and state governments share Medicaid funding. The federal government uses state per capita income to calculate each state’s reimbursement rate for Medicaid. This matching rate is known as the Federal Medical Assistance Percentage (FMAP). The FMAP is the share of state Medicaid benefit costs paid by the federal government and is recalculated each year based on a three-year average of state per capita income compared to the national average. In addition, the Stimulus Act of 2009 provides additional funding based on state unemployment rates.

Excluding Stimulus Act funding, Arkansas’s FMAP rates (based upon federal fiscal year) for the years covered in this report are as follows:

- 2009 – 72.81%
- 2010 – 72.78%
- 2011 – 71.37%
- 2012 – 70.71%

**Improper Payment**

An improper payment is any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally-applicable requirements. Incorrect amounts include overpayments and underpayments. Improper payments also include payments to ineligible recipients, payments for non-covered services, duplicate payments, and payments for services not received. In addition, when an entity with review authority is unable to discern whether a payment was proper because of insufficient documentation, this payment must also be considered improper (see 42 C.F.R. § 431.958; Improper Payments Elimination and Recovery Act (IPERA); and Appendix C to OMB Circular A-123 (M-10-13)).

**Payment Error Rate Measurement (PERM)**

According to HHS’s FY 2012 Agency Financial Report issued November 15, 2012, CMS developed the Payment Error Rate Measurement (PERM) program, which uses a 17-state, three-year rotation to measure Medicaid improper payments. To select the 17 states for the three-year cycle, states were ranked by size based on their past federal Fee For Service (FFS) expenditures, managed care, and eligibility components of Medicaid and Children’s Health Insurance Program (CHIP) and grouped into three major strata of 17 states each.

Medicaid improper payments are estimated on a federal fiscal year basis and measure three component error rates: FFS, managed care, and eligibility. HHS, through its use of federal contractors, measures the FFS and managed care components, and states perform the eligibility component measurement.

The national PERM rates for Medicaid were 7.1%, 8.1%, 9.4%, and 9.6% for federal fiscal years 2012, 2011, 2010, and 2009, respectively. HHS calculated and reported the national single-year FY 2012 PERM rate for CHIP as 8.2%. For both the Medicaid Program and CHIP, eligibility error percentages comprise the majority of the PERM rates. The last calculated PERM rate for Arkansas was 4.15% for 2009.
RESULTS OF REVIEW

The results of DLA staff review of Medicaid recipient eligibility and provider eligibility and claims payments, as well as other issues, are discussed in the sections below. Management responses to the respective sections have been included in their entirety.

Medicaid Recipient Eligibility

Overview

Medicaid recipient eligibility is overseen by the Division of County Operations (DCO), a division of DHS. Program Eligibility Specialists (PES) in 83 county offices and outstation locations determine Medicaid eligibility. All eligibility guidelines are set and approved by the federal government, unless the State has a specific waiver. Arkansas guidelines are located in the Arkansas Medical Services (MS) Manual. For certain eligibility categories, the MS Manual refers to policies in the Temporary Employee Assistance (TEA) manual that apply to a specific Medicaid category.

Individuals seeking Medicaid services complete an application at a county office. All applications and forms that applicants are required to sign explain recipient responsibilities and consequences of withholding or supplying erroneous information. Applicants are also informed that they must immediately report to their PES any changes to previously-reported information, such as increase or decrease in income, because such changes may necessitate benefits adjustments.

A PES enters the information provided into the Arkansas Networked System for Welfare Eligibility and Reporting (ANSWER). The ANSWER system contains an electronic record of all case documentation, interfaces with the fiscal agent Hewlett-Packard and the Medicaid Management Information System (MMIS) payment system, and is maintained by independent contractor Northrop Grumman.

ANSWER verifies computational accuracy and Social Security numbers. The PES utilizes other databases to verify additional information, such as citizenship and child support declarations. Based on Medicaid Program criteria, the PES then determines whether the applicant is eligible for Medicaid benefits.

According to federal regulations, recipient eligibility should be reevaluated at least once every 12 months. When a recipient’s eligibility is within three months of expiration, ANSWER generates a letter advising the recipient to reapply for benefits and generates required forms indicating the information the recipient must provide for the reevaluation. Benefits can also be reevaluated based on evaluations performed in conjunction with other services, such as the Supplemental Nutrition Assistance Program (SNAP). If it is determined after a recipient has started receiving benefits that any of the information provided was false, benefits are immediately terminated, and any claims paid are recovered from the service provider.

All recipient eligibility determinations are open to review by DCO supervisors and several DHS departments, including the Medicaid Eligibility Quality Control (MEQC) Unit, the PERM Unit, the Program Integrity (PI) Unit, and the Fraud Unit. Arkansas’s MEQC Unit has received a waiver from CMS to test only long-term care Medicaid cases for eligibility. A statistical sampling method is utilized to select cases for review by MEQC and the PI Unit. In addition, the DCO corrective action plan stated that, beginning in March 2010, all cases with paid claims totaling more than $50,000 in a 12-month period would be reviewed by the DCO Quality Assurance Unit to ensure recipient eligibility.

1CMS defines a “waiver” as the removal or modification of a previously-established, federally-approved state or federal requirement.

2“Long-term care” encompasses a variety of services, including medical or nonmedical care to people who have a chronic illness or disability. In Arkansas, these persons are registered in three Medicaid eligibility categories: Aid to the Aged, Blind, and Disabled. According to the DMS Medicaid Program Overview for SFY11, this group represents 4.2% of recipients and 18% of Program expenditures ($787 million for SFY11).
Over the past several years, DLA procedures have identified weaknesses in the eligibility determination process. Findings for SFY09 through SFY12 are discussed in the sections below. Findings are also summarized in Exhibit I on page 6.

**Findings: State Fiscal Year 2009**

In SFY09, DLA staff reviewed 155 Medicaid recipient files for eligibility and determined that 24 recipients were ineligible. Benefit expenditures for those 24 recipients totaled $800,128. Errors noted during the review included recipients whose income and resources exceeded prescribed limits as well as recipients who failed to make mandatory referral declarations (i.e., to Child Support Enforcement). Errors also included services delivered to five unqualified aliens, totaling $395,962, during SFY01 through SFY10. In one instance, DCO management was aware of the recipient’s ineligibility but allowed the case to remain open for nine years.

The error rate for SFY09 was 15.48% for ineligible recipients.

Another 37 of the 155 recipient files had insufficient documentation to support eligibility at the time of enrollment; DCO subsequently obtained the required documentation after notification by DLA staff.

**Management Response**

DHS implemented corrective actions to target improvements in all eligibility areas having identified errors. In addition to increasing the number of second party reviews and staff training opportunities, DHS made policy and procedural changes to ensure, as a condition of eligibility, that emergency medical services furnished to aliens meet the federal acute care definition.

**Findings: State Fiscal Year 2010**

In SFY10, DLA staff reviewed 645 Medicaid recipient case records for eligibility and determined that 43 recipients were ineligible. Costs paid on behalf of the ineligible recipients totaled $89,317.

The error rate for SFY10 was 6.67% for ineligible recipients.

Another 50 of the 645 recipient files had insufficient documentation to support eligibility at the time of enrollment, which DCO later obtained after DLA staff notification.

**Management Response**

2010 findings were improved as the result of corrective action measures implemented after the 2009 audit findings. Accuracy levels and case documentation were significantly improved.

The agency continued its second party reviews of targeted cases and focused on staff training. In addition, DHS initiated its conversion to electronic case records and implemented a special review of a sample of Medicaid cases each month with annual claims of $50,000 or more to identify and remedy any potential problem areas in these high dollar cases.

**Findings: State Fiscal Year 2011**

In SFY11, DLA staff reviewed 153 recipient case records for eligibility. Five recipients were determined ineligible, and costs paid on their behalf totaled $80,617.

The error rate for SFY11 decreased to 3.27% for ineligible recipients.

An additional 9 of the 153 recipient files had insufficient documentation to support eligibility at the time of enrollment, which DCO subsequently obtained after notification by DLA staff.

