2023 Annual Report

Office of Medicaid Inspector General

Department of Inspector General

Secretary Allison Bragg

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Overview

This annual report, required by Ark. Code Ann. § 20-77-2509(a), summarizes the activities of the Office of Medicaid Inspector General (OMIG) for the preceding year, Fiscal Year 2023 (FY23). OMIG opened **102** fraud investigations, conducted **581** audits and audit activities, initiated **106** administrative actions, referred **30** cases to prosecutors or licensing authorities, and identified **$1,404,683.95** of Medicaid funds for recovery.

Investigations

In FY23, OMIG opened **102** fraud investigations. OMIG receives leads for investigation from audits, public complaints received through the OMIG fraud hotline, self-reports by Medicaid agencies, referrals from outside agencies, and referrals from law enforcement including the Attorney General's Medicaid Fraud Control Unit (MFCU). OMIG continues to use data analytics to identify fraud consistent with national and federal program integrity trends.

During FY23, the OMIG investigation team continued to work closely with the Special Investigative Units of the Medicaid Management Care Organizations (MCOs), including the Dental Managed Care Organizations (DMOs) and the Provider-Led Arkansas Share Savings Entities (PASSE). These organizations refer both providers and beneficiaries to OMIG for potential or suspected fraud. Through this cooperative relationship, OMIG and MCOs are better able to identify, target, and eliminate fraud, waste, and abuse within the Medicaid program.

Audits

During FY23, OMIG conducted **581** audits and audit activities (these include on-site audits, desk audits, False Claims Act compliance reviews, contractor audits, and recoupment letters). A list of all 581 audit activities and details for each is attached (*FY23 Audits*).

Summary of Audit Activities

Onsite Audits	9
Desk Audits	58
False Claims Act Reviews	155
Contractor Audits	199
Recoupment Letters	160
TOTAL	**581**

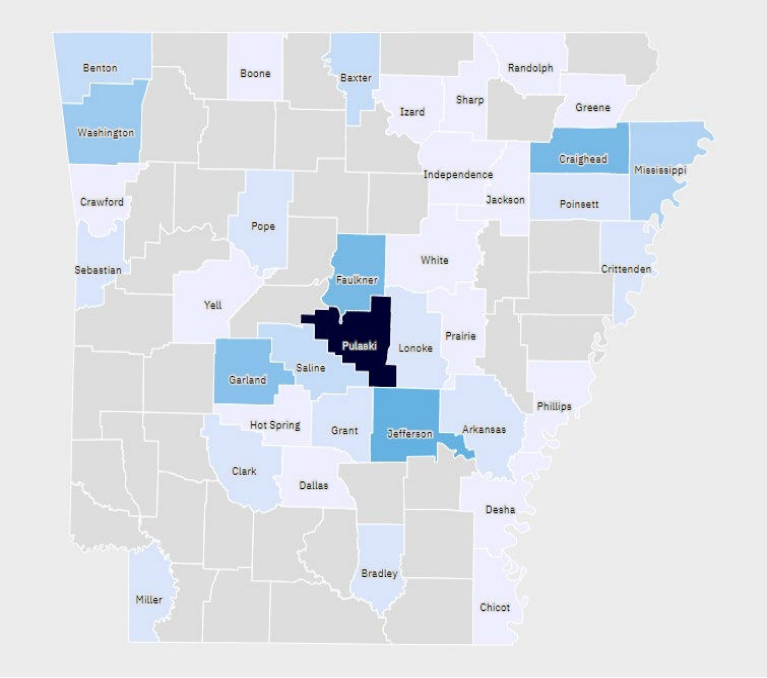
OMIG initiates data-driven recovery letters to seek the return of Medicaid funds. These letter campaigns call upon a provider to conduct a self-audit, which can be time consuming for the provider. This year, OMIG focused on enhanced recoveries while reducing both provider burden and reliance on audit staff. OMIG sent a record number of recoupment letters that identified improperly paid funds but did not require a self-audit.

Administrative Actions

OMIG initiated administrative action against **106** providers in FY23. Administrative actions are the primary form of sanctions against Medicaid providers engaging in fraud, abuse, and improper billing practices. Administrative actions include suspension from payment of Medicaid claims, exclusion from participation in the Medicaid program, and termination from the Medicaid program. When OMIG refers criminal actions to MFCU, federal law 42 C.F.R. § 455.23 requires the provider be suspended under most circumstances. Depending on the outcome of the criminal matter, OMIG with then either exclude or reinstate the provider.

In non-criminal matters, OMIG also pursues suspension, exclusion, or termination when a provider continually abuses the program by failing adhere to requirements set out in the Medicaid Provider Manuals. After OMIG imposes sanctions, each provider is afforded legal due process to appeal OMIG's decision in a hearing before an Administrative Law Judge who will confirm or deny whether a credible allegation of Medicaid fraud exists to support the sanction. During FY23, OMIG suspended 25 providers, excluded 72 providers, and terminated 9 providers. The map below depicts the suspensions, exclusions, and terminations by provider county.

