Office of Medicaid Inspector General

Annual Report
October 1, 2015

Elizabeth Smith, Medicaid Inspector General

TABLE OF CONTENTS

Introduction

Arkansas Office of the Medicaid Inspector General Mission Statement

The mission of the Office of Medicaid Inspector General (OMIG) is to prevent, detect, and investigate fraud, waste, and abuse within the medical assistance program. This mission is achieved through auditing Medicaid providers and medical assistance program functions; recovering improperly expended funds; and referring appropriate cases for criminal prosecution. OMIG works closely with providers and the medical assistance program to prevent fraud, waste, and abuse.

Creation and Statutory Authority

The Office of the Medicaid Inspector General fulfills the federal program integrity requirement to ensure compliance, efficiency, and accountability within the Medicaid program by detecting and preventing fraud, waste, and abuse under 42 CFR §455 *et al.* Prior to 2013, the program integrity function was housed within the Department of Human Services (DHS), Division of Medical Services (DMS). In order to maximize recovery of improper Medicaid payments and create a more efficient and accountable structure, the state's process for detecting and combating Medicaid fraud and abuse was reorganized and streamlined by Act 1499 of 2013. The Act created the "Office of Medicaid Inspector General," a new state agency, by consolidating the program integrity positions from DMS with two new positions of Medicaid Inspector General and its chief counsel to perform the Medicaid fraud detection, prevention, and recovery functions into a single office effective July 1, 2013. *See Ark. Code Ann. §20-77-2501.*

Pursuant to Ark. Code Ann. §20-77-2501, 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 for fraud and abuse prevention.

On June 20, 2015, Governor Asa Hutchinson appointed Elizabeth Smith as Medicaid Inspector General for the State of Arkansas. Prior to this appointment, Inspector General Smith served as chief legal counsel to Governor Hutchinson. Smith has practiced law for over twenty

years, including eight years as associate general counsel for the University of Arkansas for Medical Sciences, two years as an assistant attorney general, two years as an associate for Mitchell Williams Selig Gates and Woodyard representing health care providers, and seven and a half years as deputy prosecuting attorney for the 6th Judicial District of Arkansas.

Annual Report Statistics and Information

According to Ark. Code Ann. §20-77-2509, the Office of the Medicaid Inspector General shall submit a report summarizing the activities of the Office of the Medicaid Inspector General 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 no later than October 1 of each year.

The report shall include, the number, subject, and other relevant characteristics of: (A) Investigations initiated, and completed, including without limitation outcome, region, source of complaint, and whether or not the investigation was conducted jointly with the Attorney General; (B) Audits initiated and completed, including without limitation outcome, region, the reason for the audit, the total state and federal dollar value identified for recovery, the actual state and federal recovery from the audits, and the amount repaid to the Centers for Medicare & Medicaid Services; (C) Administrative actions initiated and completed, including without limitation outcome, region, and type; (D) Referrals for prosecution to the Attorney General and to federal or state law enforcement agencies, and referrals to licensing authorities.

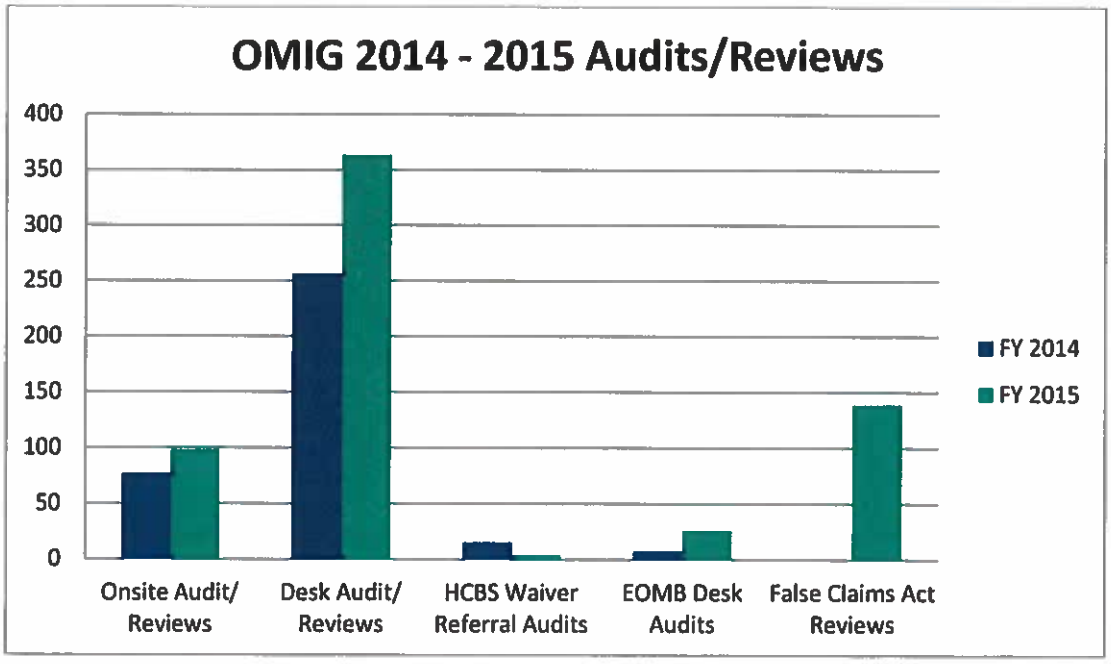
This Annual Report contains statistics, data, and information from Fiscal Year 2015 (July 1, 2014 to June 30, 2015) from the Office of the Medicaid Inspector General and is submitted pursuant to Ark. Code Ann. §20-77-2509.

