Annual Report

Fiscal Year 2020

Department of the Inspector General

Office of the Medicaid Inspector General

Message from the Medicaid Inspector General

I am pleased to present the Medicaid Inspector General's annual report for State Fiscal Year 2020 to Governor Asa Hutchinson, Attorney General Leslie Rutledge, the General Assembly, and the citizens of Arkansas. The mission of the Office of the Medicaid Inspector General (OMIG) is to identify and prevent fraud, waste, and abuse in the Arkansas Medicaid Program. OMIG utilizes traditional program integrity methods of provider auditing and education for the traditional fee-for-service populations and serves in an oversight capacity to the special investigative units for the Dental Managed Care and the PASSE entities. OMIG data analytics division continues its pivotal role in all program integrity activities.

For State Fiscal Year 2020, OMIG identified $2,435,220.17 for recovery. Since its formation in 2013, OMIG has identified over $20 million dollars in improperly paid claims, and OMIG expects that number to grow in the future. Recoveries account for only a small portion of the fiscal impact OMIG has made on the Medicaid Program. I am proud to report OMIG's recommendation to reform the billing code for group psychotherapy has resulted in savings of over $100 million since the initiative began in Fiscal Year 2017. The Outpatient Behavioral Health program began in July 2018. The reform continued when the Provider-Led Shared Savings Entities assumed full risk of much of the behavioral health population in March 2019. In Fiscal Year 2020, Medicaid fee-for-service saw an estimated $47.6 million dollar reduction in spend for this procedure code. The identification of the group psychotherapy vulnerabilities by OMIG served as the catalyst to transform the behavioral health program. OMIG will continue to monitor PASSE activities and group psychotherapy billing, however we will no longer calculate cost avoidance related to group psychotherapy. The recent move toward managed care for dental services and recipients receiving behavioral health and developmental disability services has brought changes to OMIG's method of review. OMIG has worked closely with the provider organizations to ensure program integrity compliance identifying and reporting fraud, waste, and abuse.

OMIG continued audit activities during the COVID-19 public health emergency which was declared by E.O. 20-03 on March 11, 2020, but adjusted the manner of our audit activities. Field Audits were replaced with desk audits, Medicaid providers received additional time to provide records and responses to audit inquiries, and staff performed work remotely. Temporary changes to Medicaid billing and system edits were implemented to allow for an expansion of telemedicine and services necessary to address COVID-19 and the needs of the Medicaid population during this time. OMIG has begun reviewing claims processed related to COVID-19 to identify fraud, waste, and abuse and will complete these efforts in FY21. In FY21, OMIG will work with local, state, and federal entities to protect and safeguard that Medicaid funds are being spent appropriately to provide necessary treatment and services to Arkansas Medicaid recipients.

Respectfully,

Elizabeth Thomas Smith

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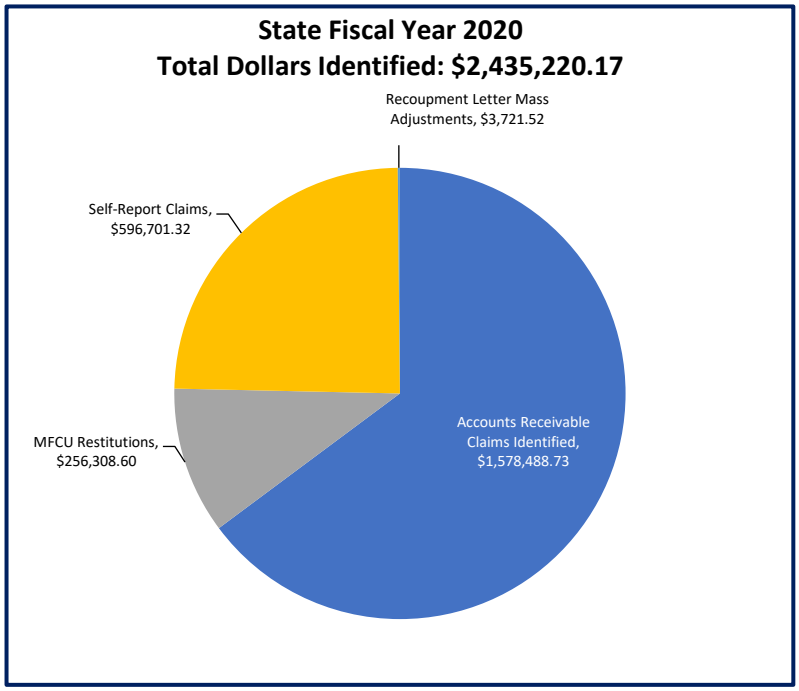
OMIG Recoveries and Recoupments