OMIG sanctioned Medicaid providers in 36 Arkansas counties as well as one provider located in Alabama, two providers located in Colorado, two in Missouri, two in Oklahoma, one in Pennsylvania, one in Tennessee, and two in Texas for FY23.



**Map does not include 16 out-of-state administrative actions for providers in states listed above.*

Provider Suspensions	25
Provider Exclusions	72
Provider Terminations	9
FY23 Total	106

Referrals

In FY23, OMIG made **30** referrals for prosecution or to licensing authorities. A total of 27 fraud investigations were referred to the Attorney General's Medicaid Fraud Control Unit (MFCU), which resulted in 21 providers suspended due to a credible allegation of fraud. Two providers were referred to the Office of Long Term Care, and one was referred to the Arkansas Medical Board. These referrals are detailed in an attached spreadsheet (*FY23 Referrals*).

OMIG sometimes receives complaints regarding potential beneficiary fraud. If a complaint involves collusion between a beneficiary and Medicaid provider, OMIG will continue the investigation and referral to MFCU. However, if the matter involves only a beneficiary, it will be referred to either the Department of Human Services or the Social Security Administration Office of Inspector General for investigation, depending on the type of benefits involved. In FY23, OMIG referred **24** cases of suspected Medicaid beneficiary fraud to DHS for determination of eligibility.

Administrative and Educational Activities

In FY23, OMIG personnel gave presentations to the National Association for Medicaid Program Integrity (NAMPI), National Healthcare Anti-Fraud Association State Information Sharing Session, the Central Arkansas chapter of the American Academy of Professional Coders, Arkansas Foundation for Medical Care Workshops, and the Healthcare Fraud Prevention Partnership.

In August 2022, OMIG Audit Coordinator Michael McNeely spoke at the NAMPI virtual conference. He presented a session titled "Is Presuming Definitive or Is Definitive Presuming: A Laboratory Urinalysis Case Study," in which he discussed Arkansas OMIG's audit findings and use of data analytics to establish the case for lab unbundling. At the same NAMPI conference, OMIG attorneys Heather Callaway and Tammera Harrelson presented a session titled "From French Fries to Fraud," a dental case study that highlighted fraud, waste, and abuse in an Arkansas dental practice.

Office Performance: OMIG Recoveries

The total amount of Medicaid funds identified by OMIG for recovery in FY23 is **$1,404,683.95**.

FY23 OMIG Dollars Recovered

Accounts Receivable Claims	$1,028,028.67
Self-Report Claims	$181,872.74
MFCU Restitution	$117,282.52
Mass Adjustments and Reversals	$77,500.02
TOTAL	$1,404,683.95

Additional Recoveries

Dental Managed Care Oversight and Collaboration

Delta Dental of Arkansas and Managed Care of North America Dental (collectively, DMOs) continue to serve as the dental benefits managers by providing dental services to Medicaid recipients. Each DMO is contractually obligated to investigate fraud, waste, and abuse internally and report to OMIG on a quarterly basis. OMIG continues to monitor the quarterly reports and act as a liaison between the organizations and MFCU. For FY23, the DMOs reported recoupments totaling **$202,249.16**.

Provider-led Arkansas Shared Savings Entity (PASSE) Oversight and Collaboration

Arkansas Total Care, CareSource, Empower Healthcare Solutions, and Summit Community Care are the full-risk benefits managers serving as PASSEs for Tier 2 and Tier 3 behavioral health recipients and developmentally disabled recipients. The PASSE contract requires quarterly reporting related to fraud, waste, and abuse. OMIG is responsible to ensure that each PASSE follows the program integrity rules. In June 2023, OMIG conducted its second annual training on the implementation and reporting of these efforts. In FY23, the PASSEs reported recoupments totaling **$4,632,432.80,** and 10 provider referrals for suspected fraud.

Optum Pharmacy

In FY23, OMIG continued its partnership with Optum to conduct pharmacy audits by reviewing selected pharmacy claims. Optum's analytics' team, along with the expertise of a licensed Arkansas pharmacist and pharmacy technician, select pharmacies to perform both desk and onsite reviews. The audit selections are approved by OMIG, and the pharmacies are notified by Optum. A total of **$1,356,891** has been identified for recoupment.

Conclusion

OMIG is continually expanding its focus on provider outreach by developing strategies that create the greatest return on investment and increase program integrity. We rely on our staff of auditors, registered nurses, professional coders, licensed clinical social workers, and investigators to fully execute our role in detecting and preventing fraud, waste, and abuse within the Medicaid program. Please feel free to contact our office any time if we can be of help or provide more information.

Thank you,

Allison Bragg
Secretary
Department of Inspector General