OMIG Audits and Investigations

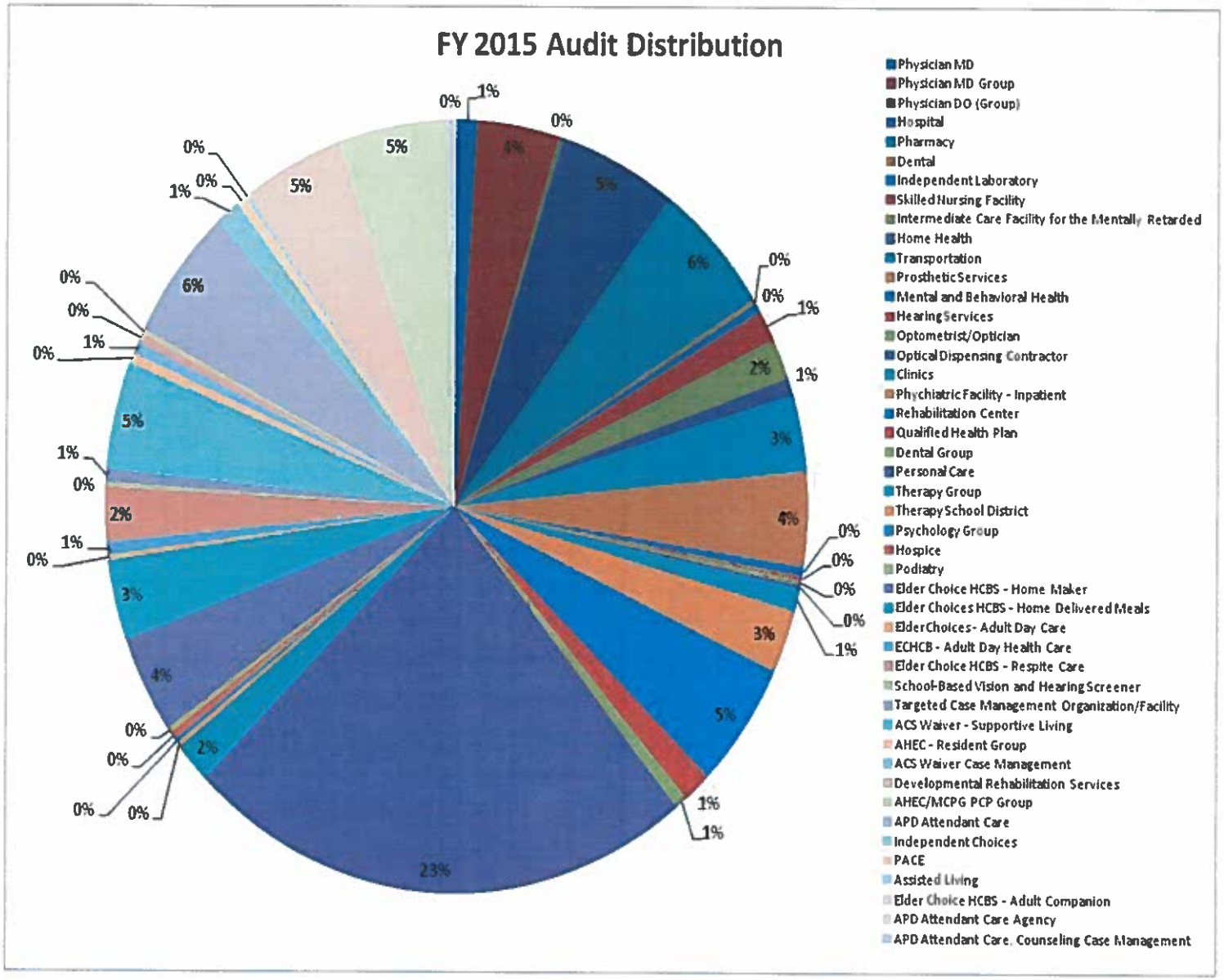
Fiscal Year 2015 Total Audits/Reviews (July 1, 2014 to June 26, 2015)

Onsite Audits/Reviews	**92**
Desk Audits	**175**
Desk Reviews – Date of Death	**54**
Desk Reviews – DAAS/DDS Duplicate Payments	**66**
Desk Reviews – EOMB	**26**
Desk Reviews – Miscellaneous	**46**
HCBS Waiver Referral Investigations	**4***
False Claims Act Compliance Reviews	**139****
Pharmacy Desk Audits (Optum) (3 Field / 20 Desk)	**23**
Medicaid Integrity Contractor Audits (3 Field / 2 Desk)	**5**
	630

For details regarding the OMIG Audits and Investigations, see Appendix A.



* As of January 1, 2015, HCBS Waiver Referral Investigations were merged into Desk Reviews—Miscellaneous.
** False Claims Act Compliance Reviews are now conducted annually after the close of the federal fiscal year.


FY 2015 Audit Distribution
Physician MD
Physician MD Group
Physician DO (Group)
Hospital
Pharmacy
Dental
Independent Laboratory
Skilled Nursing Facility
Intermediate Care Facility for the Mentally Retarded
Home Health
Transportation
Prosthetic Services
Mental and Behavioral Health
Hearing Services
Optometrist/Optician
Optical Dispensing Contractor
Clinics
Phychiatric Facility - Inpatient
Rehabilitation Center
Qualified Health Plan
Dental Group
Personal Care
Therapy Group
Therapy School District
Psychology Group
Hospice
Podiatry
Elder Choice HCBS - Home Maker
Elder Choices HCBS - Home Delivered Meals
ElderChoices- Adult Day Care
ECHCB - Adult Day Health Care
Elder Choice HCBS - Respite Care
School-Based Vision and Hearing Screener
Targeted Case Management Organization/Facility
ACS Waiver - Supportive Living
AHEC - Resident Group
ACS Waiver Case Management
Developmental Rehabilitation Services
AHEC/MCPG PCP Group
APD Attendant Care
Independent Choices
PACE
Assisted Living
Elder Choice HCBS - Adult Companion
APD Attendant Care Agency
APD Attendant Care, Counseling Case Management

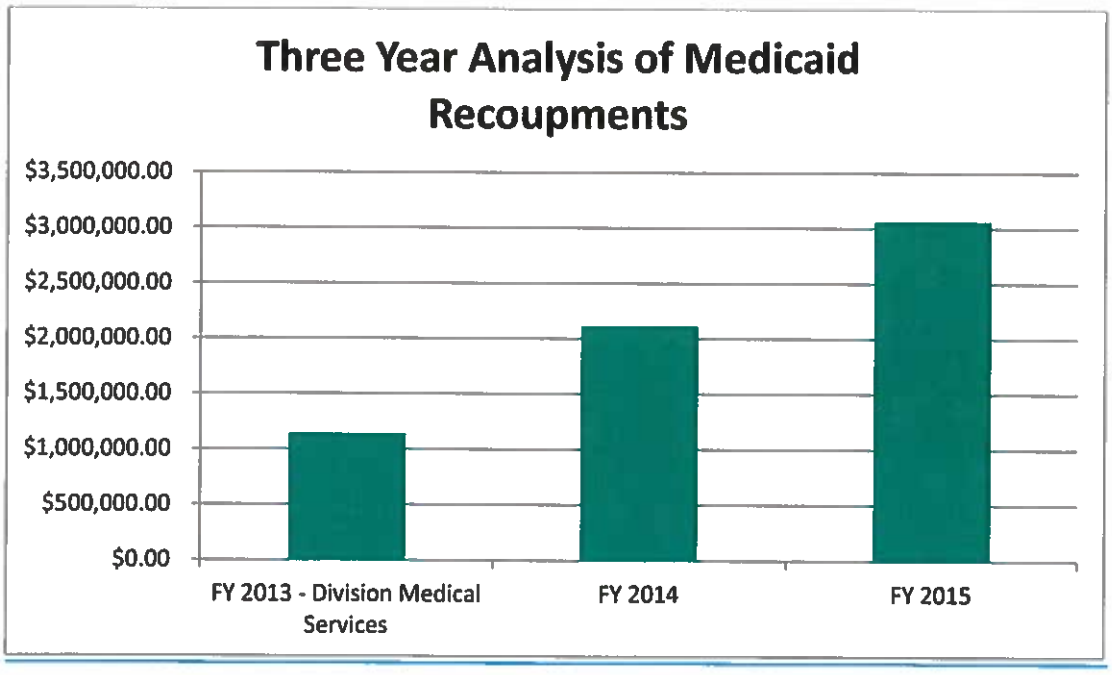
OMIG Recoveries/Recoupment

OMIG – Recoveries July 1, 2014 through June 30, 2015

- Fiscal Year 2015 Recoveries of Overpayments by OMIG **$2,353,079.66**

- Fiscal Year 2015 Recoupments and Reversals of Claims and Payments Submitted to DHS Accounts Receivable **$3,061,890.75**

The graph below is an analysis of Program Integrity's Medicaid recoupments for Fiscal Years 2013 through 2015.