**Management Response**

DHS’ emphasis on supervisory reviews, case documentation, and sampling of high-dollar complex cases, continued to positively impact performance. The 2011 Single Audit reported improvements in eligibility accuracy (96.73%) and case documentation (94%). DHS completed the conversion from paper to electronic case records in SFY 2011, which increased the agency’s ability to quickly locate requested documentation for the audit.
Findings: State Fiscal Year 2012

DLA reviewed recipient eligibility for 149 Medicaid recipients during SFY12 and found 21 to be ineligible. Costs paid on behalf of those individuals totaled $389,007.

The error rate for SFY12 was 14.09% for ineligible recipients.

An additional 43 recipient files lacked sufficient documentation at the time of enrollment, which DCO subsequently obtained after DLA notification.

Management Response

DLA shifted the focus of the draft 2012 Single Audit to primarily target the Medicaid Spend-Down categories. There are only about 1,000 active Spend-Down cases at any point in time. All of the error cases identified in the SFY 2012 audit were from this small group of Medicaid eligibles. DCO disagrees with four of the cited errors, but appreciates learning that DCO staff was misapplying a section of the Spend-Down policy. DHS will clarify the policy and retrain staff. The audit did not identify any errors in the remaining sample cases from other Medicaid coverage categories.

ARKids

For SFY09 through SFY11, DLA staff noted ineligible Medicaid recipients based on income requirements. After several DLA audit findings, DCO decided to amend the State’s Medicaid Plan to eliminate the self-imposed income verification requirement for ARKids applicants utilizing the Workforce Employment Security Division (WESD) database, making ARKids strictly a self-declared income program beginning January 18, 2012. MS Manual 16075 states, “Self-declaration for all eligibility factors will be accepted with the exception of age, citizenship status or alien status for non citizens.” The section goes on to state that if verification of income through other programs is on file, it will be used. However, the caseworker is not required to verify income in this manner.

Findings: Internal Controls

DLA noted a lack of internal controls in each of the years covered in this report. DCO county offices often lack sufficient staff, resulting in heavy case loads. In addition, staff are often inadequately trained. An inadequate number of trained staff may result in errors and insufficient documentation of Medicaid recipient eligibility.

For several years, DLA has recommended that DCO strengthen internal controls and increase staffing, training, and monitoring of recipient eligibility. As a result of SFY09 findings, DCO’s corrective action plan, implemented in March 2010, called for an increase in the number of reviews conducted. One measure called for MEQC to review all Medicaid beneficiaries with claims payments exceeding $50,000 per year. For SFY12, 8,982 Medicaid recipients had claims payments exceeding $50,000. Total benefit payments on behalf of these individuals were $805 million (almost 21% of benefit payments).

In SFY12, of the 149 cases DLA reviewed, 55 had single-year costs exceeding $50,000. DLA determined that DHS had reviewed 28 of the 149 cases. DLA staff found additional errors in 11 cases, 4 of which resulted in recipient ineligibility with benefits totaling $118,623. An inadequate review process results in ineffective controls and risk mitigation in terms of eligibility decisions.

Additional Medicaid eligibility issues involved the computer system ANSWER. In SFY10, user access to ANSWER data was not properly restricted, and DHS failed to test its
## Exhibit I

### Arkansas Medicaid Program

Results of Testing for Eligibility – Selected Medicaid Recipient Files

State Fiscal Years 2009 through 2012

<table>
<thead>
<tr>
<th>Year Tested</th>
<th>Note</th>
<th>Number of Recipients Tested</th>
<th>Recipient Files with Errors</th>
<th>Error Rate</th>
<th>Amount Paid on Behalf of Ineligible Recipients</th>
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<tr>
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<td>116</td>
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<td></td>
<td>Totals</td>
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<td>14.09%</td>
<td>$389,007</td>
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</table>

### Notes

- **Note A:** Recipients were selected from several counties, including Craighead, Dallas, Madison, Poinsett, Pulaski, Sebastian, and St. Francis. Recipients were stratified to remove those individuals automatically eligible for benefits as Social Security recipients or enrolled in either ARKids A or B Programs. Recipients were selected from the following Medicaid eligibility aid categories: Working Disabled, Aid to the Aged, Aged Exceptional, Aged Spenddown, Transitional Medicaid, AFDC Exceptional, AFDC Grant, AFDC Spenddown, Aid to Blind, Aid to Disabled, Disabled Exceptional, Disabled Spenddown, Disabled QMB, TEFRA, Under Age 18 Spenddown, Unemployed Parent Exceptional, and Unemployed Parent Spenddown.

- **Note B:** Recipients were selected from the following Medicaid eligibility aid categories: Breast and Cervical Cancer, ARKids B Program, Pregnant Women and ARKids A, Pregnant Women Presumption, SOBRA Newborn, Pregnant Women Exception, and Refugee Resettlement.

- **Note C:** Recipients were selected from across the State in the following Medicaid eligibility aid categories: Working Disabled, Aid to the Aged, Aid to the Blind, AR Senior Program, AFDC, Transitional Medicaid, AFDC Exceptional, AFDC Spenddown, Aged Exceptional, Aged Spenddown, Blind Qualified Medicare Beneficiary, Aid to the Disabled, Disabled Exceptional, Disabled Spenddown, Disabled QMB, Qualified Individual, Refugee Resettlement Exceptional, Special Low QMB, and TEFRA.

- **Note D:** Recipients were selected from across the State in the following Medicaid eligibility aid categories: ARKids, Breast and Cervical Cancer, TB Services, and Family Planning.

- **Note E:** Recipients were selected from across the State in the following Medicaid eligibility aid categories: Aid to the Aged, Aged Exceptional, Aged Spenddown, Aid to the Blind, Transitional Medicaid, AFDC Grant, AFDC Spenddown, Aid to the Disabled, Disabled Spenddown, Disabled QMB, Working Disabled, AR Senior Program, AFDC Exceptional, Qualified Individual, Under Age 18 Spenddown, Unemployed Parent Exceptional, Unemployed Parent Spenddown, and TEFRA.

- **Note F:** Recipients were selected from across the State in the following Medicaid eligibility aid categories: AFDC Spenddown, Aged Spenddown, Blind Spenddown, Disabled Spenddown, Pregnant Women Spenddown, Under Age 18 Spenddown, and Unemployed Parent Spenddown.

- **Note G:** Recipients were selected from across the State in the following Medicaid eligibility aid categories: Aid to the Aged, Aid to the Disabled, and ARKids.

### Source

Arkansas Department of Human Services documents
disaster recovery plan. In addition, the ANSWER server’s operating system was not adequately controlled, and its firewall was inadequate to detect or prevent changes to the system. As a result, DHS developed policies to address user access and updated its disaster recovery plan in April 2012; however, the plan had not been tested as of October 2012. Computer system deficiencies could result in loss of information integrity and improper payments on behalf of ineligible Medicaid recipients.

**Management Response**

DHS implemented several initiatives designed to increase both eligibility processing efficiency and accuracy, including: conversion from paper to electronic case records; development of an on-line electronic application process; and use of centralized processing for specialized programs and high-volume activities. DHS continues to identify opportunities to increase efficiency through computer technology by expanding the use of data matches and information verification hubs.

Because the agency’s review of large claim cases and the DLA audits are both based on samples and targeted groupings, it is highly unlikely in a population as large as the Medicaid caseload that DLA will randomly select the same cases as those identified by MEQC or the local county offices.

DHS conducted several tests of its disaster recovery plan and implemented portions of the plan at various times in response to local disasters. A test of the Business Continuity and Contingency Plan is scheduled for the spring of 2013.

**Summary**

In summary, the DCO error rate for recipient eligibility ranged from 3.27% to 15.48% from SFY09 through SFY12. This variation in error rates partially resulted from DLA changes to sample population selection. In SFY09, DLA staff modified past audit procedures to focus on those recipient aid categories that DLA determined to be “high-risk.” Factors used to determine level of risk included number of eligibility criteria, average per claims payments, and past audit history. The error rate for high-risk categories for SFY09 was 15.48%.

Due to the high error rate, the same categories were selected as the sample population for the SFY10 audit. Results showed an improvement in the overall error rate for recipient eligibility, which dropped to 6.67%. In SFY11, DLA staff continued to examine those areas previously noted as high-risk, and the error rate dropped to 3.27%.

Continual improvement in error rate over the three-year period resulted from improved DCO staff training and monitoring of those recipient aid categories previously determined to be high-risk. With improvement seen in those areas, DLA staff chose other aid categories for review in SFY12. The result was an increase in error rate to 14.09%. This increase resulted from differing aid categories being determined high-risk and highlighted recipient aid categories on which DCO should continue to focus.

