Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Arkansas Comprehensive Program Integrity Review

Final Report

February 2014

Reviewers:
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Executive Summary and Introduction

Note: This review was conducted prior to the transition of the program integrity function in Arkansas from the Division of Medical Services to the Office of the Medicaid Inspector General.

The Centers for Medicare & Medicaid Services (CMS) regularly conducts reviews of each state's Medicaid program integrity activities to assess the state's effectiveness in combating Medicaid fraud, waste, and abuse. Through state comprehensive program integrity reviews, CMS identifies program integrity related risks in state operations and, in turn, helps states improve program integrity efforts. In addition, CMS uses the reviews to identify noteworthy program integrity practices worthy of being emulated by other states. Each year, CMS prepares and publishes a compendium of findings, vulnerabilities, and noteworthy practices culled from the state comprehensive review reports issued during the previous year in the *Program Integrity Review Annual Summary Report.*

The purpose of this review was to determine whether Arkansas's program integrity procedures satisfy the requirements of federal regulations and applicable provisions of the Social Security Act. A related purpose of the review was to learn how the State Medicaid Agency receives and uses information about potential fraud and abuse involving Medicaid providers and how the state works with the Medicaid Fraud Control Unit (MFCU) in coordinating efforts related to fraud and abuse issues. Other major focuses of the review include but are not limited to: provider enrollment, disclosures, and reporting; program integrity activities including pre-payment and post-payment review, methods for identifying, investigating, and referring fraud, appropriate use of payment suspensions, and appropriate monitoring of False Claims Act education.

The review of Arkansas's program integrity activities found the state to be in compliance with many of the program integrity requirements. However, the review team did note the state's Medicaid program is at risk because it has a number of vulnerabilities in its program integrity activities. Ranked below in order of risk to the program these are:

1) Inadequate program integrity oversight and activities, including: not having a written work plan, not having adequate policies and procedures, not monitoring False Claims Act education, and not having any Division of Medical Services – Program Integrity Unit (DMS-PI) involvement into decisions regarding Medicaid Management Information System (MMIS) edits.
2) Inadequate attention to fraud and abuse detection and referral, including not referring all suspected provider fraud to the MFCU, not making timely referrals to law enforcement, not maintaining proper documentation, and insufficient coordination with the MFCU.
3) Ineffective provider enrollment practices and reporting, including but not limited to, failing to properly capture disclosure information at enrollment and failing to implement key provisions of the Affordable Care Act related to provider screening and enrollment.

These risks include instances of regulatory non-compliance by the state as well as areas where the state does not have adequate program safeguards, creating a risk to the Medicaid program. These issues and CMS's recommendation for improvement are described in detail in this report.

CMS is concerned that several of the issues described in this review were also identified in CMS's 2010 review and are still uncorrected. CMS will work closely with the state to ensure that all issues, particularly those that remain from the earlier review are satisfactorily resolved as soon as possible.

Methodology of the Review

In advance of the onsite visit, the review team requested that Arkansas complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as state program integrity infrastructure, provider enrollment and disclosure activities, fraud and abuse detection, interagency and intra-agency relationships, and oversight of managed care and other special programs. A three-person team reviewed the responses and materials that the state provided in advance of the onsite visit. The review team also conducted an in-depth telephone interview with representatives from the MFCU.

During the week of April 22, 2013, the CMS review team visited the Division of Medical Services (DMS) offices. The team conducted interviews with numerous DMS officials as well as with staff from the fiscal agent. In addition, the team conducted sampling of provider enrollment applications and program integrity cases and other primary data to validate Arkansas's program integrity practices.

Scope And Limitations of the Review

This review focused on the activities of the DMS-PI within the Department of Human Services, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment. Arkansas operates its Children's Health Insurance Program (CHIP) as a Medicaid expansion program. The expansion program operates under the same billing and provider enrollment policies as the Arkansas Medicaid program. For this reason, the same risks 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-PI provided.

Medicaid Program Integrity Unit

In Arkansas, the DMS-PI is the organizational component dedicated to fraud and abuse activities. At the time of the review, DMS-PI had 33 full-time equivalent positions allocated to Medicaid program integrity functions. The table below presents the total number of preliminary and full investigations, and the amount of identified and collected overpayments related to program integrity activities in the last four complete state fiscal years (SFYs).

