Office of Medicaid Inspector General

Annual Report
October 1, 2014

Jay Shue, Medicaid Inspector General

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Introduction

A. Mission Statement of the Arkansas Medicaid Inspector General

Pursuant to Ark. Code Ann. §20-77-2105, the Office of the Medicaid Inspector General, (OMIG) shall:

(1) Prevent, detect, and investigate fraud and abuse within the medical assistance program;
(2) Refer appropriate cases for criminal prosecution;
(3) Recover improperly expended medical assistance funds;
(4) Audit medical assistance program functions; and
(5) Establish a medical assistance program fraud and abuse prevention.

B. Creation and Statutory Authority

On April 23, 2013, Act 1499 was signed into law creating the Arkansas Office of the Medicaid Inspector General. The legislative purpose of the law was to create a new state agency in order to consolidate staff and other Medicaid fraud detection prevention and recovery functions into a single office, create a more efficient and accountable structure, reorganize and streamline the state's process for detecting and combating Medicaid fraud and abuse, and to maximize the recovery of improper Medicaid payments. *See Ark. Code Ann. §20-77-2101.* Act 1499 contained an emergency clause authorizing July 1, 2013, as the agency starting date.

On June 19, 2013, Governor Mike Beebe appointed Jay Shue to be Arkansas' first Medicaid Inspector General. Before accepting the appointment, Mr. Shue spent six years as the director of the Arkansas Attorney General's Medicaid Fraud Control Unit. Mr. Shue also has approximately ten years of experience as a prosecutor for the State of Arkansas.

With the creation of the Office of the Medicaid Inspector General, the Program Integrity Unit of the Arkansas Department of Human Services, Division of Medicaid Services, and its staff were transferred to the supervision and direction of the Arkansas Medicaid Inspector General. The program integrity functions as required by the Center for Medicaid Services

(CMS) under 42 CFR §455 *et al*. All states that participate in the federal Medicaid program are required to maintain a program integrity function to ensure compliance, efficiency, and accountability within the Medicaid Program by detecting and preventing fraud, waste, and abuse. The Office of the Medicaid Inspector General fulfills that federal requirement.

Pursuant to Ark. Code Ann. §20-77-2106, the Office of the Medicaid Inspector General shall conduct and supervise activities to prevent, detect, and investigate medical assistance program fraud and abuse. Ark. Code Ann. §20-77-2109, requires the Office of the Medicaid Inspector General to submit to the Governor, the President Pro Tempore of the Senate, the Speaker of the House of Representatives, Division of Legislative Audit, Legislative Council, and the Attorney General a report summarizing the activities during the preceding calendar year.

Annual Report Statistics and Information

This annual report contains statistics, data, and information from Fiscal Year 2014 (July 1, 2013 to June 30, 2014) from the Office of the Medicaid Inspector General.

Recoveries/Recoupment

OMIG – Recoveries and Recoupments from Fiscal Year 2014

- Fiscal Year 2014 recoveries of overpayments by OMIG $1,606,742.51
- Fiscal Year 2014 recoupments submitted to DHS Accounts Receivable $2,114,403.28

Audits and Investigations

Fiscal Year 2014 Total Audits/Reviews (July 1, 2013 through June 30, 2014)

Onsite Audits/Reviews	77
Desk Audits/Reviews	1
Desk Reviews utilizing Health Information Technology	51
Desk Reviews – DAAS/DDS Duplicate Payments	204
HCBS Waiver Referral Investigations	15
EOMB Desk Audit	7
	355

For details about Audits and Investigations, see Appendix A.

Administrative Actions

Pursuant to Ark. Code Ann. §20-77-2106 the OMIG may pursue civil and administrative actions against an individual or entity that engages in fraud, abuse or illegal or improper acts within the medical assistance program. Administrative Actions include a number of provider sanctions that result from audits, investigations, and reviews by OMIG.

Fiscal Year 2014 OMIG statistics

- Provider suspensions from the Medicaid Program 19
- Provider terminations from the Medicaid Program 1
- Provider exclusions from the Medicaid Program 13
- Providers placements on pre-pay status in the Medicaid Program 1

For details about Administrative Actions, see Appendix B.

Administrative Appeals

Administrative Appeals occur when Medicaid providers request appeals of the findings of OMIG after an audit or administrative action occurs. Medicaid Providers are entitled to appeal all findings and sanctions pursuant to the Arkansas Medicaid Fairness Act, Ark. Code Ann. §20-77-1702, and pursuant to the Arkansas Medicaid Manual §160.00 et seq.