A summary of testing of recipient eligibility is provided in Exhibit I on page 6.

In addition, DCO’s internal controls relating to staffing, monitoring, and ANSWER access are insufficient to adequately reduce the risk of approving ineligible applicants.

**Provider Eligibility and Payments**

**Overview**

DMS is comprised of several layers of management and departments, each with its own responsibilities (see Appendix A on page A-1). Many of these departments are federally-mandated and developed to safeguard against fraud, waste, and abuse and to establish the policies that govern the Medicaid Program. DMS also contracts with other DHS divisions and third-party vendors, such as a fiscal agent.
Medicaid benefit payments are made to eligible enrolled providers for delivery of goods or services to Medicaid-eligible beneficiaries. All provider activity and enrollment information is housed in MMIS. Enrollment criteria for each provider type are based on federal and state laws and regulations outlined in the Medicaid provider manuals. Providers' enrollment applications and documentation are reviewed by the DMS Program and Provider Management and Contracting Units, and newly-enrolled providers, on a sample basis, are subject to a quarterly DMS review to ensure all provider-specific requirements are met.

**Enrollment Process**

Potential providers submit an application, fees, and documentation to the fiscal agent. The fiscal agent then searches various databases to ensure that the provider has not been terminated, sanctioned, or debarred by Medicare or state entities. The fiscal agent also performs a complete background search utilizing LexisNexis and searches the website of the Office of Inspector General (OIG) for HHS to ensure that sanctions or negative actions have not been issued to or taken against the potential provider. If the search reveals sanctions or negative actions, the potential provider's file is forwarded to the DMS Program and Provider Management Unit for further review. Otherwise, the provider is assigned a unique identification number in MMIS, and DMS approves enrollment.

**Billing and Payment Processes**

Once an enrolled provider has determined a recipient is Medicaid-eligible and has delivered the appropriate goods or services to the recipient, the provider has 12 months from the date of first service to file an electronic or paper claim with the fiscal agent. Some exceptions apply for beneficiaries eligible for both Medicaid and Medicare. Once a claim has been submitted, the fiscal agent electronically verifies that the beneficiary is Medicaid-eligible based on information in ANSWER, which DCO updates daily.

The fiscal agent processes each week's accumulated claims during a weekend cycle, and payout for those claims is the following Thursday. Several payment methods exist. The fee for service method reimburses the provider at an agreed-upon rate for particular goods or services each time they are delivered to an eligible beneficiary. Some providers (e.g., hospitals) are reimbursed at a daily rate per bed. Capitated payments (i.e., fees for non-emergency transportation) and case management by primary care physicians constitute a flat monthly rate, regardless of delivery of goods or services.

The claim information goes through a series of edit and audit checks to mitigate the risk that payments will be made for goods or services for which the beneficiary is ineligible. Additional post-payment audits and reviews are conducted by the PI Unit, Utilization Review, and third party contractors. Rejected claims are sent back to the provider for correction or to another approving department at DHS. The original claim submission is maintained in MMIS. When an overpayment is detected, an adjustment or recoupment of funds is requested. If fraud is detected, the case is referred to the Medicaid Fraud Control Unit (MFCU), a division of the Arkansas Attorney General’s Office.

While most transactions are processed as described above, a third-party financial intermediary receives payment for services prior to delivery for certain provider types. PALCO, the financial intermediary for Home and Community-Based Service providers, receives funds from DMS prior to delivery of services. Providers submit documentation to PALCO, which assists in the claims process and is responsible for withholding payroll taxes from payments made to Home and Community-Based Service providers. PALCO receives a pre-calculated amount from DMS, rather than an amount based on
services rendered. DMS provided DLA staff with a description of PALCO’s process for refunding prospective payments after a client’s case has been closed; however, it appears that prospective payments and refunds are not reconciled by DMS.

Management Response

PALCO is the financial intermediary for Home and Community Based Services (“HCBS”) Medicaid programs administered by the DHS Division of Aging and Adult Services (DAAS). Each month PALCO reconciles prospective payments and actual services provided (and reported) by HCBS programs to DAAS/DMS and refunds any overpayments to the fiscal agent.

DHS has various processes and internal controls to monitor payments made to HCBS providers. In the past 5 years, 4 separate DHS offices or units audited or reviewed PALCO at least once. In addition, CMS reviewed PALCO.

We are not aware of any substantial questioned cost related to PALCO’s performance of its contract.

Findings

DLA has noted a number of issues with regard to provider enrollment and payment over the past several years.

In SFY10, DLA staff conducted procedures as part of the Statewide Single Audit to verify provider eligibility. DLA discovered that a provider operating under the Alternative for Adults with Physical Disabilities (APD) program also served as caregiver for an individual receiving services; this provider/caregiver arrangement is not allowed by the APD program. In SFY10, payments for services totaling $28,305 were disallowed for this provider and are subject to recoupment.

Management Response

DHS agreed with this SFY 2010 Single Audit finding and referred the finding to Medicaid’s Program Integrity Unit (“PI Unit”) for investigation and resolution. The PI Unit made a formal overpayment finding and initiated recoupment. The provider appealed, but died before the hearing could be held. As a result, no further action was taken and case was closed.

After DLA released the final SFY 2010 Single Audit Report, CMS contacted DHS about this finding (which is part of the normal CMS follow up process). Because DHS agreed with DLA, DHS paid CMS the federal portion of $28,305 and closed the matter.

DLA’s audit was helpful in constructing a corrective action plan, which in this case included additional processes and internal controls to strengthen the enrollment process for HCBS programs, especially related to caregivers/legal guardians. (E.g., more information on application forms, certification of application data, cases pulled for review, and data mining.)

As a result of this discovery, further understanding of the Arkansas Medicaid Program, and the risk of fraud, DLA staff conducted additional procedures for the APD program during SFY11. The Arkansas Medicaid Provider Manual and service agreements for APD require providers to meet certain documentation requirements to receive Medicaid payments. DLA staff reviewed 64 provider files to determine if supporting documentation existed for the payments received by providers. In 53 cases (82.81%), discrepancies resulted in insufficient information to determine if the service was rendered in accordance with requirements. For SFY11, payments to these 53 providers totaled more than $1.3 million; in all, 2,609 APD providers received payments totaling $31.3 million. Without documentation of services, it is impossible to determine what, when, and where services were delivered to Medicaid beneficiaries and whether delivery of services complied with state and federal requirements. As a result of this finding, DMS amended the APD provider manual by removing references to service agreements.
Management Response

Of the 53 cases DLA identified, DHS agreed with only 1 finding, a case that DHS identified and corrected before the audit.

Of the 52 other cases identified in finding, 45 had “lack of documentation” findings.

DLA contends that in-home caretakers providing consumer-directed services must document each function performed. Such documentation is common for provider-directed care and services. (In some circumstances Medicaid not only reviews task-specific documentation, but also prior-authorizes care plans as a condition of payment.)

However, for consumer-directed home care, CMS and DHS agree that the question is whether the consumer actually received the care he or she determined was necessary on that day. Accordingly, DHS requires documentation of: 1) each caregiver’s arrival and departure times; and 2) each consumer’s certification that the caregiver provided care in accordance with the consumer’s directions.

The remaining 7 cases were cited as “unable to locate provider.” DHS located all 7 providers.

CMS contacted DHS about DLA’s findings, and requested only that DHS return the federal portion of the one finding that DHS identified before the audit.

Though DHS disagreed with the audit findings, the findings shed light on policy areas that needed improvement. Accordingly, DHS amended the Medicaid Provider Manual to clarify the policies.

Also during SFY11 and SFY12, DLA staff reviewed records maintained by case managers associated with the beneficiaries and providers noted previously to ensure that those case managers were following procedures identified in the Medicaid provider manuals.

In SFY11, DLA staff examined files for 20 Home and Community-Based Service case managers in the APD Program. Of the 20 files, 18 (90%) did not contain adequate documentation that services were provided in accordance with program requirements, and questionable benefit payments totaled $7,770. In SFY11, 6,468 Medicaid recipients received Home and Community-Based case management services with total benefits costs of $7 million based on the MMIS Medicaid universe provided to DLA in July 2011.

Management Response:

DHS concurred with this finding that Case Managers must maintain more detailed documentation.