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified***	Amount of Overpayments Collected***
2009	170	121	$3,847,328	$1,548,467
2010	199	135	$4,446,524	$1,634,594
2011	233	151	$3,843,145	$1,948,736
2012	278	124	$7,891,586****	$449,860 ****

*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.
***Overpayments identified and collected are based on the results of audits and investigations. They do not include global settlements.
****The increase in overpayments identified in 2012 as compared to the prior years was due to one audit that had an estimated overpayment of over $4 million. The state did not have an explanation as to why the amount of overpayments collected in 2012 was less than the prior years.

Results of the Review

The CMS review team found a considerable number of regulatory compliance issues and vulnerabilities related to program integrity in Arkansas's Medicaid program. Several of the issues are significant and represent risks to the integrity of the state's Medicaid program. These issues fall into three major categories of risk as outlined and discussed below. To address them, Arkansas should improve oversight and build more robust program safeguards.

RISK 1: Inadequate program integrity oversight and activities, including: not having a written work plan, not having adequate policies and procedures, not monitoring False Claims Act education, and not having any DMS-PI involvement into decisions regarding MMIS edits.

The DMS-PI did not have a written work plan that outlines strategic goals to help guide the state's endeavor in combating Medicaid fraud and abuse. Because the state did not have a written work plan, it is unclear whether or not the state gives priority to high risk provider types or high risk services; how DMS-PI is involved in programs outside of the State Medicaid Agency such as personal care services, non-emergency medical transportation, and other home and community based services waiver programs; or how DMS-PI's resources will be used to address these areas. In addition, a number of high and moderate risk provider types are not being audited to detect overpayments or fraudulent activities. Without a written work plan, it will be difficult for the state to proactively target provider types and service areas where the risk of fraud and abuse remains an ongoing concern and to effectively utilize staff resources.

Additionally, the DMS-PI had a policy and procedure manual that only consisted of a list of applicable federal regulations. The manual did not include detailed step by step instructions for staff to use in handling fraud and abuse complaints. Also, the manual did not provide any direction to DMS-PI staff on how to interact with other divisions when undertaking program integrity activities; how to identify aberrant billings; how to open and conduct preliminary investigations; or how to prepare cases for referral to the MFCU. The absence of written criteria leaves the state vulnerable to inconsistent operations and ineffective functioning in the event the state loses experienced program integrity or provider enrollment staff.

Another weakness identified in the state's program integrity oversight involves its monitoring of provider compliance with False Claims Act education requirements. Section 1902(a)(68) of the Social Security Act requires a state to ensure that providers and contractors receiving or making Medicaid payments of at least $5 million annually provide their employees and contractors with information on the federal False Claims Act and the whistleblower protections it requires. In

Arkansas, the Medicaid State Plan section covering False Claims Act education states that DMS-PI will identify any new entities meeting the payment threshold requirement by December 31 of each year and request an attestation certifying that the entity meets the requirements of the regulation. The DMS-PI is supposed to validate the attestations on a sample basis each year as part of its provider review activities. During the onsite visit, Arkansas was able to provide reports documenting how many entities received payments of more than $5 million in federal fiscal years 2011 and 2012. However, the state noted it had not performed any look behind activities since 2010 to verify that these providers were furnishing the appropriate education. This is a repeat risk from the 2010 CMS review.

Finally, it should be noted that at the time of the review, the function of utilization review had been moved out of DMS-PI. Although the audit and investigative work done by program integrity staff offers them considerable insight into MMIS edits and screens that might catch problematic billings, DMS-PI has much less opportunity to provide input on MMIS edits and safeguards.

Recommendations:

- Develop a written work plan that identifies key issues and available resources and share the work plan across the state agencies involved in Medicaid. Ensure that the work plan addresses program integrity involvement in programs outside of the State Medicaid Agency including non-emergency medical transportation, home and community based services, and other special programs.
- Develop written policies and procedures for key program integrity activities to meet the regulatory requirements and program weaknesses described in this report.
- Implement compliance reviews to ensure appropriate providers are meeting the False Claims Act education requirements as detailed in the Social Security Act and the Medicaid State Plan.
- Develop a process to ensure that DMS-PI is consulted on decisions to implement or revise MMIS edits and audits.