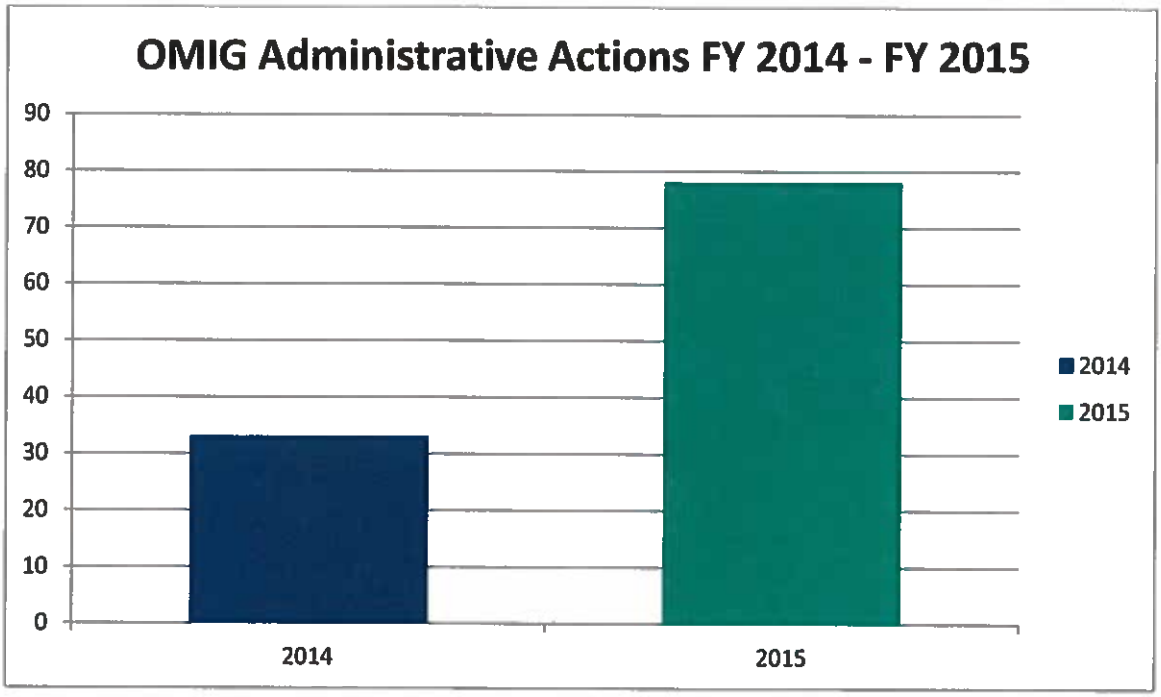


OMIG Administrative Actions

Pursuant to Ark. Code Ann. §20-77-2106, 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 2015 OMIG Statistics

• Provider suspensions[1] from the Medicaid Program	11
• Provider terminations[2] from the Medicaid Program	1
• Provider exclusions[3] from the Medicaid Program	66
Total Administrative Actions	**78**



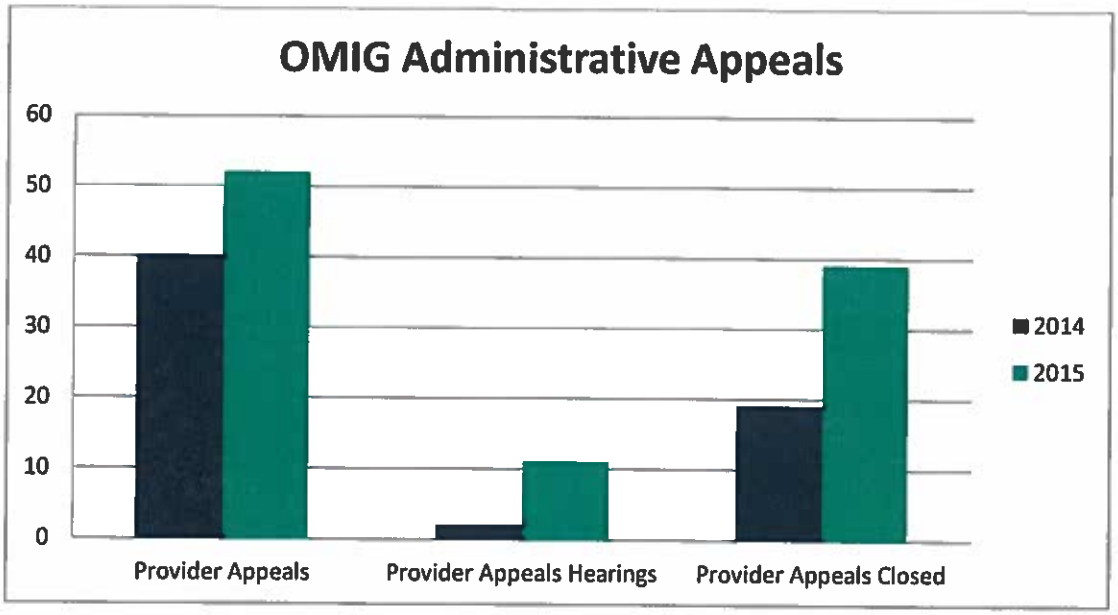
For details regarding Administrative Actions, see **Appendix B.**

[1] A suspension is the withholding of all payments due to a provider until the resolution of a matter in dispute between the provider and the state agency.
[2] A termination is the permanent exclusion from participation in the Medicaid program.
[3] An exclusion is a payment prohibition in which an excluded provider will receive no payment by any state health care program for any items or services furnished, ordered, or prescribed.

OMIG Administrative Appeals

Administrative appeals occur when Medicaid providers request appeals of OMIG findings 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 §160.000 et seq.