OMIG Identified Dollars for Recovery

The total amount of Medicaid funds identified for recovery in State Fiscal Year 2020 by OMIG activities is $2,435,220.17. As noted in the chart, OMIG uses various methods to identify improperly paid Medicaid dollars, including: restitution from criminal fraud and civil false claim referrals to the Medicaid Fraud Control Unit, audits and recoupment letters identified as accounts receivable claims, provider self-reports, and recoupment letters based on data analysis. OMIG continues the Provider Awareness Letter initiative and provider educational seminars to impress upon providers the importance of self-reporting overpayments. These efforts continue to show results.



OMIG Collections

In State Fiscal Year 2020, $1,966,660.59 was collected as a result of OMIG activities from this and prior state fiscal years. Recoupment and adjustment of claims occur through the Medicaid Management Information System (MMIS) and often spans several months or even state fiscal years. Therefore, identified claims and recovery amounts do not always occur in the same year. Most dollars recovered were a result of collections through DHS claims adjustments.

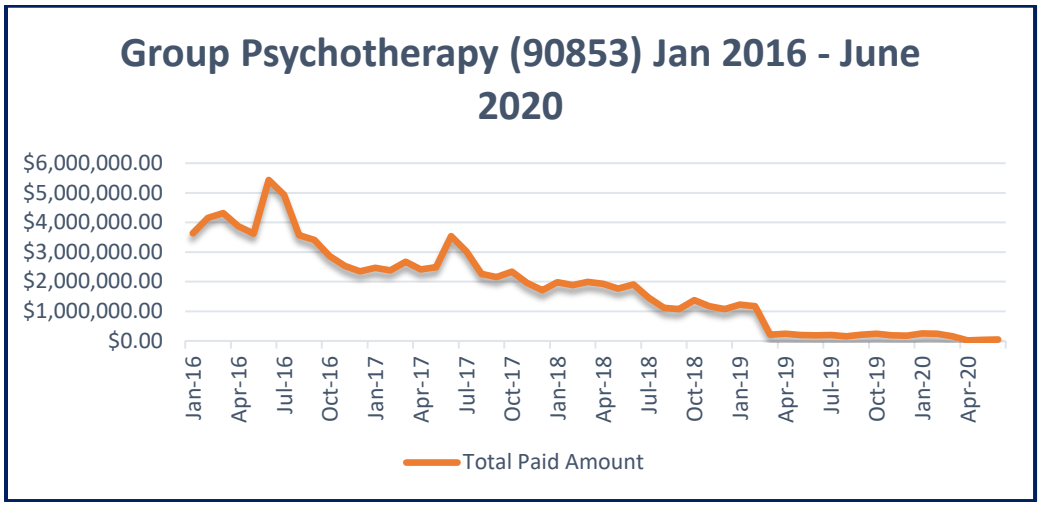
SFY 20 OMIG Dollars Recovered

Accounts Receivable Claims	$1,209,961.95
Self-Report Collections	$537,635.88
Claims Reversals/Adjustments	$3,721.52
Restitution and False Claims	$215,341.24
TOTAL	**$1,966,660.59**

Cost Avoidance

Group Psychotherapy

The 90853 Group Psychotherapy Initiative has been one of the most successful initiatives since the creation of OMIG. The previous policy for 90853 Group Psychotherapy billing created vulnerability in the Medicaid program for fraud, waste, and abuse. OMIG's recommendation to reform the 90853 code has resulted in savings of over $100 million since the initiative began in Fiscal Year 2017. The Outpatient Behavioral Health program began in July 2018 and then the Provider-Led Shared Savings Entities assumed full risk of much of the behavioral health population in March 2019. In Fiscal Year 2020, Medicaid fee-for-service saw an estimated $47.6 million dollar reduction in spend for this procedure code. As most of the spend for behavioral health services have now shifted to the managed care model, OMIG will continue to audit and investigate behavioral health issues in collaboration with the PASSE Special Investigations Units while implementing necessary interventions to combat fraud, waste, and abuse for this vulnerable population of recipients.