- Total number Fiscal Year 2014 Provider Appeal Requests 40
- FY14 appeal requests still open/pending 21
    - *FY14 Appeals of OMIG Reports* *15*
    - *FY14 Appeals of CMS MIC Contractor Reports* *6*
- FY14 appeal hearings before Department of Health ALJ 2
- FY14 appeal requests closed 19
    - *FY14 appeal requests settled/appeals withdrawn* *18*
    - *FY14 appeal requests with ALJ decision in favor of OMIG* *1*

Civil Actions

OMIG has the authority to pursue civil and administrative enforcement actions against an individual or entity that engages in fraud, abuse, or illegal improper acts within the medical assistance program. Additionally, OMIG has the authority to initiate and maintain actions for civil recovery including the seizure of property and assets connected with improper payments and entering into civil settlements. *See Ark. Code Ann. 20-77-2106(6).*

Referrals of Fraud and Prosecutions

A. Arkansas Attorney General's Medicaid Fraud Control Unit

Pursuant to Ark. Code Ann. §20-77-2106 the Medicaid Inspector General shall work with the Medicaid Fraud Control Unit (MFCU) of the Office of the Arkansas Attorney General, prosecuting attorneys, and law enforcement agencies. The Medicaid Inspector General refers audit investigations to MFCU when there is a credible allegation of fraud. *See 42 CFR §455.23*.

- In Fiscal Year 2014, fifteen (15) Medicaid provider investigations were referred for consideration to the Medicaid Fraud Control Unit of the Attorney General's Office. For details about Medicaid Fraud Control Unit referrals, see Appendix C.
- Upon referral of a potential case to MFCU, OMIG does not issue its audit report or pursue recoupment until the MFCU action is resolved, however, OMIG does track the original questioned costs of all referrals.
    - Total original questioned cost for 15 FY14 MFCU referrals $1,374,292.39
- In Fiscal Year 2014, the Attorney General's office has charged five individuals with Medicaid fraud based upon Program Integrity Unit and/or Office of the Medicaid Inspector General referrals.
- Additionally, the Attorney General's office obtained three convictions for Medicaid fraud based upon investigations prompted by Program Integrity Unit and/or Office of the Medicaid Inspector General referrals.
- The Attorney General's office has four pending criminal cases set in Fiscal Year 2015 based upon investigations prompted by Program Integrity Unit and/or Office of the Medicaid Inspector General referrals.

B. Other Suspected Fraud Referrals

In addition to referrals of suspected fraud to the Arkansas Attorney General's office, the OMIG shall also make referrals and coordinate efforts with other federal, state, and local law enforcement agencies. *See Ark. Code Ann. §20-77-2106(2).* The OMIG will continue to

coordinate efforts and make referrals to the appropriate law enforcement agencies when criminal fraud is suspected or uncovered during an audit or investigation.

In Fiscal Year 2014, the OMIG referred a case to the Pine Bluff Police Department for investigation and prosecution. OMIG has also consulted with the FBI about a potential criminal investigation.

Administrative and Education Activities

Pursuant to the requirements of Ark. Code Ann. §20-77-2506, the Office of the Medicaid Inspector General has worked diligently to enhance both the administrative and educational activities of the agency, including:

(1) Developing self-disclosure protocols for providers;

(2) Implementing and maintaining a hotline for reporting complaints regarding fraud, waste, and abuse;

(3) Implementing and maintaining an agency website; and

(4) Enhancing provider resources and educational outreach.

A. OMIG Website

On November 21, 2013, the Office of Medicaid Inspector General launched its agency website. The OMIG website includes all information required under the statutory duties and powers of Ark. Code Ann. §20-77-2501, et. al.

- The website URL is: http://OMIG.Arkansas.gov.
- The OMIG hotline number is 1-855-5AR-OMIG (1-855-527-6644)

Features of OMIG website

- Online Referral and Fraud complaint form
- Information regarding audit protocols and corrective action plans
- Medicaid Fraud Hotline information
- Exclusion list of Medicaid providers

- Provider Self-Disclosure Protocol
- Provider Compliance Program
- News about the Office of the Medicaid Inspector General
- Links to other federal and state agencies or resources
- Education on Medicaid fraud, waste, and abuse
- Employment information and link to Arkansas state jobs website

Below is a screenshot of the OMIG website homepage.

In Fiscal Year 2014, OMIG received 23 online complaints and 171 complaints either by the hotline or via email. For November 21, 2013 through September 10, 2014, the OMIG website had 18,287 individual pageviews and 4,181 viewer sessions. For further information regarding website analytics, please see Appendix D