• Fiscal Year 2014 Outstanding Provider Appeal Requests	21
• Fiscal Year 2015 Provider Appeal Requests	52
	73
• Fiscal Year 14 Appeal Requests Closed in Fiscal Year 2015	15
• Fiscal Year 15 Appeal Requests Closed in Fiscal Year 2015	24
	39
• Appeals Open/Pending as of June 30, 2015	34
• Total Negotiated Settlement Amount for Fiscal Year 15 Appeals/Reports	**$1,203,401.84**
• Fiscal Year 15 Medicaid Provider Suspensions and Recoupment Hearings	**11**



OMIG Referrals of Fraud and Prosecutions

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 2015, forty-seven Medicaid provider investigations were referred for consideration to the Medicaid Fraud Control Unit of the Attorney General's Office. For further details about Medicaid Fraud Control Unit referrals, see Appendix C.

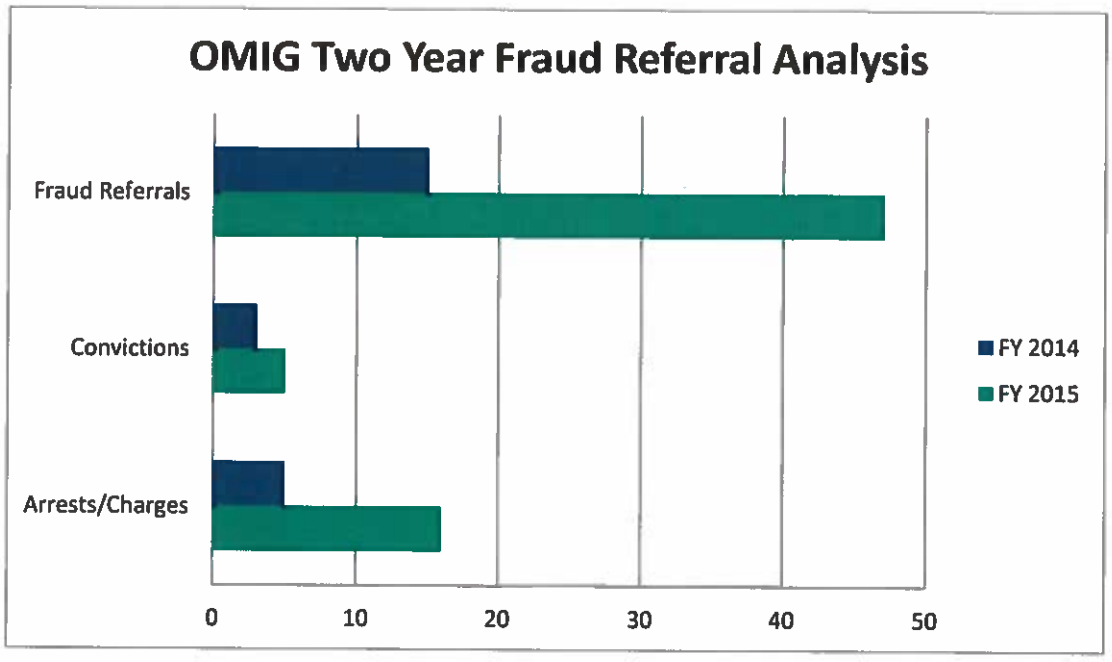
Upon referral of a potential case to MFCU, OMIG may not issue an audit report or pursue recoupment until the MFCU action is resolved. However, OMIG continues to track the original questioned costs of all MFCU referrals.

- Total Original Questioned Cost for FY15 MFCU Referrals **$1,535.537.65**
- Total Original Questioned Cost for FY14 MFCU Referrals $1,374.292.39

In Fiscal Year 2015, the Attorney General's office charged sixteen individuals with Medicaid fraud based upon Program Integrity Unit and/or Office of the Medicaid Inspector General referrals. The previous Fiscal Year 2014 resulted in five individuals charged.

Additionally, the Attorney General's office obtained five convictions for Medicaid fraud based upon investigations prompted by Program Integrity Unit and/or Office of the Medicaid Inspector General referrals. The previous Fiscal Year 2014 resulted in three individuals convicted of Medicaid fraud.

- Total Restitution submitted to DHS based on OMIG and Program Integrity referrals founded on a credible allegation of fraud in Fiscal Year 2015 **$106,540.44**

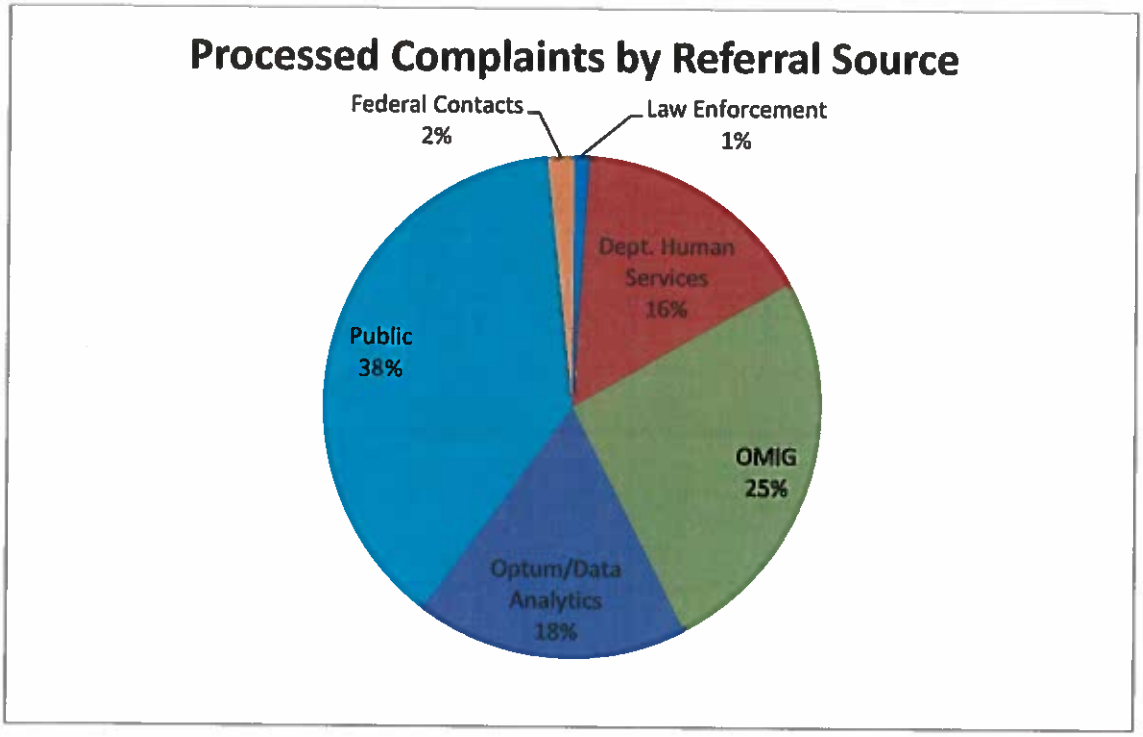


Other Suspected Fraud Referrals

Pursuant to Ark. Code Ann. § 20-77-2106(2), the Medicaid Inspector General shall make available to appropriate law enforcement information and evidence relating to suspected criminal acts. In addition to referrals of suspected fraud to the Arkansas Attorney General's office, 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)*. OMIG refers and provides information and evidence of suspected beneficiary fraud to appropriate law enforcement agencies and state prosecuting attorneys' offices. 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 2015, OMIG referred two cases to the Federal Bureau of Investigation (FBI), and one case of recipient fraud to the Fort Smith Police Department for criminal investigation.