DHS repaid the federal share of $7,770 and implemented corrective actions including more statewide training for Case Managers and monthly on-site audits of Case Managers.

In SFY12, DLA staff examined files for 90 Home and Community-Based Service providers in four programs (i.e., Independent Choices Waiver Program, Elder Choices Waiver Program, Alternative Community Service Waiver Program, and Personal Care) due to continued risk. The review revealed that 55 (61.11%) had inadequate documentation that services had been delivered in accordance with program requirements. For SFY12, payments to those 55 providers totaled over $1.3 million. In all, 411 providers served 18,499 individuals and received a total of $274.6 million for SFY12.

In addition, DLA staff found that 25 of 30 case manager records examined (83.33%) did not contain adequate documentation that services had been provided to Medicaid beneficiaries; providers were paid approximately $33,000 for these services.

Shown in Exhibit II on page 11 are the results of DLA testing of provider files for adequate documentation in SFY11 and SFY12.
Management Response

Note: Legislative audits provide the greatest benefit to DHS when they examine difficult program categories and complicated processes, because those are the areas most in need of attention and innovation. General ongoing monitoring is of course important, but focusing on problem areas is more cost-effective. It should be remembered, however, that even when audits review a statistically valid sample in a focus area, the audit findings rarely form a basis to make conclusions outside that area.

This section relates to a “draft” SFY 2012 DLA Single Audit finding to which DHS will respond via the normal interactive process. Therefore, this comment is preliminary and subject to revision.

DHS will continue to review documents provided recently to support DLA’s findings for:

Personal Care
ElderChoices, and

Alternative Community Services.
(All “draft” findings related to Independent Choices have been cleared through normal interactive process.)

Beginning in September 2008, DMS policy changes required provider disclosure of business ownership and criminal convictions; however, DLA noted that these disclosures had not been made by providers selected for testing in 2009 and 2010. DLA staff found that a current Medicaid provider had been convicted in 2000 in federal court of possession of sexually explicit material involving sexual exploitation of a minor. Section 142.100 of the Arkansas Medicaid Provider Manual requires that providers immediately notify the Medicaid Provider Enrollment Unit in writing regarding any change to their application or contract, such as conviction of a crime. DMS was made aware of this issue in early 2012, and as of the date of this report, DHS has not requested that the provider make the required disclosures. A report generated in September 2012 showed that for the first eight months of 2012, 70% of

Exhibit II
Arkansas Medicaid Program
Results of Testing for Documentation
Selected Home and Community-Based Service Provider Files
State Fiscal Years 2011 and 2012

Note 1: One program tested: Alternative for Adults with Physical Disabilities. For SFY11, the term “providers” refers to individuals who both perform and bill for services.

Note 2: Four programs tested: Independent Choices Waiver Program, Elder Choices Waiver Program, Alternative Community Service Waiver Program, and Personal Care. For SFY12, the “number of providers tested” refers to individuals who perform services.

Source: Arkansas Department of Human Services documents

<table>
<thead>
<tr>
<th>Year Tested</th>
<th>Number of Providers Tested</th>
<th>Number of Provider Files Without Proper Documentation</th>
<th>Error Rate</th>
<th>Amount Paid to Providers Without Proper Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011 (Note 1)</td>
<td>64</td>
<td>53</td>
<td>82.81%</td>
<td>$1,317,466</td>
</tr>
<tr>
<td>2012 (Note 2)</td>
<td>90</td>
<td>55</td>
<td>61.11%</td>
<td>$1,335,817</td>
</tr>
</tbody>
</table>
this provider’s Medicaid recipients were under age 18. Since reenrollment on August 1, 2006, this provider has received $489,813 in benefit payments as of January 11, 2013.

Management Response

This section relates to the draft SFY 2012 DLA Single Audit.

Nothing in the provider’s history suggests any impropriety related to the practice of medicine or the delivery of care to Medicaid patients. Nevertheless, the DLA recommends that DHS require the provider to report a conviction that is already known. In determining whether to impose a sanction or terminate the provider’s Medicaid provider agreement, DMS considered the following:

1) Because DMS has knowledge of the provider’s conviction, no purpose would be served by requiring disclosure now;

2) The State Medical Board reinstated the provider’s practice privileges having knowledge of the provider’s conviction and Ark. Code Ann. § 17-95-409(a)(2)(A)(i), which authorizes the Board to revoke the medical license of any physician who is convicted of “any crime involving moral turpitude or ... a felony.” The State Medical Board, not DMS, determines whether a person is qualified and fit to practice medicine. DMS will not substitute its judgment for the Board’s by prohibiting the provider from delivering health care services to Medicaid recipients.

DMS sanctions providers for rule violations in order to mitigate any harm resulting from the violation, and to deter similar conduct in the provider pool at large. Imposition of sanctions in this case would advance neither of those goals.

Other Issues

In addition to the recipient eligibility and provider eligibility and payment issues previously discussed, DLA staff have noted lack of restricted access to DHS’s network and the MMIS system, Health Insurance Portability and Accountability Act (HIPAA) violations, an interpretation of the Medicaid Fairness Act by DHS that limits overpayment recoupment, and program integrity issues. These issues are discussed in the sections below.

System Access

According to the report Information Technology Control Weaknesses Found at the Arkansas Department of Human Services, issued in February 2012, the OIG for HHS cited DHS for seven access vulnerabilities, including data encryption, remote access, and physical security weaknesses.

In SFY10, DLA staff conducted testing on the MMIS system and noted that of 17 software change requests reviewed, 7 could not be located, and 3 lacked appropriate approval signatures. These deficiencies place the confidentiality, integrity, and availability of Medicaid information at risk and could potentially allow unauthorized access to beneficiaries’ personal data.

Management Response

As a result of these findings, DHS, as part of its corrective action plan, revised and continues to review the formal approval process to implement additional signature requirements by a system administrator at the three critical stages of the development/programming process.

HIPAA Violation

In SFY12, DLA staff discovered that an individual had unrestricted access to protected health information and distributed it to another non-state entity. This individual redirected the flow of information from MMIS to a non-state entity through a change request submitted to the fiscal agent with no other approval required. Confidentiality or user agreements did not exist for this individual or the other entity, in violation of HIPAA. As a result, DMS has taken action to have all users complete agreements as necessary, and access to the individual has been suspended.
Management Response

This section relates to DLA’s draft SFY 2012 Single Audit.

DHS mistakenly believed the individual identified was a Department of Education (DOE) employee. DMS’ belief was based upon, among other things, individual’s completed security form indicating that she was a state employee and her state email address. After individual accessed the Medicaid Management Information System (MMIS) it was learned that she was an employee of Medicaid in the Schools (MITS).

Upon learning of the disclosures to MITS, the privacy officer investigated and determined that no breach occurred as that term is defined by HIPAA because the incident did not pose a significant risk of financial, reputational, or other harm to the affected individuals.

After discovering the mistake, DMS implemented corrective actions such as new access controls and quarterly data security audits.

Centers for Medicare and Medicaid Services: Comprehensive Program Integrity Review

Section 1936 of the Social Security Act requires the Medicaid Integrity Group (MIG), a division of CMS, to provide support and assistance to state Medicaid program integrity efforts. To fulfill this requirement, MIG began conducting comprehensive program integrity reviews in 2006.

MIG conducted a comprehensive program integrity review of the Arkansas Medicaid Program for federal fiscal year 2009. This review focused on the activities of DMS, which is responsible for Medicaid program integrity in Arkansas.

The Medicaid Integrity Program: Arkansas Comprehensive Program Integrity Review, issued by CMS in February 2011, is provided in Appendix B on pages B-1 through B-16.

According to this report, DHS applies several effective program integrity practices:

- Requiring personal care attendants to have individual provider numbers
- Performing unannounced onsite investigations
- Holding quarterly meetings with MFCU and involving other agencies in fraud cases
- Utilizing a national information data system for provider enrollment

This report also noted the following program integrity deficiencies:

- 42 C.F.R. § 456.3 requires the State to administer a statewide surveillance and utilization (SUR) control program to prevent unnecessary or inappropriate use of Medicaid services and excess payments of Medicaid funds, evaluate the quality of Medicaid services, and provide for the control and utilization of inpatient services and of all Medicaid services provided under the plan.
- Although the State uses timeline analysis to detect patterns in provider billing, the PI Unit does not generate systematic analysis from an active SUR program. As a result, the State does not have a program in place to effectively and proactively analyze medical care and service delivery data, which is demonstrated by the fact that the majority of investigations result from complaints.
- A SUR program would assist the State with recouping funds, which the Medicaid Fairness Act hinders the PI Unit from doing until it can establish a “pattern of waste, fraud, and abuse.” The Act may prevent the State from recovering overpayments to providers, but it does not prevent the federal government from recovering
the federal share of overpayments from the State. The State is placed at a disadvantage because it must return federal funds, although it may have no way to recover the funds from a provider.