B. OMIG Provider Education

- The OMIG has made a concentrated effort to contact Arkansas provider associations and organizations. The OMIG has attended meetings and scheduled presentations with a number of Medicaid provider organizations, including: Arkansas Residential Assisted Living Association; Arkansas Hospital Association; Arkansas Mental Health Association; Arkansas State Medical Board; and the Arkansas Developmental Disabilities Association. The OMIG is available to any Medicaid providers or associations that have questions or concerns going forward.
- OMIG participates in provider task force meetings and other provider meetings on a regular basis.
- OMIG has placed a greater focus on Corrective Action Plans (CAPs); including providing information on its website about preparing and submitting CAPs and making an increased effort to ensure compliance with a provider's CAP response through follow up audits.
- Field Audit personnel are increasingly providing on-the-spot provider education through entrance and exit conferences during onsite audits.
- OMIG has added numerous provider resources to its agency website, including information on audit protocols, self-disclosure protocols, reconsideration, appeals, corrective action plans, False Claims Act Education compliance, and statutory compliance programs. The provider-specific resources can be found at: http://omig.arkansas.gov/providers.
- Provider education materials and information are available upon request and providers receive education and information through audit reviews, corrective action plans, and observations.

C. OMIG Personnel Education and Training

- On July 8-9, 2013, staff members of the Office of Medicaid Inspector General participated in educational training sessions with staff from MFCU. Additionally, OMIG has conducted mandatory in-service training for OMIG staff on Bates Stamping, Audit Protocols, and the OMIG Complaint/Referral Database.

- On May 19, 2014, OMIG staff participated in a training session with Credible, Inc., a provider of electronic health records software, in order to better understand the capabilities of the system and streamline onsite provider audits that use the Credible software.
- Throughout the year, staff and personnel are encouraged to register and attend federally-funded education courses and classes at the Medicaid Integrity Institute which is located in Columbia, South Carolina. These courses are provided to qualified state employees and are 100% funded by the federal government.
- OMIG has monthly staff meetings with a staff educational component, including power point presentations on various provider types and best audit practices.
- OMIG staff has both attended and presented at local and national conferences pertaining to program integrity, Medicaid policy, and Arkansas Medicaid programs.
- The OMIG has developed and created an OMIG policy manual that addresses work protocols and job expectations, as well as state statutes and policies. The OMIG policy manual will be released in Fiscal Year 2015.

D. Other OMIG Functions and Duties

- OMIG participates in quarterly and as-needed meetings with the Arkansas Attorney General's Medicaid Fraud Control Unit (MFCU). Pursuant to 42 CFR §1007.9, OMIG and MFCU entered into an updated Memorandum of Understanding on February 28, 2014.
- OMIG continues participating in the Centers for Medicare and Medicaid Services (CMS) Medi/Medi program which allows the OMIG to analyze dually eligible beneficiary claims, as well as perform other improper payment analysis from the perspective of both Medicare and Medicaid. OMIG also worked with Medi/Medi contractors on various projects in Fiscal Year 2014 and participates in biannual meetings with the Health Care Task Force which includes local and federal law enforcement
- OMIG participates in Regional Task Force calls with CMS Center for Program Integrity (CPI) and other state Medicaid Inspector Generals and Program Integrity Units.
- Through monthly meetings, OMIG coordinates and collaborates with Health Integrity, the Medicaid Integrity Contractor (MIC) for the State of Arkansas. OMIG and Health Integrity

have worked to develop an efficient and productive strategy for audits to be performed by Health Integrity beginning in Fiscal Year 2015.

- OMIG is working with DHS and OPTUM to help develop the DSS FADS (Fraud and Abuse Detection System). FADS is expected to go live during Fiscal Year 2015.
- Pursuant to Act 259 of the Fiscal Session, OMIG is required to establish an Enterprise Fraud Program which utilizes state of the art technology to detect and prevent fraud, waste, abuse, and improper payments within the Arkansas Medicaid Program. OMIG has been coordinating with both DHS and the Office of State Procurement (OSP) in the development of the Enterprise Fraud Program, including issuing a Request for Information (RFI) and drafting a Request for Proposals (RFP).

OMIG Performance Narrative

Act 1499 of the 2013 Arkansas Legislative session marked a significant change in the regulation and enforcement of the Arkansas Medicaid Program. The creation of the Office of the Medicaid Inspector General provided new opportunities for policy implementation and regulation in order to detect fraud, waste, and abuse in medical assistance programs.

- **OMIG Personnel** - 31 former DHS/DMS positions were transferred under the authority of the OMIG. A number of personnel have been reassigned to address new agency functions that were previously covered by DHS such as: Human Resources; general accounting; purchasing; AASIS certification; and administrative support.
- **Budget and Appropriation Concerns** – OMIG received the same budget appropriation for Fiscal Year 2015 that it did for Fiscal Year 2014. The 2015 budget appropriation will not adequately fund the projected maintenance, operating expenses, and payroll for the operating costs of the OMIG. Additional operating expenses are anticipated in order to adequately operate the OMIG in Fiscal Year 2015.
- **OMIG Audits and Recoupments** - The OMIG has made a concerted effort to improve the overall quality and professionalism of audits, reviews, and investigative reports. OMIG is held to higher standards and prompt reporting requirements in the Arkansas Medicaid

Fairness Act, *Ark. Code Ann. §20-77-1702*, all of which OMIG has met or exceeded. Additionally, OMIG has worked to create protocols and procedures to reduce mistakes and errors in audit, review, and investigation processes and reporting. In response to OMIG's recognition of issues and the new requirements of the Medicaid Fairness Act, OMIG has had an average turnaround time of 90 days on audit reports and 51 days on reconsideration reports in Fiscal Year 2014.