OMIG Complaint and Referral Statistics

In Fiscal Year 2015, OMIG processed 703 complaints and referrals originating from multiple sources. The sources of the processed complaints and referrals are categorized as follows: Law Enforcement; Arkansas Department of Human Services; OMIG internal referrals; Data Analysis and Optum Fraud and Abuse Detection System (FADS) tool analytics; General Public; and CMS Federal MIC Contractor.



In Fiscal Year 2015, OMIG processed 282 complaints and referrals that were initiated by the OMIG Hotline and the Online Complaint tab that is located on the agency website. This represented a significant increase over the previous fiscal year's total number of 194.

Provider Self-Disclosures

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. In Fiscal Year 2015, twenty-nine self-disclosures were made to OMIG for a total of $59,648.14.

False Claims Act Compliance Initiative

OMIG conducted 139 total False Claims Act Compliance Reviews during Fiscal Year 2015. OMIG conducts annual compliance checks to seek a facility's certification to employee education about the False Claims Act. This annual campaign ensures compliance with the Deficit Reduction Act Section 6032 and Section 1902(a)(68) of the Social Security Act regarding the education of false claims recovery to employees.

The Deficit Reduction Act of 2005 established the "Employee Education about False Claims Recovery." The act requires entities that receive or make payments totaling at least $5,000,000 annually during the Federal Fiscal Year approved under Title XIX or under any waiver of such a plan, to provide detailed information to employees about the False Claims Act. This $5,000,000 annual aggregated amount is determined by taxpayer identification number.

The Arkansas Medicaid Provider Manual § 142.800(A)(1) states that a qualifying provider is:

> Any entity, including any Medicaid managed care organization, irrespective of the form of business structure arrangement by which it exists, whether for profit or not for-profit, which receives or makes payments, under a State Plan approved under Title XIX or under any waiver of such plan, totaling at least $5,000,000 annually, regardless of whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

OMIG's False Claims Act Compliance Review during Fiscal Year 2015 prompted first-time qualifying providers to draft required policies and to begin educating their employees about

the False Claims Act. False Claims Act Compliance Reviews are now completed annually after the close of the federal fiscal year per the requirements of the Arkansas Medicaid State Plan.

OMIG Deceased Beneficiary Initiative

In the spring of 2014, the agency began researching and analyzing data and information to address concerns that Medicaid recipients and beneficiaries remained eligible for claims and benefits after their death. OMIG personnel developed claims details, and submitted an initial batch of "date of death" review notification letters to suspected Medicaid providers on July 31, 2014. Subsequent notification letters were sent in September 2014, December 2014, February 2014, and April 2014. In total, fifty-five deceased beneficiary letters were submitted to Medicaid providers. These notifications included letters involving the Department of Human Services, Division of Medical Services transportation contracts, and private option carriers. In total, the OMIG Deceased Beneficiary Initiative led to $508,012.78 in claims and private option premium payments being recouped or reversed.

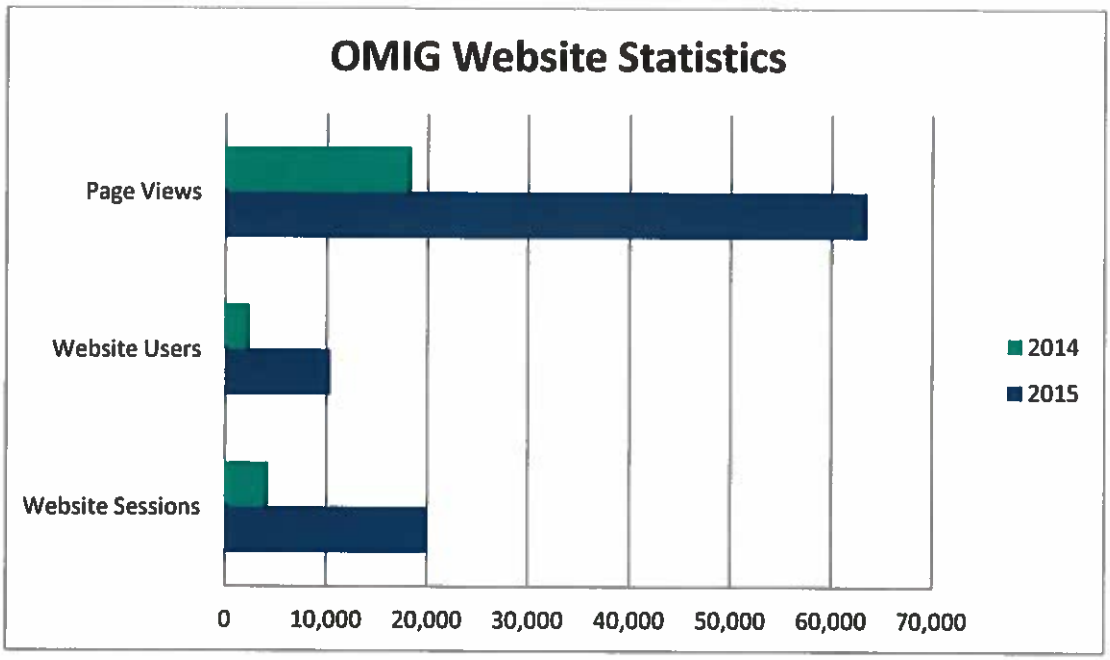
More importantly, OMIG collaborated with the Department of Human Services (e.g., Division of County Operations), the Arkansas Department of Health, and the Division of Medical Services as well as the Medicaid Fiscal Agent, Hewlett Packard, to find a solution and plan to purge the Medicaid rolls of deceased Medicaid recipients. The collaboration's overall objective was to find a quicker turnaround for the removal of Medicaid and private option recipients once they are deceased. The latest data from June 2015 made available by the Division of Medical Services showed private option recoupments due to deceased beneficiaries to be $17,004,022.16.