RISK 2: Inadequate attention to fraud and abuse detection and referral, including not referring all suspected provider fraud to the MFCU, not making timely referrals to law enforcement, not maintaining proper documentation, and insufficient coordination with the MFCU.

The Memorandum of Understanding (MOU) between DMS and the MFCU confirms that DMS must refer to the MFCU any matter in which DMS suspects fraud or abuse involving the Medicaid program in order to comply with the regulation at 42 CFR 455.15. During case sampling, the review team identified a durable medical equipment provider case that involved what appeared to be a credible allegation of fraud. However, there was no documentation in the case file to indicate that it was referred to or discussed with the MFCU during quarterly meetings.

Moreover, cases that were referred to the MFCU contained incomplete and inconsistent documentation in the file, making logical tracking of the cases impossible. The team reviewed eleven cases referred to the MFCU since March 25, 2011. Of these, six cases did not have a written response from the MFCU. The DMS-PI and MFCU staff meet at least quarterly to discuss

the status of ongoing cases as well as potential referrals. Through this process, the MFCU indicates whether or not they are interested in a case. However, there are no minutes or notes taken at these meetings, and cases are not documented to reflect the decisions made at these meetings.

The state is also not making timely referrals to the MFCU as required by 42 CFR 455.23(d)(2)(i). In three of the eleven cases sampled in Arkansas, the review team noted that there was a delay between when the payment suspension was enacted and when the case was sent to the MFCU. These delays were 2 business days, 32 business days, and 41 business days, respectively.

Further, the state is not obtaining a quarterly certification from the MFCU to continue payment suspensions in accordance with the regulation at 42 CFR 455.23(g)(3)(ii). During case sampling, the team reviewed all cases the state referred to the MFCU since March 25, 2011. None of the cases involving a payment suspension included a quarterly certification from the MFCU that the suspension should continue.

Additionally, the MOU between DMS and the MFCU has not been updated since May 31, 2010. The MOU only addresses referrals of suspected cases of provider fraud under 42 CFR 455.21 and not the payment suspension requirements at 42 CFR 455.23 that became effective on March 25, 2011. This may be a contributing factor to the issues the team observed in the state's payment suspension process. In September 2013, the HHS-OIG conducted an onsite review of the Arkansas MFCU which also found issues with the MOU. Per HHS-OIG, the MOU did not include "language to reflect current law. . ., specifically. . . the regulation [at 42 CFR 455.23] that allows for suspending provider payments based on a credible allegation of fraud."[1]

The MFCU accepted only 10 cases referred by the state agency from federal fiscal years 2009 – 2012. This figure includes zero referrals in federal fiscal year 2010 and amounts to an average of fewer than three referrals per year. In addition, the MFCU Director indicated that less than 1% of the MFCU's cases come from the State Medicaid Agency. These numbers are low for a program with expenditures totaling more than $5 billion and a program integrity unit with 33 full time equivalents. For example, in federal fiscal year 2011, similar sized Medicaid programs referred between 17 and 30 cases to the MFCU. The September 2013 HHS-OIG MFCU review also found that the number of state agency referrals "was a relatively small number for a 3-year period given the size of the State program and the number of participants and providers."[2]

Neither DMS, its sister agencies, or the MFCU conduct any type of cross component fraud and abuse training. This could be a useful way of helping program staff identify potential cases for discussion with DMS-PI and training new staff in DMS-PI in how to pursue case investigations and develop appropriate MFCU referrals. It might also offer the MFCU guidance in how to identify Medicaid fraud schemes. The general lack of training may be a contributing factor to the low number of fraud cases being developed and referred to the MFCU.

[1,2] HHS-OIG, *Arkansas State Medicaid Fraud Control Unit: 2013 Onsite Review*, OEI-06-12-00720 (September 2013).

Recommendations:

- Refer all cases of suspected fraud to the MFCU. Develop and implement policies and procedures to refer cases to the MFCU no later than the next business day after a payment suspension is enacted.
- On a quarterly basis, request a certification from the MFCU that any matter accepted on the basis of a referral continues to be under investigation thus warranting continuation of a payment suspension.
- Strengthen communication between the state agency and the MFCU by amending the MOU with mutual goals and expectations.
- Conduct periodic trainings that involve DMS, sister agencies, and the MFCU to improve staff skills concerning how to identify and investigate fraud, waste, and abuse and how to develop cases with the goal of increasing the number of referrals to the MFCU.