Duplicate Refraction

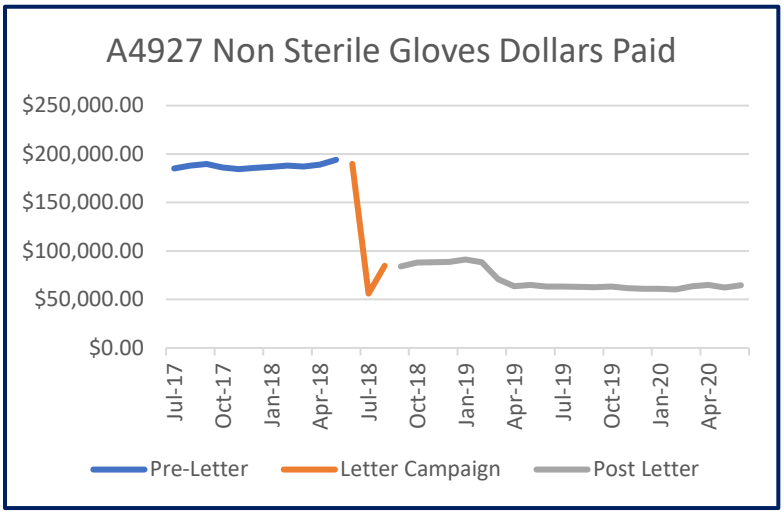
Beginning in State Fiscal Year 2017, OMIG identified multiple instances in which vision providers billed for duplicate refraction exam claims by submitting a refraction procedure on the same date of service as a comprehensive ophthalmological exam, which includes refraction. This review revealed that the duplicate claims resulted from an incorrect interpretation of Medicaid rules or problems with electronic billing software. In 2017, OMIG notified Providers of recoupment of improper payments and educated the Providers on proper billing procedures.

Cost Avoidance

In State Fiscal Year 2020, OMIG conducted a lookback review of refraction claims to determine compliance with previous fiscal years' education efforts. (see detail on pg. 18) This review showed a significant increase in compliance; only 27 providers billed these procedures improperly in SFY20 compared to 65 in SFY17. This successful initiative resulted in a 98.6% decrease in identified improper payments for duplicate refraction billing which equates to an approximate $160K cost avoidance based on this initiative. OMIG will continue to review claims for these procedures for compliance in State Fiscal Year 2021.

Non-Sterile Gloves

In June of 2018, OMIG sent 166 courtesy letters to durable medical equipment/prosthetics providers to clarify the unit definition and reimbursement rate in the Arkansas Medicaid Provider Manual for non-sterile gloves (procedure code A4927). OMIG identified a discrepancy between the Medicaid Provider Manual and the Medicaid Fee Schedule for reimbursement of non-sterile gloves. OMIG conducted a thorough analysis of paid claims and consulted with DME and Home Health providers. OMIG then recommended DHS review and revise the Fee Schedule to correct the discrepancies as well as to save Medicaid funds.