OMIG Website Information - http://omig.arkansas.gov

Features of OMIG website

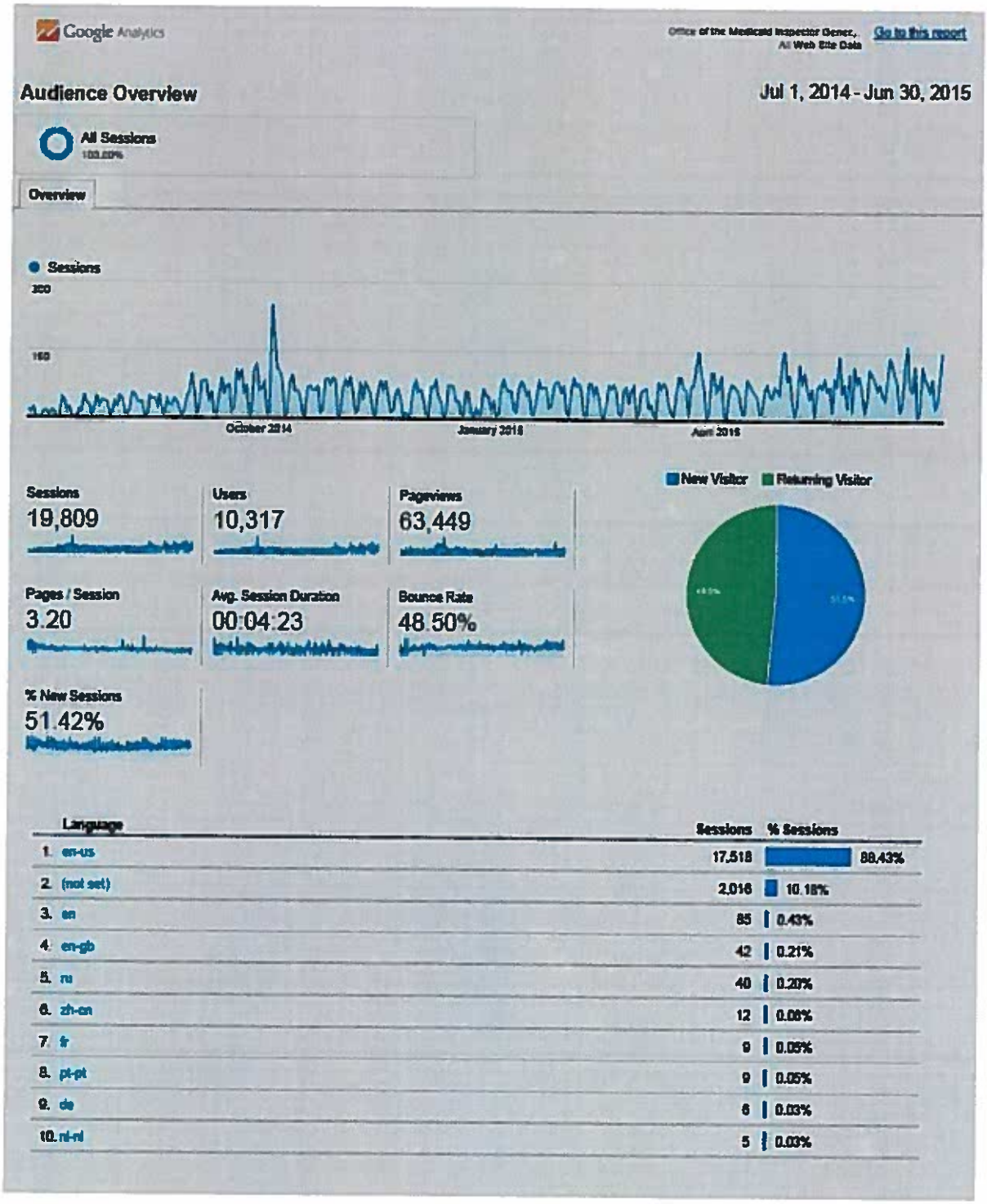
- Online Referral and Fraud complaint form
- Information regarding audit protocols and corrective action plans
- Medicaid Fraud Hotline information
- Exclusion list of Medicaid providers
- Provider Self-Disclosure Protocol
- Provider Compliance Information
- News about the Office of the Medicaid Inspector 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



For July 1, 2014 through June 30, 2015, the OMIG website had 63,449 individual page views and 19,809 viewer sessions.

Website Analytics for Fiscal Year 2015

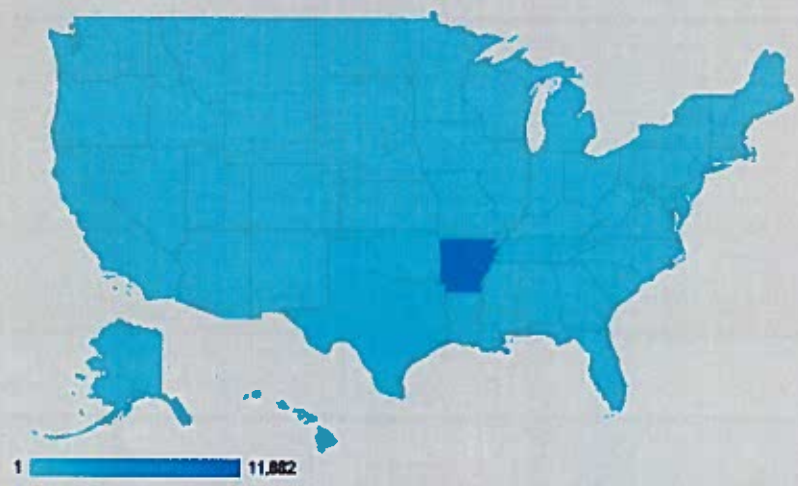


Website Analytics for Fiscal Year 2015

All Sessions

Map Overlay

Summary



Region	Acquisition			Behavior			Conversions		
	Sessions	% New Sessions	New Users	Bounce Rate	Pages / Session	Avg. Session Duration	Goal Conversion Rate	Goal Completions	Goal Value
	18,014 % of Total: 92.94% (19,809)	47.64% Avg for View: 51.42% (-7.34%)	8,582 % of Total: 84.26% (10,185)	44.92% Avg for View: 48.59% (-7.56%)	3.39 Avg for View: 3.39 (0.03%)	00:04:46 Avg for View: 00:04:23 (9.09%)	0.00% Avg for View: 0.00% (0.00%)	0 % of Total: 0.00% (0)	$0.00 % of Total: 0.00% ($0.00)
1. Arkansas	11,882 (65.96%)	34.76%	4,130 (48.12%)	42.24%	3.64	00:05:02	0.00%	0 (0.00%)	$0.00 (0.00%)
2. Texas	782 (4.34%)	68.41%	535 (6.23%)	40.66%	3.25	00:02:21	0.00%	0 (0.00%)	$0.00 (0.00%)
3. Oklahoma	627 (3.48%)	59.97%	376 (4.38%)	44.34%	3.04	00:02:38	0.00%	0 (0.00%)	$0.00 (0.00%)
4. (not set)	583 (3.24%)	96.80%	576 (6.71%)	74.44%	1.33	00:00:48	0.00%	0 (0.00%)	$0.00 (0.00%)
5. Tennessee	562 (3.12%)	66.73%	375 (4.37%)	39.32%	3.36	00:02:48	0.00%	0 (0.00%)	$0.00 (0.00%)
6. California	351 (1.95%)	70.09%	246 (2.87%)	65.24%	2.13	00:01:49	0.00%	0 (0.00%)	$0.00 (0.00%)
7. Missouri	313 (1.74%)	67.94%	214 (2.49%)	41.27%	3.36	00:03:25	0.00%	0 (0.00%)	$0.00 (0.00%)
8. Louisiana	250 (1.39%)	52.00%	130 (1.51%)	41.60%	3.38	00:03:30	0.00%	0 (0.00%)	$0.00 (0.00%)
9. New York	240 (1.33%)	83.33%	200 (2.33%)	65.83%	2.36	00:01:19	0.00%	0 (0.00%)	$0.00 (0.00%)
10. Illinois	225 (1.25%)	68.00%	153 (1.78%)	46.33%	3.20	00:02:55	0.00%	0 (0.00%)	$0.00 (0.00%)