RISK 3: Ineffective provider enrollment practices and reporting, including but not limited to, failing to properly capture disclosure information at enrollment and failing to implement key provisions of the Affordable Care Act related to provider screening and enrollment.

Ownership and Control Disclosures

Arkansas failed to properly capture ownership and control information required by the regulations at 42 CFR 455.104 during the enrollment process. The Ownership and Conviction Disclosure form (DMS-675) used for all provider types did not solicit the required enhanced address for corporate entities as described at 455.104(b)(1)(i) which must include, as applicable, the primary business address, every business location, and P.O. Box address. The form only solicits "Address". In addition, the name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest is not requested as required by 455.104(b)(3).

During the 2010 CMS review, the state was not collecting ownership and control interest disclosures from non-emergency medical transportation brokers or the fiscal agent. Since then, brokers and the fiscal agent have been required to complete the same DMS-675 form so that the state can collect the appropriate disclosures. However, as mentioned above, the form is not compliant with the regulation.

Business Transaction Disclosures

The Arkansas Medicaid provider agreements did not contain language that the provider agrees to furnish information related to business transactions within 35 days of request by the State Medicaid Agency or the Secretary of the Department of Health and Human Services as required by 42 CFR 455.105. This issue remains uncorrected from the CMS 2010 review.

Enrollment and Screening of Providers

Arkansas is not requiring all enrolled providers to be screened under 42 CFR 455 Subpart E. Arkansas's State Plan Amendment implementing the Affordable Care Act's provider screening

and enrollment requirements became effective on July 1, 2012. Since that time, the state has enrolled 4,705 providers that were not screened under this subpart. The state indicated that it will not begin implementing these provisions until July 1, 2013.

Additionally, the state agency had not yet begun to enroll all ordering or referring physicians or other professionals providing services as participating providers in accordance with 42 CFR 455.410(b). The state indicated that it will begin enrolling these providers after July 1, 2013.

Verification of Provider Licenses

The state's fiscal agent does not have a method to verify the validity of a provider's license as required by the regulation at 42 CFR 455.412(a). Providers are required to submit a copy of a valid license at enrollment. However, the only time a provider license is verified is when it is out of date or contains an apparent flaw such as altered text or unreadable or incomplete information.

Termination or Denial of Enrollment

The state does not have a method to check for terminated providers at enrollment with Medicare or any other state Medicaid or CHIP program as required by the regulation at 42 CFR 455.416(c). This leaves the state at risk for having terminated providers in its program.

Application Fee

The State Medicaid Agency is not collecting application fees from enrolling institutional providers not already enrolled by Medicare or another State Medicaid Agency as required by the regulation at 42 CFR 455.460. The state enrolled 1,764 Medicaid-only institutional providers since the State Plan Amendment became effective on July 1, 2012 without collecting the appropriate application fees.

Site Visits

At the time of the review, the state had not conducted pre or post-enrollment site visits of moderate or high risk providers nor had a method to determine if a site visit was performed within the prior 12 months by Medicare, another state Medicaid or CHIP program to ensure that information submitted to the state was accurate and complied with the requirements of 42 CFR 455.432. The state agency had drafted limited, moderate and high risk provider categories that it planned to put into effect on July 1, 2013, but provided no information on how it plans to screen providers based on categorical level of risk or undertake site visits when required by the regulation.

Exclusion Searches

During a provider enrollment demonstration, the team observed that only providers were searched for exclusions and debarments against the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE) and the

Excluded Parties List System (EPLS)[3]. These searches occurred upon initial enrollment but they were not performed on a monthly basis as required by the regulation at 42 CFR 455.436. The Social Security Administration's Death Master File was not checked at the time of enrollment.

In addition, it was not clear that other disclosed parties were searched against the required databases. All names listed on the Ownership and Conviction Disclosure form are searched through a vendor site. However, a review of literature of the vendor's product indicates that while they search hundreds of financial, legal, licensure, and law enforcement databases, it does not include searches of the LEIE, EPLS, or Death Master File. This is a repeat risk from the 2010 CMS review.