- **OMIG Office Location** – All OMIG staff and administration are now located on the 12th floor of the Tower Building. The OMIG staff was moved at the beginning of August 2014 after many months of work and a complete renovation of the space. Both OMIG and MFCU are already benefitting from the close proximity of the two offices.
- **Provider Resources** - OMIG is working to establish working relationships with providers and provider associations. The OMIG website includes, but is not limited to, Medicaid provider information about audit protocols, self-disclosure programs, corrective action plans, and contact information. OMIG plans to expand the resources available to providers in Fiscal Year 2015. Medicaid providers have access to information and resources that were either not previously available to them or difficult to obtain.
- **Provider Self-Disclosure** - The OMIG has made an effort to form partnerships with Medicaid providers through the self-disclosure program. It is anticipated that the provider self-disclosure program will continue to enhance OMIG's overall efforts to eliminate fraud, waste, and abuse while simultaneously offering Medicaid providers a mechanism or method to reduce their legal and financial exposure. OMIG has created a system going forward to separately track self-disclosures made to the agency and has received 11 self-disclosures in Fiscal Year 2015.
- **Public Complaints** – In Fiscal Year 2014, OMIG received 23 online complaints and 171 complaints either by the hotline or via email. Complaints are reviewed in a timely manner as to whether to open a full audit, refer to the appropriate agency, or other appropriate action.
- **Referrals to Licensure Boards** - Pursuant to Ark. Code Ann. §20-77-2506, the Medicaid Inspector General shall refer information and evidence to regulatory agencies and licensure boards. In Fiscal Year 2014, OMIG made a referral to the Arkansas State Board of Nursing (ASBN) pertaining to an individual in Paragould, AR holding himself out to be a Registered

Nurse Practitioner despite having a suspended license in the State of Arkansas. The referral resulted in an Order to Cease and Desist issued by the ASBN on April 7, 2014.

- **Referral of Beneficiary Fraud for Prosecution** - Pursuant to Ark. Code Ann. §20-77-2106, the Medicaid Inspector General shall make available to appropriate law enforcement information and evidence relating to suspected criminal acts. The OMIG will make referrals and provide information and evidence of suspected beneficiary fraud to appropriate law enforcement agencies and state prosecuting attorneys' offices.
- **OPTUM –** The implementation of the OPTUM DSS FADS and case tracking systems in Fiscal Year 2015 will provide OMIG with a more efficient method for data mining and tracking cases from inception through completion.
- **Enterprise Fraud Program** – OMIG, in conjunction with DHS and OSP, has established and is developing the Enterprise Fraud Program. The Request for Proposal (RFP) for a state of the art technology solution will be released upon approval from CMS.
- **Meeting with CMS** – On September 25, 2014, the Medicaid Inspector General and Chief Counsel traveled to Dallas, TX to meet with the Centers for Medicare and Medicaid (CMS) State Liaison and Audit Liaison for the State of Arkansas. The purpose of this meeting was to discuss oversight of the state with Arkansas' regional contacts and potential joint efforts, as well as discuss issues related to recoupments, appeals, reporting, and MIC audits.
- **Cost Avoidance** – OMIG's recoupments are just one part of addressing fraud, waste, and abuse in the Medicaid program. Cost avoidance, though difficult to quantify, is accounted for through MFCU referrals, provider suspensions, education of providers on correct billing practices, and increased focus on self-disclosures.
- **Deterrence** – OMIG has also focused on preventing particular acts or practices from occurring. A key part of deterrence has been increased visibility and transparency with providers, education, and encouragement of self-disclosure regarding individual bad actors.

Contact Information

Office of the Medicaid Inspector General
323 Center Street, Ste. 1200
Little Rock, AR 72201
501-683-8349
FAX: 501-682-8350
Website: http://omig.arkansas.gov
Hotline: 1-855-5AR-OMIG (1-855-527-6644)

Jay Shue, Medicaid Inspector General
Office of the Medicaid Inspector General
323 Center Street, Ste. 1200
Little Rock, AR 72201
501-537-1590
Jay.Shue@dhs.arkansas.gov

Bart Dickinson, Chief Counsel
Office of the Medicaid Inspector General
323 Center Street, Ste. 1200
Little Rock, AR 72201
501-537-1591
Bart.Dickinson@dhs.arkansas.gov