Rows 1 - 10 of 53

OMIG Partnerships and Initiatives

OPTUM DSS FADS Initiative

The Optum Decision Support System (DSS) Fraud and Abuse Detection System (FADS) which contains the Surveillance and Utilization and Review Subsystem (SURS), fraud and abuse detection, and program integrity functions, went live Fiscal Year 2015 on February 3, 2015. Optum's FADS solution features a suite of tools designed to help manage fraud and abuse investigations ranging from detection to collection. It allows users the ability to research aberrant behaviors while identifying only a minimum of false positives. The ranges of services and data extraction tools create a comprehensive Program Integrity solution which includes:

FADS Peer Group Profiling

This tool provides OMIG flexibility in the creation of meaningful peer grouping studies of providers or beneficiaries that deliver actionable results. Peer grouping studies can be run on a scheduled or on-demand basis. Peer Group Profiling uses a peer grouping, aggregate methodology, while algorithms employ intra-claims and cross-claims which allow OMIG to detect hidden, collusive, and more complicated fraud schemes.

FADS Fraud Algorithms

Through working sessions with OMIG and DHS, Optum develops for the State of Arkansas customized algorithms to identify potential areas of fraud, waste, and abuse. This is a collection of comprehensive algorithm strategies that employ advanced technologies to detect suspicious fees for service claims, non-compliance with Medicaid policy, and complex healthcare, fraud, abuse, and waste. The algorithms are systematically available (refreshed multiple times a year) providing the most recent and up-to-date data for the user to select claims for further review. Initially, only three algorithms were developed. OMIG is scheduled to receive one new algorithm per quarter.

FADS Provider Activity Spike Detection

The Provider Activity Spike Detection is a batch process that runs after each data load to detect significant increases or decreases in provider activity. A provider's current week of activity is compared to the previous week for the most recent twenty-six weeks based on the first date of service. An online report displays the suspicious increases or decreases in the number of claim lines, dollars paid, and the distinct number of beneficiaries serviced based on thresholds defined by the provider. New providers are also reported within this process.

FADS Browse and Search Capability

The Browse and Search Capability allows OMIG access to claims data that is grouped according to claim type based on claim header or based on detail designation. It can be used for both provider and beneficiary data. Users can browse or search tables using sorts, filters, or a combination thereof. This tool is quicker than writing a query against the database.

FADS Case Tracking

OMIG has quickly adapted and became proficient in utilizing Optum's FADS Case Tracking system to maintain an audit case from initiation to completion. The Case Tracking system allows OMIG to effectively organize and manage an audit while maintaining all historic information pertaining to any work conducted on an audit case. The Case Tracking tool was enhanced after implementation to create a separate but similar work space for both OMIG and DHS-SURS to enter and track fraud, waste, and abuse cases. While neither group can view cases entered by the other, DHS-SURS can forward selected case information to OMIG. Nineteen cases were referred by DHS-SURS to OMIG during Fiscal Year 2015.

Pharmacy Audits

Through various technology and software elements of Optum's analytics and the expertise of a licensed Arkansas pharmacist and certified technicians, audits are selected for desk or on-site review. Beginning February 2015, Optum and OMIG created a seamless Pharmacy Audit Program reflecting the current OMIG audit components. As of May 6, 2015, a pilot program was launched to conduct twenty desk audits and three on-site audits. After pre-approval

by OMIG, pharmacies selected based on Optum analytics are notified and the audit process begins. Of the twenty-three cases selected, 1,076 claims totaling a paid amount of $95,700.71 were reviewed. This analytically determined amount includes those claims identified as valid claims associated with questionable claims as well as claims composed of compound drugs. All twenty-three cases identified findings and observations for a total questioned cost of $21,391.50 pending further administrative procedures outlined in the Arkansas Medicaid Manual.

Medical Necessity Review/Physician Peer Review Program

Optum is partnering with MultiPlan, previously known as Medical Audit and Review Solutions (MARS), to assist OMIG in medical necessity reviews and claim selection of cases identified for further review. As a collective exchange, OMIG presents cases to MultiPlan requiring additional review for medical necessity or physician-led review decisions. MultiPlan also identifies cases through analytic algorithms to suggest to OMIG for further review. The physician peer review process is led by licensed MultiPlan professionals with various medical specialties that provide clear, unbiased, evidence-based determinations. During the past six months, Optum, MultiPlan, and OMIG have been working together to create an efficient process reflecting OMIG's current audit procedures. As of today, there are three audits in progress requesting additional medical record review by MultiPlan.

Provider on Review/Physician Peer Review Program

Optum, OMIG, DHS, and HP are collaborating to create a program designed to review pre-adjudicated claims. These organizations are working together to determine the most efficient, uninterrupted process to review claims to selected providers before payment or denial of the claims. Implementing this process will allow an additional, comprehensive review of a claim to prevent any payment to be made that should not have been processed. This will avoid the 'pay-and-chase' method thereby creating additional savings on the front end. As the program is still in the planning process, ideally, claims will be selected before payment is made for further review and providers will be required to submit documentation for review. Based on the documentation submitted, MultiPlan will conduct a review and provide the determination to OMIG and DHS for review to continue onto the processing cycle.