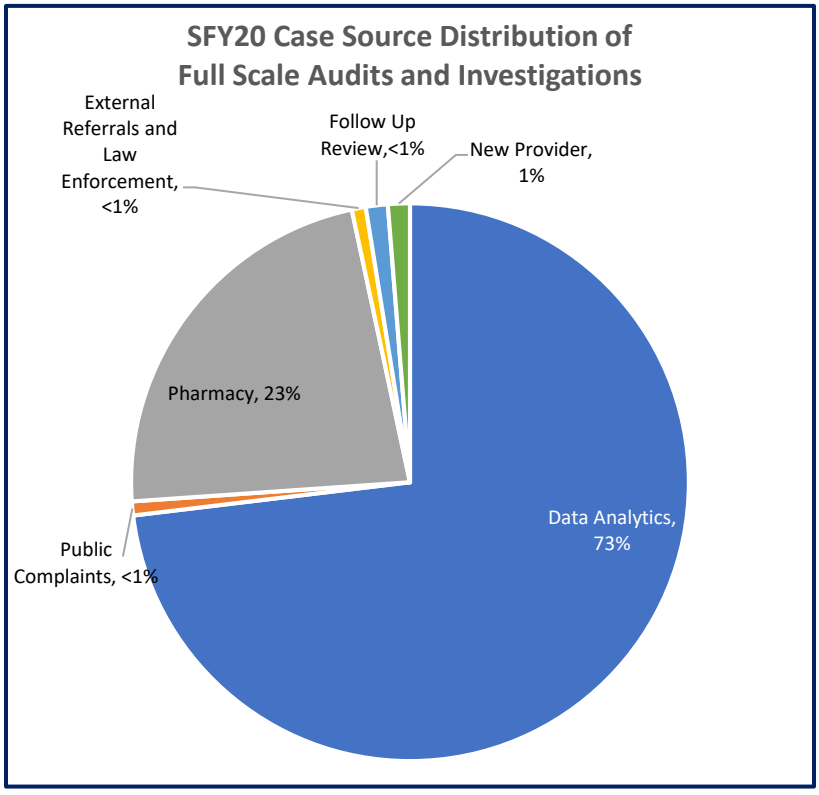
As a result, the review resulted in a change in the reimbursement amount for procedure code A4927 to $5.22 per 100 gloves effective August 1, 2018.

Based on billing volume from the year prior to the change, this fee schedule change has resulted in an estimated $1.5M in cost avoidance in Fiscal Year 2020, and a total cost avoidance to date of approximately $2.8M. This equates to approximately a 66% reduction in cost for this item to the Arkansas Medicaid program.

OMIG Audit Activities

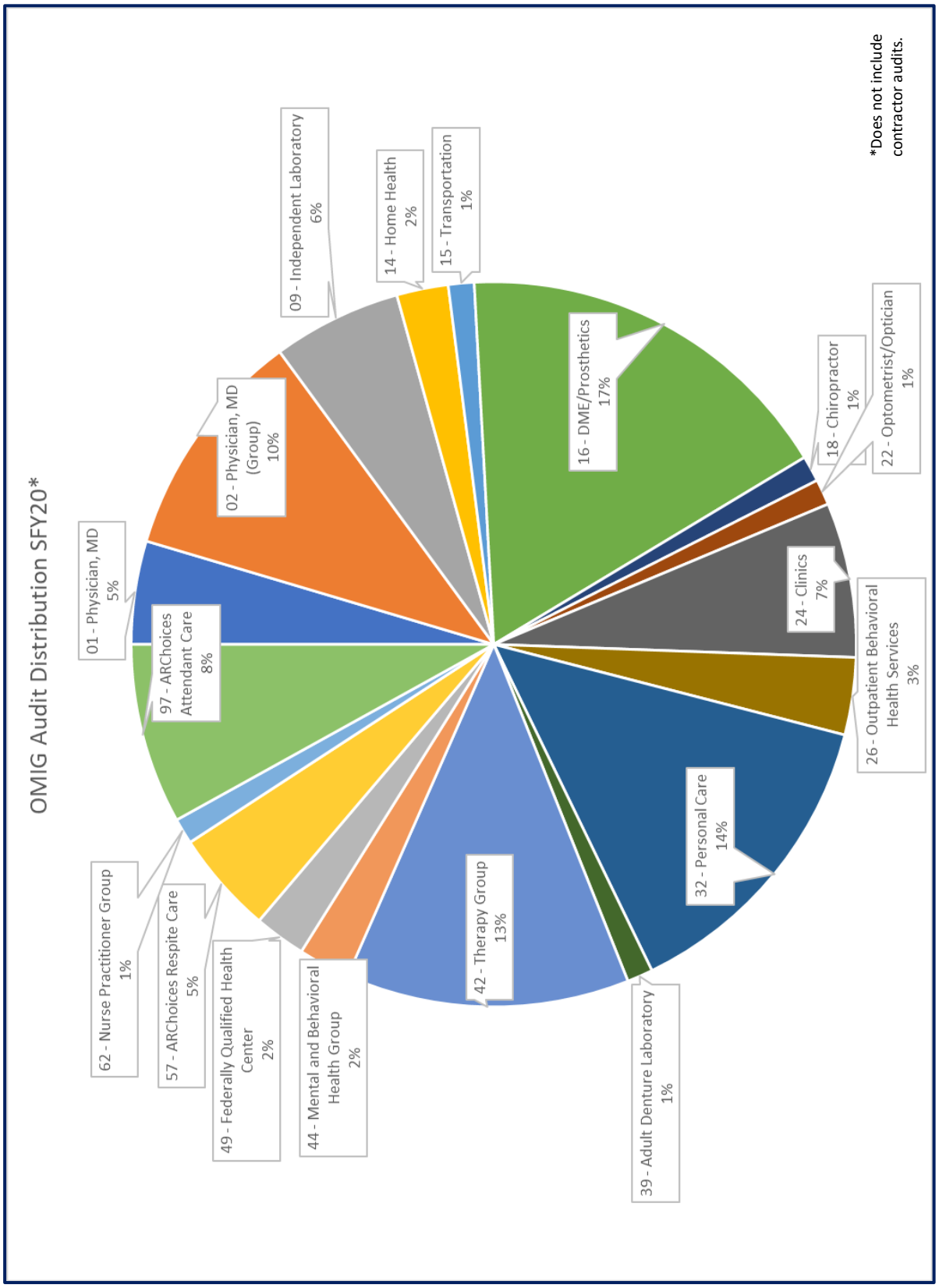
OMIG uses a multi-faceted audit approach with professionally trained auditors, coders, and medical professionals to review medical records for fiscal integrity. Providers are also directed by OMIG to perform self-audits which are then reviewed by OMIG for compliance. Reports of potential violations of the Arkansas or Federal False Claims Act (FCA) are investigated through a compliance review process.