Management Response

CMS has reviewed and certified DHS’ Medicaid Management Information System (“MMIS”), of which SUR is a mandatory component. The issue appears to be the Program Integrity Unit’s use (or lack of use) of the existing SUR system. DHS will establish a work plan for the PI Unit to generate systematic analysis from the SUR program.

Medicaid Fairness Act

The Medicaid Fairness Act of 2005, codified as Ark. Code Ann. §§ 20-77-1701 — 20-77-1716, is intended to ensure that DHS and its outside contractors treat providers fairly and follow due process. Specifically, DHS cannot use a technical deficiency as grounds for recoupment unless identifying the deficiency as an overpayment is mandated by a specific federal statute or regulation or the State is required to repay the funds to CMS.

DHS interprets the Medicaid Fairness Act to prohibit extrapolating error rates to the sample population to determine potential provider overpayments. Therefore, the PI Unit can recoup overpayments based only on cases it has reviewed.

Management Response

The Medicaid Fairness Act: 1) prohibits most recoupments based on technical deficiencies; and 2) restricts Medicaid recoupments to claim-specific adverse actions for which specific facts and grounds are stated. DHS will be happy to discuss these and any other provisions of the Medicaid Fairness Act that DLA finds are limiting appropriate recoveries of Medicaid funds.

Program Integrity

According to HHS’s FY 2012 Agency Financial Report issued November 15, 2012, CMS has two broad responsibilities under the Medicaid Integrity Program (MIP). The first responsibility is to hire contractors to review Medicaid provider activities and audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues. The second responsibility is to provide effective support and assistance to states in their efforts to combat Medicaid provider fraud, waste, and abuse.

Federal regulations require that a state’s Medicaid agency have a method to verify whether services reimbursed by Medicaid were actually furnished to beneficiaries. Federal regulations also grant CMS oversight responsibility for the verification method established. In Arkansas, the PI Unit serves this function. The PI Unit’s self-assessment of its activities for federal fiscal year 2009 is provided in Appendix C on page C-1.

DLA staff noted three restrictions that inhibit the PI Unit’s effectiveness.

- The Director of the PI Unit does not report directly to the DMS Director or the DHS Director (see Appendix A on page A-1 for organization chart).
- At the request of management, the PI Unit did not issue six reports regarding Home and Community-Based Service providers that included improper payments totaling $79,921. Total payments to those providers were in excess of $1.8 million.
- Management’s interpretation of the Medicaid Fairness Act does not allow results of the PI Unit’s provider field reviews to be extrapolated to the sample population to determine provider overpayments subject to recoupment.
Management Response

DHS strongly agrees with the importance of an effective investigative capability within Medicaid to ensure compliance with program requirements and to identify and address realized or potential waste, fraud and abuse. CMS allows states to determine the organizational placement and reporting relationships of Medicaid investigatory resources. In Arkansas, the Medicaid PI Unit is located in the Program and Provider Management section of the Division of Medical Services at DHS. The office of the manager of the Medicaid PI Unit is two doors down from the office of the DMS Director. The PI Unit manager is free to contact the Director to discuss investigations, reports, or policy concerns, and has done so a number of times over the past year. These conversations include informal, unscheduled one-on-one discussions as well as more formal and larger meetings.

The PI Unit completed and issued 410 reports in SFYs 2010, 2011, and 2012. The amount collected to date from these reports totals over $3.8 million, nearly the same as the final questioned costs. Over that same timeframe, the number of reports that the PI Unit completed but did not issue before DLA’s review included 6 provider numbers and total questioned costs of $79,921.36. Upon review, DHS determined that no clear violation could be shown for 4 of the 6 providers, and those 4 cases have now been closed with no request for refunded payments from providers.

The PI Unit referred 1 of the 2 remaining reports to the Medicaid Fraud Control Unit (MFCU) at the Office of the Attorney General. However, the MFCU has now returned that report to the PI Unit, which will initiate recovery on $486.00 in questioned costs. DMS issued the second of the 2 remaining reports, questioning $3,803.52, on 1/14/13.

APPENDICES

Appendix A – Organizational Chart – Arkansas Department of Human Services – Division of Medical Services

Appendix B – Department of Health and Human Services – Centers for Medicare and Medicaid Services – Medicaid Integrity Program – Arkansas Comprehensive Program Integrity Review – Final Report – February 2011

Appendix C – Centers for Medicare and Medicaid Services – Federal Fiscal Year 2009 State Program Integrity Assessment (SPIA) – State of Arkansas
Source: Arkansas Department of Human Services, Division of Medical Services
Department of Health and Human Services
Centers for Medicare & Medicaid Services

Medicaid Integrity Program
Arkansas Comprehensive Program Integrity Review
Final Report

February 2011

Reviewers:
Barbara Davidson, Review Team Leader
Bonnie Harris
Eddie Newman
Eddie Sottong
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INTRODUCTION

The Centers for Medicare & Medicaid Services’ (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Arkansas Medicaid Program. The MIG review team conducted the onsite portion of the review at the Division of Medical Services (DMS) offices and the office of the Medicaid fiscal agent. The review team also met with the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of DMS, which is responsible for Medicaid program integrity in Arkansas. This report describes one noteworthy practice, three effective practices, five regulatory compliance issues, and three vulnerabilities in the State’s program integrity operations.

THE REVIEW

Objectives of the Review

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

Overview of Arkansas’ Medicaid Program

The DMS, within the Department of Human Services, administers the Arkansas Medicaid program. As of January 1, 2009, the program served a total of 634,704 beneficiaries, all of whom were enrolled in fee-for-service (FFS). Medicaid expenditures during State fiscal year (SFY) 2009 were $3,208,308,484. The State had 26,029 participating providers. The Federal medical assistance percentage (FMAP) for Arkansas for Federal fiscal year (FFY) 2009 was 72.81 percent. However, with adjustments attributable to the American Recovery and Reinvestment Act of 2009, the State’s effective FMAP was 79.14 percent in the first three quarters of FFY 2009 and 80.46 percent in the fourth quarter.

Program Integrity Section

The Program Integrity Unit (PI Unit), within DMS, is the organizational component dedicated to fraud and abuse activities. At the time of the review, the PI Unit had 34 full-time equivalent staff focusing on Medicaid program integrity. However, DMS was not conducting its statewide surveillance and utilization system responsibilities. The table below presents the total number of investigations, identified overpayments, and amounts recouped in the past four SFYs as a result of program integrity activities. In some years the overpayments collected exceed the amounts identified due to the lag in collecting overpayments and the results of national global settlements.
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Table 1

<table>
<thead>
<tr>
<th>SFY</th>
<th>Number of Preliminary Investigations*</th>
<th>Number of Full Investigations**</th>
<th>Amount of Overpayments Identified</th>
<th>Amount of Overpayments Collected</th>
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<td>2005</td>
<td>10</td>
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<td>2006</td>
<td>59</td>
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<td>2007</td>
<td>105</td>
<td>105</td>
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<tr>
<td>2008</td>
<td>88</td>
<td>88</td>
<td>$297,587.65</td>
<td>$293,216.44</td>
</tr>
</tbody>
</table>

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.
**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.

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

During the week of January 11, 2010, the MIG review team visited the DMS, fiscal agent, and MFCU offices. The team conducted interviews with numerous DMS officials, the State’s provider enrollment contractor, and the MFCU director. Finally, to determine whether non-emergency medical transportation (NEMT) providers were complying with contract provisions and other Federal regulations relating to program integrity, the MIG team interviewed NEMT staff. In addition, the team conducted sampling of provider enrollment applications, selected claims, 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 DMS as they relate to program integrity but also considered the work of other components and contractors responsible for a range of program integrity functions including provider enrollment and NEMT.