Arkansas Medi-Medi Partnership

OMIG is making use of all available resources to fight fraud, waste, and abuse in the Arkansas Medicaid Program. In particular, OMIG is participating in the Centers for Medicare and Medicaid Services funded Medicare-Medicaid Data Matching Program known as the 'Medi-Medi Data Match Program.' The Medi-Medi Program has provided new insight into the complete impact of providers who bill both programs, and the program offers analytic and investigative resources to supplement those already available to OMIG. As a participant in the Medi-Medi Program, OMIG has access to the Medicare data for all Arkansas dual eligible recipients that are receiving services in both the Medicare and Medicaid programs. This allows OMIG to monitor Arkansas providers who are enrolled as both a Medicaid and Medicare provider. This specifically permits OMIG to monitor the following:

- Services that are being billed to both Medicaid and Medicare
- Services that should be billed to Medicare as the primary payor instead of Medicaid
- Services that are being billed to Medicaid during a Medicare inpatient stay

OMIG staff worked with Medi-Medi Program contractors on various projects in Fiscal Year 2015, including a joint audit. OMIG participates in biannual meetings with the Health Care Task Force which includes local and federal law enforcement, the FBI, Arkansas Attorney General's Medicaid Fraud Control Unit, the United States Attorney's Office, and various insurance agencies.

Medicaid Integrity Contractor – Health Integrity

Through monthly meetings, OMIG coordinates and collaborates with Health Integrity, the Medicaid Integrity Contractor (MIC) for the State of Arkansas. OMIG and Health Integrity worked to develop an efficient and productive strategy for reviews to be performed by Health Integrity beginning in Fiscal Year 2015. Based on the work and efforts of OMIG and the MIC auditor, five specific and intricate hospital one-day stay reviews were initiated in Fiscal Year 2015. Health Integrity is still in the claims review stage, but upon completion, OMIG will review the information provided by Health Integrity to determine if a recoupment letter and request for

recoupment is appropriate. OMIG and Health Integrity are considering other potential avenues moving forward in order to efficiently utilize the Federal MIC audit contract.

EMFAD Initiative

Pursuant to Act 259 of the 2014 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 coordinated with both DHS and the Office of State Procurement (OSP) to develop the Enterprise Fraud Program, including issuing a Request for Information (RFI) in 2014 and drafting a Request for Proposal (RFP).

In May of 2015, DHS submitted the required Proposed Advanced Planning Document, (PAPD) for the Enterprise Fraud Program, along with the RFP to CMS. On September 1, 2015, CMS approved the PAPD for the EMFAD initiative.

Administrative and Education Activities

According 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;

(4) Developing and Implementing a False Claims Act Compliance Program; and

(4) Enhancing provider resources and educational outreach.

OMIG Provider Education

OMIG has made a concentrated effort to contact Arkansas provider associations and organizations. OMIG has attended meetings and scheduled presentations with a number of Medicaid provider organizations. OMIG is available to any Medicaid provider or association that

has questions or concerns going forward. OMIG continues to provide education through the audit and review process as well as requiring Medicaid providers to submit Corrective Action Plans (CAPs) when deficiencies are substantiated in a Program Integrity Review. Moving forward, OMIG will consider other methods for encouraging provider education including requiring providers to attend training and review courses as part of negotiated settlements.

OMIG regularly participates in provider task force meetings and other provider meetings. OMIG has placed a greater focus on CAPs, including providing information on its website about preparing and submitting CAPs, and OMIG is making an increased effort to ensure compliance with a provider's CAP response through performing follow- up audits. Field audit personnel are increasingly providing on-the-spot provider education through conducting entrance and exit conferences during on-site audits.

OMIG has added numerous provider resources to its' agency website, including information on audit protocols, self-disclosure protocols, reconsideration, appeals, CAPs, False Claims Act Education compliance, and a statutory compliance program. The provider-specific resources can be found at: http://omig.arkansas.gov/providers.

OMIG Deterrence and Cost Avoidance

Although difficult to quantify or measure, deterrence and cost avoidance are important factors for OMIG to consider and review in order to fully determine the impact the agency has on the overall medical assistance program. OMIG strives to increase awareness and its presence by having contact, communication, billing and service reviews, program education, and monitoring of the Medicaid program and Medicaid providers.

OMIG has conducted preliminary studies and reviews to consider cost avoidance and to determine if the agency initiatives have an impact on the Medicaid program. Although preliminary and subject to other factors, the limited studies and reviews have resulted in some statistical reductions in spending by Medicaid providers where OMIG intervention has resulted in administrative actions, MFCU referrals, suspensions, provider education, provider settlements, and self-disclosures. OMIG's insistence on the submission and completion of Corrective Action Plans by Medicaid providers in order to remedy deficiencies and prevent further improper billing play a significant role in cost avoidance.

OMIG has also focused on preventing inappropriate acts or improper billing and service practices from occurring. The significant increase in Medicaid provider suspension and referrals for fraud investigation may also play a role in deterrence among Medicaid providers. A key factor in deterrence is increased visibility and transparency with providers, education initiatives, encouragement of self-disclosures by Medicaid providers regarding individual bad actors, and increasing awareness and working with law enforcement groups and medical and health care service associations.

OMIG Personnel Education and Training

Throughout the year, OMIG staff and personnel are encouraged to attend federally-funded education courses and classes at the Medicaid Integrity Institute, which is located in Columbia, South Carolina. These courses are provided to qualifying state employees, and are 100% funded by the federal government.

OMIG has monthly staff meetings which often include educational components, including power point presentations on various provider types and best audit practices. OMIG staff has attended local and national conferences pertaining to program integrity, Medicaid policy, and Arkansas Medicaid programs. OMIG has developed and created an OMIG Policy Manual that addresses work protocols and job expectations as well as state statutes and policies. The policy manual was released in Fiscal Year 2015.

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 Audits and Recoupments

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 audits, reviews, and investigative processes and reporting. In response to OMIG's recognition of issues and the new requirements of the Arkansas 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 2015.

Budget and Appropriation Concerns

OMIG received a reduction in funding for Fiscal Year 2016. The Fiscal Year 2016 funding reduction will not adequately cover the projected budget for maintenance, operating expenses, and appropriated employee payroll and benefits of the agency. During the last quarter of Fiscal Year 2015 and the first quarter of Fiscal Year 2016, OMIG has operated with a significant reduction in staff and personnel. The reductions in staff will impact production and operations for the 2016 Fiscal Year. Due to the reduction in state and federal funds, OMIG's Fiscal Year 2016 budget does not allow the agency to be fully staffed with the maximum appropriated positions.

OMIG Edits and Audit Review

OMIG has communicated and will work with DMS and its employed fiscal agent to operate the Medicaid Management Information System (MMIS) of the Department of Human Services regarding edits and audits in order to identify potential issues or concerns that may give rise to fraud, waste, or abuse in the Medicaid billing and claim process.

Provider Resources

OMIG is striving to establish working relationships with providers and provider associations. The OMIG website includes, but is not limited to, Medicaid provider information pertaining to audit protocols, self-disclosure programs, Corrective Action Plans, and contact information. OMIG plans to expand the resources available to providers in Fiscal Year 2016.

Medicaid providers now have access to information and resources that were either not previously available to them or difficult to obtain.

Respectfully Submitted,

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