Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Arkansas Comprehensive Program Integrity Review

Final Report

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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.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified	Amount of Overpayments Collected
2005	10	10	$29,693.81	$173,650.52
2006	59	59	$14,278.19	$56,543.93
2007	105	105	$70,762.48	$253,039.30
2008	88	88	$297,587.65	$293,216.44

*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

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 inappropriate 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

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.

***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

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 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 20 I 0, 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

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.
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.

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, 20 II.

* Attachment B contains an example of the wording modifications to be promulgated.

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/fraudlexclusions.asp). The United States General Services Administration maintains a list of excluded providers at https://www.epls.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/procurementlguidelineslPages/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.

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.**