Arkansas operates a Medicaid expansion Children’s Health Insurance Program (CHIP) under Title XIX of the Social Security Act. The expansion program operates under the same billing and provider enrollment policies as the Arkansas Medicaid program. The same findings, vulnerabilities, and effective practices discussed in relation to the Medicaid program also apply to the expansion CHIP.

Unless otherwise noted, Arkansas 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 DMS 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.

*Personal care attendants (PCAs) are required to have individual provider numbers*
Arkansas Medicaid requires individual PCAs to enroll as regular Medicaid providers, allowing the State to track the activities of PCAs. Each PCA enrollee must meet the same requirements as do other FFS providers. In addition, the PCA must submit time sheets reflecting arrival and departure times from the beneficiary’s home, either to the division that operates the program or the fiscal agent, as a condition of payment. The PCAs must also re-enroll annually.

Effective Practices
As part of its comprehensive review process, the 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. Arkansas reported *unannounced onsite investigations*, quarterly meetings with the MFCU, and use of a national information database during the provider enrollment process.

*Unannounced onsite investigations*
The PI Unit conducts unannounced onsite investigations for all cases where it has a reason to question billings submitted by Medicaid providers. The majority of field investigations are generated from complaints. The PI Unit conducts field investigations with a nurse and one other staff person, either an investigator or an accountant. Desk reviews are normally not conducted due to concerns with providers altering records. Onsite investigations allow the PI Unit to have access to original records, as well as allow the PI Unit to detect problems and educate the provider while onsite. In SFYs 2007 and 2008, the PI Unit performed an annual average of 95 investigations resulting in a total collected overpayment of $546,255. While the PI Unit identified unannounced onsite investigations as an effective practice, and MIG finds the practice commendable, a combination of onsite investigations and desk reviews could be even more effective and would allow more providers to be reviewed.

*Quarterly meetings with the MFCU and involvement of other agencies in fraud cases*
The Arkansas PI Unit conducts quarterly meetings with the MFCU. In addition, informal meetings are conducted whenever the need arises. If fraud is detected during the PI Unit’s record/case review, the MFCU is contacted and an informal meeting is scheduled to determine if the record/case warrants a referral for further investigation. The two agencies have a face to face discussion on every referral prior to the MFCU accepting a case. This collaboration results in the MFCU and the PI Unit agreeing on every case in
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question. This process also allows for immediate feedback to the PI Unit on the
disposition of cases.

The team noted in its sampling activity that PI Unit referrals closely adhered to the
criteria laid out in the “CMS Performance Standard For Referrals of Suspected Fraud
from a Single State Agency to a Medicaid Fraud Control Unit” document issued in
September 2008. Based on the current practice, the MFCU director stated that the MFCU
has accepted all referrals sent from the PI Unit in the past two years.

Additionally, the MFCU and the PI Unit have successfully partnered with other Federal
agencies. On one occasion the PI Unit and the MFCU involved the Food and Drug
Administration and on a second case they brought in an investigator from the Federal
Railroad Administration. The outreach to other agencies is undertaken to strengthen
pending cases and has reinforced the ability of the PI Unit and MFCU to act effectively
against problem providers.

National information data system utilized for provider enrollment
Arkansas has used a commercial national information data system as a provider
enrollment tool since September 2008. Provider enrollment staff at the fiscal agent use
this system to check the applicant enrolling into Medicaid. The information data system
can also be used to see if other corporations are involved with the provider. For example,
the process is effective in seeing if an applicant such as a dentist runs or owns another
business. Use of the national information data system has allowed Arkansas to
significantly enhance its ability to detect individuals whose undesirable actions or past
practices should exclude them from participation in the Arkansas Medicaid program.
Because this system requests the Social Security Number of all employees at a
management level or higher, as well as for the owners of enrolling organizations, it
becomes more difficult for an individual who is committing fraud to close shop and get a
new Tax Identification number (ID). Providers are tracked on a one-to-one level, even
while enrolling under a group. Historically, a group application would be checked only
on the Tax ID for that business. The national information data system allows Arkansas to
determine if any of the owners of that business have issues which would preclude them
from enrollment or if a group that is enrolling does significant business with any other
business that has been sanctioned in the past for fraud or other issues.

Regulatory Compliance Issues
The State is not in compliance with Federal regulations related to the lack of a statewide
surveillance and utilization review (SUR) program, False Claims Act requirements, and required
disclosure and notification activities.
The State does not have a statewide SUR program.
The regulation at 42 CFR § 456.3 requires that the State implement a statewide surveillance and utilization control program that can safeguard against the unnecessary or inappropriate use of Medicaid services and against excess payment of Medicaid funds; assess the quality of those services; provide for the control of the utilization of all Medicaid services provided under the plan; and provide for the control of the utilization of inpatient services.

In 2004, the State Medicaid agency contracted with its fiscal agent to perform SUR activities; however, this contract expired in June 2009. Arkansas’ Medicaid agency has not operated a statewide SUR program that ensures the safeguards as outlined in 42 CFR § 456.3 since that contract ended. During the review, the program integrity director informed the review team that the State agency is close to awarding a SUR contract.

Although the State does analyze provider billing patterns for unusual spikes and trends (i.e., time line analysis), the PI Unit has no systematic analysis being generated from having an active SUR program. Consequently, the State does not have a program in place to effectively and proactively analyze medical care and service delivery data, which is demonstrated by the bulk of their investigations being generated from complaints.

A SUR program would also assist the State agency in regards to the Medicaid Fairness Act, a State law that hinders the PI Unit from collecting recoupments until the State can establish a “pattern of fraud waste or abuse.” The Act may preclude the State from recovering mappropriate overpayments from providers, but it does not preclude the Federal government from recovering the Federal share of such overpayments from the State. This puts the State at a disadvantage because it must return Federal funds when it may have no way to recover the funds from a provider.

Recommendation: Implement a statewide SUR program that ensures the safeguards as outlined in 42 CFR § 456.3.

The State has not complied with the State Plan requirement to review providers’ policies and employee handbooks pertaining to the False Claims Act.
Section 1902(a)(68) of the Social Security Act [42 U.S.C. 1396a(a)(68)] requires a State to ensure that providers and contractors receiving or making payments of at least $5 million under a State’s Medicaid program have: (a) established written policies for all employees (including management) about the Federal False Claims Act, whistleblower protections, administrative remedies, and any pertinent State laws and rules; (b) included as part of these policies detailed provisions regarding detecting and preventing fraud, waste, and abuse, and (c) included in any employee handbook a discussion of the False Claims Act, whistleblower protections, administrative remedies, and pertinent State laws and rules.

Arkansas has a State plan amendment for False Claims education in place; however, the State indicated that it did not begin reviewing providers’ policies and employee handbooks until January 2010. Furthermore, the State indicated that it is conducting compliance reviews only
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with providers receiving at least $10 million rather than $5 million as required by the Act. Arkansas could not show any evidence of reviews that had been conducted, nor did it provide any evidence that it had determined providers or contractors are in compliance with the law.

Although the State’s policy manual was updated regarding false claims requirements in August 2007, Arkansas relies primarily on the respective trade association meetings to make providers aware of False Claims Act requirements. The PI Unit is not an integral part of policy development and, therefore, is not kept abreast of modifications to the provider manual.

Recommendations: Modify and implement procedures to review all entities in accordance with the statute. Involve the PI Unit in the policy development process.

The State does not capture all required ownership, control, and relationship information from the fiscal agent and the NEMT broker.
Under 42 CFR § 455.104(a)(1), a provider, or “disclosing entity,” that is subject to periodic survey under § 455.104(b)(1) must disclose to the State surveying agency, which then must provide to the Medicaid agency, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. A disclosing entity that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. In addition, under § 455.104(c), the State agency may not contract with a provider or fiscal agent that has not disclosed ownership or control information required under this section.

Arkansas has successfully revised its provider applications to address the ownership and control disclosure issues identified in MIG’s last program integrity review in May 2007. However, even though the revised applications address providers and the fiscal agent, the State was unable to provide evidence that the fiscal agent disclosed the required ownership and control information prior to entering into a contract.

In addition, Arkansas’ NEMT contract does not require the broker to disclose the name and address of persons with ownership and control interests in the provider entity or in any subcontractor in which the provider has 5 percent or more interest, nor does it require the disclosure of any other provider in which the owner of the provider entity has ownership or control interest.
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Recommendations: Modify the NEMT contract to require disclosure of ownership, control, and relationship information. Obtain necessary disclosures from the fiscal agent and the NEMT broker.