OMIG continues to heavily utilize data analysis capabilities to detect potential practices of fraud, waste, or abuse, and initiates data-driven recovery letters seeking the return of Medicaid funds. Data analysis cases account for the source of most cases, totaling 73% of all cases opened for the fiscal year. In State Fiscal Year 2020, the number of onsite audits, desk audits, provider self-audits, FCA Compliance Reviews, and recoupment letters totaled 866 separate events or cases, broken down in the following charts. OMIG places special emphasis on reviewing high-risk and new providers for compliance, as illustrated in the distribution of provider types reviewed in State Fiscal Year 2020 as seen on the next page.



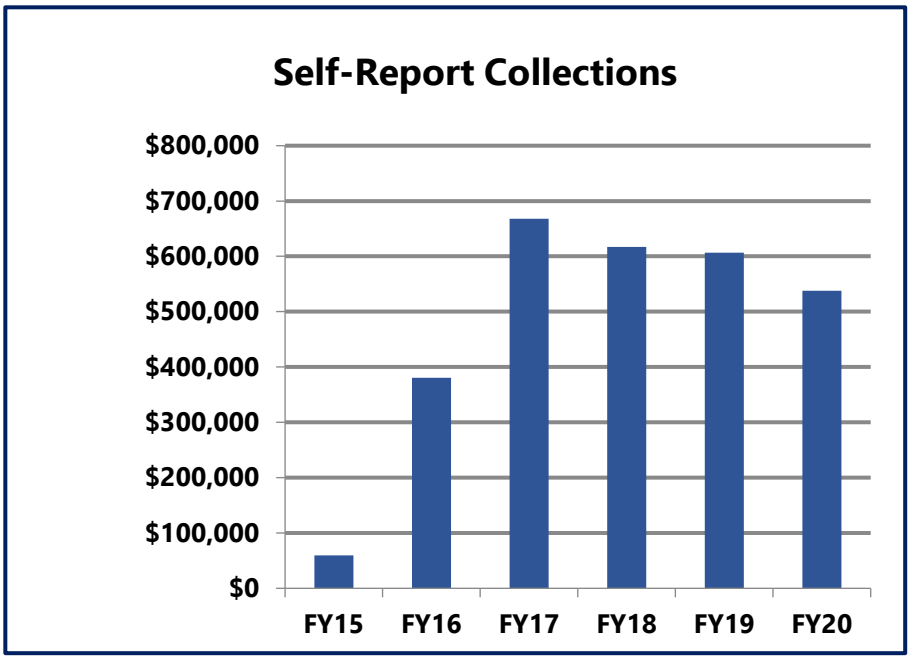
Summary of Audit Activities	
Onsite Audits	11
Desk Audits	76
Provider Self Audits	220
False Claims Act Reviews	97
Contractor Audits	197
Recoupment Letters	265
TOTAL	**866**