Recommendations: This section included eight regulatory compliance issues, three of which were repeat issues from the 2010 review. The state should ensure that all compliance issues are addressed by undertaking the following:

- Collect the full range of ownership and control disclosures from providers and the fiscal agent during the enrollment process.
- Modify all provider agreements to require business transaction disclosures upon request.
- Develop policies and procedures to implement the new provider enrollment and screening requirements as described in the 42 CFR 455 Subpart E. These include requiring all ordering or referring physicians or other professionals to enroll as participating providers; developing methods for verifying provider licenses; terminating providers terminated by Medicare or other state Medicaid or CHIP programs; and collecting application fees from certain Medicaid only providers during enrollment.
- Develop and implement policies and procedures to conduct site visits of moderate and high risk providers or verify that this action was performed within the prior 12 months by Medicare or another state Medicaid or CHIP program.
- Check the exclusion status of providers, persons with an ownership or control interest in the provider, agents, and managing employees against all required federal databases at the time of enrollment and reenrollment. Check the EPLS and the LEIE or MED on a monthly basis to ensure that the state does not pay federal funds to excluded persons or entities.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Arkansas to consider utilizing:

- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute, which can help address the risk areas identified in this report. This includes courses that are periodically held on program integrity fundamentals and on Medicaid provider enrollment. More information can be found at http://www.justice.gov/usao/training/mii/training.html.
- Access the annual program integrity review summary reports on the MIG's website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-

[3] In July 2012, the EPLS was migrated into the new System for Award Management (SAM).

Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html. These reports contain information on noteworthy and effective program integrity practices in states. We recommend that Arkansas review the noteworthy practices on provider enrollment and disclosures and the effective practices in program integrity and consider emulating these practices as appropriate.

- Consult with other states that have gone through the process of creating an OIG model to discuss best practices and lessons learned.
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Consult with other states on the Regional Program Integrity Directors calls to generate ideas for cross-training opportunities as well as to obtain examples of program integrity policies and procedures and a comprehensive MOU with the MFCU.
- Use the program integrity and MFCU modules on the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts.
- Work with the assigned CMS MIG State Liaison to discuss program integrity issues and request technical assistance as needed.

Summary

Arkansas applies some effective practices that demonstrate program capabilities and the state's commitment to program integrity. CMS supports Arkansas's efforts and encourages it to look for additional opportunities to improve overall program integrity. However, the identification of significant areas of risk and numerous findings of non-compliance with federal regulations is of great concern and should be addressed immediately. CMS is also particularly concerned about uncorrected, repeat problems that remain from the time of the agency's last comprehensive program integrity review.

To that end, we will require the state to provide a corrective action plan (CAP) for each of the areas of concern within 30 calendar days from the date of the final report letter. The CAP should address all specific problems identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will occur and identify which area of the state is responsible for correcting the issue. The state should provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. Please provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

CMS looks forward to working with Arkansas to build an effective and strengthened program integrity function.

Official Response from Arkansas
March 2014

Office of the
Medicaid Inspector General

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March 11, 2014

Peter Leonis
Director of the Division of Field Operations
Peter.Leonis@cms.hhs.gov

Dear Mr. Leonis,

The Arkansas Office of the Medicaid Inspector General and the Arkansas Department of Human Services, Division of Medical Services are hereby sumitting the Arkansas Medicaid Program Integrity Comprehensive Program Integrity Review Corrective Action Plan Proposal. This proposal is being submitted jointly because of July 1, 2013, the Program Integrity Unit was transferred to the Arkansas Office of the Medicaid Inspector General.

The Risk 1 and Risk 2 deficiencies and recommendations are addressed by the Office of the Medicaid Inspector General. The Risk 3 deficiencies and recommendations are addressed by the Arkansas Department of Human Services, Division of Medical Services based on their retention of provider enrollment functions.

Please feel free to contact me if you have any questions.

Sincerely,

Jay Shue
Arkansas Medicaid Inspector General
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Cc. John Selig, Director, Arkansas Department of Human Services
Andy Allison, DHS, Division of Medical Services, Director