Arkansas’ provider agreements do not contain all required business transaction language.
(Partial Repeat Finding)
The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or U.S. Department of Health and Human Services (HHS) information about certain business transactions with wholly owned suppliers or any subcontractors. Providers must submit business information within 35 days of a request by the State Medicaid agency or HHS. Although Arkansas has revised its provider enrollment forms since MIG’s 2007 program integrity review to include language relating to 42 CFR § 455.105(b), the provider agreements do not include a statement that the provider agrees to furnish business transaction disclosures within 35 days of a request by the State Medicaid agency or HHS. The 35 day language is a repeat finding from the previous MIG review.

Recommendation: Modify provider agreements to include language specified in 42 CFR § 455.105.

The State does not solicit health care-related criminal convictions from the NEMT broker.
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 application for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify the HHS Office of Inspector General (HHS-OIG) whenever such disclosures are made.

Arkansas’ NEMT contract prohibits the broker from employing anyone if they have been convicted of Medicaid fraud or have been terminated from the Medicaid program, but it does not solicit disclosure of health care-related criminal convictions from the broker.

Recommendation: Modify the NEMT contract to require solicitation of disclosure of health care-related criminal convictions from the broker.

Vulnerabilities
The review team identified three areas of vulnerability in Arkansas’ program integrity practices. These included not conducting monthly exclusion checks, not verifying provider licenses, and inadequate oversight of the NEMT program.

Not conducting monthly exclusion checks.
The Medicaid agency checks the HHS-OIG List of Excluded Individuals/Entities when providers apply to the Medicaid program. However, the State does not check on a monthly basis.
APPENDIX B (Continued)

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thereafter. This practice does not follow the directives on exclusion checking issued in State Medicaid Director Letters of June 12, 2008 (#08-003) and January 16, 2009 (#09-001). The former directed States to conduct monthly exclusion checks on providers, owners and managing employees within the FFS program, while the latter directed the Medicaid agency to require that its providers perform similar checks on employees within their businesses.

Recommendation: Develop and implement policies and procedures to perform monthly checks on Medicaid providers, owners, and managing employees.

Not verifying provider licenses. (Uncorrected Repeat Vulnerability)
Even though a commercial national information data system is used during the enrollment process, the fiscal agent staff interviewed indicated that the fiscal agent does not validate provider licenses as part of the process. In addition, the State’s contract with the fiscal agent does not require verification of provider licenses. This leaves the program vulnerable to enrolling providers with serious restrictions on their licenses and to allowing billings for services that are beyond the limitations imposed on a provider’s license. The lack of license verification could result in enrollment of a provider with a fraudulent license. This vulnerability was cited in Arkansas’ 2007 review and has not yet been corrected.

Recommendation: Modify the fiscal agent contract to require verification of provider licenses during the enrollment process.

Inadequate oversight of the NEMT program.
The NEMT program is particularly vulnerable because of several issues identified by the review team, in addition to the two previously cited regulatory findings related to NEMT.

- Not collecting managing employee information from the NEMT broker and its subcontractors.

Under 42 CFR § 455.101, a managing employee is defined as a “general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency.”

Arkansas’ NEMT contract does not solicit managing employee information during the contracting process, nor does it require the broker to capture managing employee information during the enrollment process of its subcontractors. Thus, the State has no way of knowing if excluded individuals are working for the transportation broker or its subcontractors in such positions as billing managers and department heads.

Recommendation: Modify the NEMT contract to require capture of managing employee information from the transportation broker and its subcontractors.
• Not collecting the full range of ownership and control disclosure information from NEMT providers.

The NEMT broker’s contract with its subcontractors does not require subcontractors to submit the same range of disclosure and ownership information that is required from the State’s FFS providers. In addition, the State-broker contract does not require the broker to capture this information from its network providers.

Recommendations: Modify the NEMT contract to require collection of the same disclosure and ownership information that is required from the State’s FFS providers. Obtain necessary disclosures from NEMT network providers.

• Not requiring disclosure of business transaction information from NEMT providers upon request.

The NEMT broker’s contract with its subcontractors does not require subcontractors to provide disclosure of business transactions upon request of the State Medicaid agency or HHS. In addition, the State-broker contract does not require the broker to capture this information from its network providers.

Recommendations: Modify the transportation broker’s credentialing application to include disclosure of business transaction information upon request. Modify the State-broker contract to require disclosure of the required business transaction information upon request from subcontractors of the NEMT broker.

• Not collecting disclosure of criminal conviction information from NEMT providers.

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 HHS-OIG whenever such disclosures are made. The transportation broker’s credentialing application does not request information on the provider applicant’s criminal convictions. In addition, the State-NEMT contract does not require such disclosure from the broker’s subcontractors.

Recommendations: Modify the transportation broker’s credentialing application to include disclosure of criminal conviction information. Modify the State-NEMT contract to require disclosure from NEMT providers.
CONCLUSION

The State of Arkansas applies one noteworthy practice and three effective practices that demonstrate program strengths and the State’s commitment to program integrity. These practices include:

- requirement for PCAs to have individual provider numbers,
- performance of unannounced onsite investigations,
- quarterly meetings with the MFCU and involvement of other agencies in fraud cases, and
- national information data system utilized for provider enrollment.

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

However, the identification of five areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, three areas of vulnerability were identified. The CMS encourages DMS to closely examine the vulnerabilities that were identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require Arkansas 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 Arkansas 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 Arkansas 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 Arkansas on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.
Official Response of Comprehensive PI Review from Arkansas
June 2011

OFFICIAL RESPONSE FROM ARKANSAS

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June 21, 2011

The following is a detailed response addressing the action already taken by Arkansas to correct the five regulatory compliance issues and three program integrity operation vulnerabilities described in the Arkansas Comprehensive Program Integrity Review.

REGULATORY COMPLIANCE ISSUES

The State does not have a statewide SUR program.
Recommendation: Implement a statewide SUR program that ensures the safeguards as outlined in 42 CFR § 456.3.

State PI Unit Response: DMS has continually had SURS capabilities through the Profiler program, however, prior to this review, the program was not being used to its full potential due in part to system reporting constraints. Since the time of this review, OMS has improved its ability to proactively analyze medical care and service delivery data. In April 2010, the SURS contractor, HP, updated their Profiler program in Business Objects. Program Integrity has two full-time Registered Nurses dedicated to the SURS function who use the Profiler program to analyze data. The PI Unit also established a monthly meeting with our contractor to work with our Medical Director and a SURS nurse to update the case types utilized to analyze claims for predictive modeling. In addition, PI Unit staff meets monthly with our contractor to discuss new trends based on our own data as well national trends and to suggest improvements to the process and programs learned from data analysis. Based on this new approach to the SURS process, PI unit has been able to identify eight cases of over utilization of services and one case rose to the level of potential fraud. This has been referred to MFCU for further investigation.

The State has not complied with the State Plan requirement to review providers’ policies and employee handbooks pertaining to the False Claims Act.
Recommendations: Modify and implement procedures to review all entities in accordance with the statute.

State PI Unit Response*: Beginning in December 2009 and concluding in January 2010, the Program Integrity Unit conducted reviews of all providers receiving $10 million and above. Our reports are complete and no major deficiencies were noted during our review. This threshold was
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set due to lack of staff to complete all tasks required in the PI Unit. During 2011, PI Unit increased the reviews to include all providers receiving between $5 million and $10 million. The field work for these reviews was completed on June 10, 2011 and the program integrity review reports are scheduled to be complete as of June 30, 2011. Systems have been put in place to allow for the timely completion of these reviews in the future.

Though each unit of OMS is responsible for developing policy related to its respective program area, policy development is coordinated by our Program Development and Quality Assurance Unit. The PI Unit participates in policy development by reviewing all proposed changes and making comments before the policy is finalized. If the PI Unit has concerns over policy, the PI Unit may request that the policy be held until a consensus is reached. PI Unit will increase emphasis in participating on the medical policy discussion and plans to institute a sign off process to ensure the revised or new policies were reviewed and commented on by the PI unit.

* Attachment A contains an example of the audit tool utilized during the reviews.

The State does not capture all required ownership, control, and relationship information from the fiscal agent and the NEMT broker.
Recommendation: Modify the NEMT contract to require disclosure of ownership, control, and relationship information. Obtain necessary disclosures from the fiscal agent and the NEMT broker.

State PI Unit Response*: DMS has begun a re-enrollment process of all providers. The providers are required to complete the DMS Disclosure Forms which are reviewed by HP and PI Unit to ensure they meet the requirements to be enrolled. This process will include any vendors or contractors providing services to the Medicaid program. Due to the high volume of providers, we are staggering our re-enrollment process by provider type. We anticipate this process to be complete by December 2011. Additionally, the Division of Medical Services just completed the procurement process for NEMT brokers and the disclosure requirements were added to the contract.

* Attachment C contains the revised NEMT contract.

Arkansas' provider agreements do not contain all required business transaction language. (Partial Repeat Finding)
Recommendation: Modify provider agreements to include language specified in 42 CFR §455.105.

State PI Unit Response*: The Division of Medical Services will comply with this requirement by initiating the promulgation process to add the required language to Medicaid policy and forms. This process is scheduled to begin in July 2011 and will take approximately six to eight months to institute the modifications. This process is currently anticipated to be complete as of December 31, 2011.

* Attachment B contains an example of the wording modifications to be promulgated.
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The State does not solicit health care-related criminal convictions from the NEMT broker. **Recommendation:** Modify the NEMT contract to require solicitation of disclosure of health care-related criminal convictions from the broker.

**State PI Unit Response:** The NEMT Broker contract has been revised to include the requirement of completing disclosure forms for contractors and subcontractors. PI unit will validate this process to ensure compliance during this fiscal year.

*Attachment C contains the revised NEMT contract.*

**VULNERABILITIES**

Not conducting monthly exclusion checks. **Recommendation:** Develop and implement policies and procedures to perform monthly checks on Medicaid providers, owners, and managing employees.

**State PI Unit Response:** The Medicaid agency has taken steps to comply with this directive. The Medicaid policy section 142.50 was implemented on June 1, 2010 to comply with this requirement. The language outlined in our policy is provided below:

142.500 Conditions Related to Fraud and Abuse 6-1-10

D. Providers are obligated to screen all employees and contractors to determine if any of them are excluded from participation in Federal health care programs.

1. Providers can search the LEIE website maintained by the United States Health and Human Services Office of Inspector General which contains the names of any excluded individual or entity (http://www.oig.hhs.gov/fraud/exclusions.asp). The United States General Services Administration maintains a list of excluded providers at https://www.epis.gov. Providers should search the website monthly to capture exclusions and reinstatements that have occurred since the last search.

2. Providers can find a Department of Human Services excluded list on the Arkansas Department of Human Services website at: https://ardhs.sharepointsite.net/EXcludedProvidersList/Excluded%20Provider%20List.html. This list contains the names of any excluded individuals or entities. The Arkansas Department of Finance and Administration, Office of State Procurement, maintains a list of suspended or debarred vendors at: http://www.dfa.arkansas.gov/offices/procurement/guidelines/Pages/suspendedDebarredVendors.aspx

3. If providers discover any exclusion information other than what is provided on the websites, providers should report that information to Provider Enrollment.

4. Providers should check the websites monthly to capture exclusions and reinstatements which may have occurred since the last search.
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Not verifying provider licenses. (Uncorrected Repeat Vulnerability)
Recommendation: Modify the fiscal agent contract to require verification of provider licenses during the enrollment process.

State PI Unit Response: The Medicaid agency is now working with the state licensing entities to obtain clinician and other entities who require a license to practice or to participate in Medicaid program electronically so that we can eliminate the vulnerability and also make our enrollment process more efficient.

Inadequate oversight of the NEMT program.

- Not collecting managing employee information from the NEMT broker and its subcontractors.
  Recommendation: Modify the NEMT contract to require capture of managing employee
- Not collecting the full range of ownership and control disclosure information from NEMT providers.
  Recommendations: Modify the NEMT contract to require collection of the same disclosure and ownership information that is required from the State’s FFS providers. Obtain necessary disclosures from NEMT network providers.
- Not requiring disclosure of business transaction information from NEMT providers upon request.
  Recommendations: Modify the transportation broker’s credentialing application to include disclosure of business transaction information upon request. Modify the State-broker contract to require disclosure of the required business transaction information upon request from subcontractors of the NEMT broker.
- Not collecting disclosure of criminal conviction information from NEMT providers.
  Recommendations: Modify the transportation broker’s credentialing application to include disclosure of criminal conviction information. Modify the State-NEMT contract to require disclosure from NEMT providers.

State PI Unit Response*: As stated previously, DMS has modified the NEMT contract and processes to address each of these stated vulnerabilities.

* Attachment C contains the revised NEMT contract.
### Program Characteristics

**Medicaid Enrollment:** Total: 777,169
- Fee-for-service recipients: 777,169
- Comprehensive managed care: 0
- Primary care case management: 0
- Other: Not Reported

**Organizational structure for Medicaid Integrity:**
- Direct Program Integrity Model

**Activities that the State includes under the scope of Medicaid Integrity:**
- Audits: Investigations, SURS/Data Mining
- Other review enrollment packets that have background issues

**Medicaid Integrity activities that the State conducted:**
- Provider Enrollment, Provider Education/Communications
- Other: Not Reported

**Estimate of expenditures ($) for Medicaid Integrity activities:**
- $1,327,244.49

### Planning

**Staffing:**
- Total number of full-time equivalent employees (FTEs) for all functions considered to be Medicaid Integrity:
  - Audits: Filled: 25, Vacant: 3
  - Investigations: Filled: Not Reported, Vacant: Not Reported
  - SURS/Data Mining: Filled: 2, Vacant: 0
  - Provider Enrollment: Filled: Not Reported, Vacant: Not Reported
  - Provider Education/Communications: Filled: Not Reported, Vacant: Not Reported
  - Other: Not Reported

**Strategic Planning:**
- State has a documented strategic plan to address Medicaid Integrity: For its Fee-For-Service program(s): Yes, For its managed care program(s): Not Applicable

### Prevention

**Total number of participating Medicaid providers:** 16,298
**Number of providers applied for enrollment in Medicaid:** 9,443
**Number of providers denied enrollment in Medicaid:** 3,486

**Pre-enrollment screening conducted on individuals/entities applying for Medicaid provider numbers:** In state licensing board, Out of State licensing board, HHS OIG’s List of Excluded Individuals and Entities (DIE), Choice Point or textbook reviews, Criminal background investigations, Credentialing, Check if provider has another provider number under which the provider made inappropriate payments
**State maintains its own list of providers who have been involuntarily dis-enrolled:** Yes

### Investigation and Recovery

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<th>Referrals to Law Enforcement</th>
<th>Number of referrals accepted by the BFPU</th>
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<td>Number of referrals made to the BFPU</td>
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<table>
<thead>
<tr>
<th>Provider Suspensions &amp; Sanctions</th>
<th>State suspends provider payments due to inappropriate or fraudulent activities:</th>
<th>Yes</th>
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<td>State imposes provider sanctions due to inappropriate or fraudulent activities:</td>
<td>Not Reported</td>
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<tr>
<td>Cost Avoidance</td>
<td>State calculates the dollars cost avoided from providers that withdrew due to program integrity concerns:</td>
<td>No</td>
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<tr>
<td>State calculates the dollars cost avoided from providers that withdrew due to changes in payment systems:</td>
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<td></td>
</tr>
<tr>
<td>State receives cost avoidance dollars due to policy changes:</td>
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<td></td>
</tr>
</tbody>
</table>

**Total recoveries ($) from provider audits:**
- Desk Audits: Not Reported
- Field Audits: $579,751.00
- Provider Self-Audit: Not Reported
- Combination Desk/Field audits: Not Reported
- Cost Report Audits: Not Reported

**Total:** $579,751.00

**Overpayments ($) identified as a result of provider audits:**
- Desk Audits: Not Reported
- Field Audits: $3,847,328.00
- Provider Self-Audit: Not Reported
- Combination Desk/Field audits: Not Reported
- Cost Report Audits: Not Reported

**Total:** $3,847,328.00

**Total dollars recovered from ALL Medicaid Integrity activities:** $6,906,884.00

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Source: U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services