OMIG Audit Activities



Medicaid Provider Self-Reports

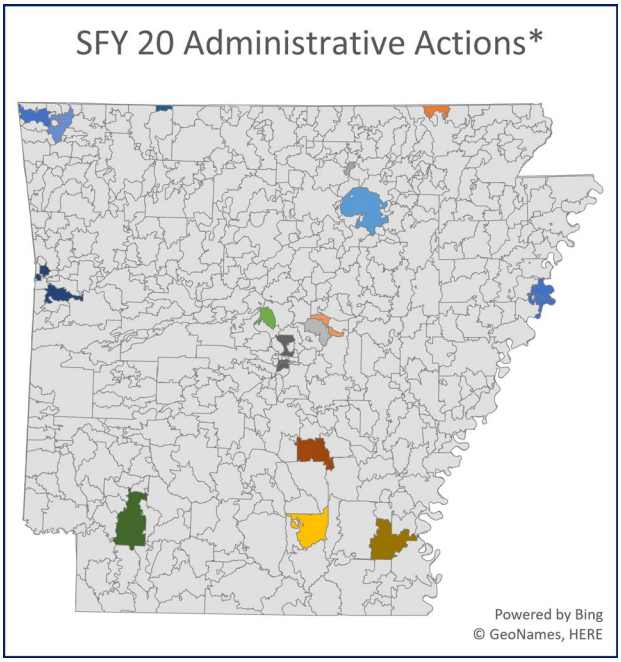
In State Fiscal Year 2020, a total of $596,701.32 was reported by Medicaid Providers as improper payments received in error from the Arkansas Medicaid program, and a total of $537,635.88 was collected for this fiscal year and other previous fiscal years. OMIG's self-report procedure enhances elimination of fraud, waste, and abuse, while decreasing provider burden by offering Medicaid providers a mechanism to reduce their legal and financial exposure through compliance. Providers who are self-reporting must submit a Corrective Action Plan (CAP) including appropriate measures to prevent recurrence of identified issues.



Administrative Actions

Suspensions and Exclusions

OMIG pursues administrative actions against individuals and entities engaging in fraud, abuse, and improper billing practices. Administrative actions include suspension from payment or exclusion from participation in the Medicaid program. When OMIG refers criminal actions to MFCU, the law requires that the provider be suspended under most circumstances. OMIG will then exclude or reinstate the provider, depending on the outcome of the criminal matter. OMIG also pursues suspension or exclusion as a sanction outside of criminal matters in cases when a provider continually abuses the program. Regardless of the circumstances of suspension or exclusion, each provider is afforded legal due process to appeal OMIG's decision in a hearing before an Administrative Law Judge. During this Fiscal Year, OMIG suspended 4 medical providers and excluded 31. The map below depicts the suspensions and exclusions by county in which the Medicaid Provider's home office is located. OMIG excluded Medicaid Providers in 15 Arkansas counties and 2 additional states for State Fiscal Year 2020.



Provider suspensions	4
Provider exclusions	31
SFY 2020 Total	**35**

*Map does not include 2 out-of-state administrative actions for providers in Memphis, TN and Cleveland, MS

Fraud Referrals

OMIG has increased the use of and reliance on data analytics to identify fraud consistent with national and federal program integrity trends which produces more effective and efficient investigations. OMIG also receives leads for investigation from audits, public complaints received through the OMIG fraud hotline, agency referrals, and law enforcement referrals. In State Fiscal Year 2020, 64 cases were opened for fraud investigation, with 8 cases still open and active at this time.

Twelve (12) fraud investigations were referred to the Attorney General's Medicaid Fraud Control Unit (MFCU) for fraud with 4 of the providers being suspended for a credible allegation of fraud.

During the course of State Fiscal Year 2020, the OMIG investigation team has begun to work more closely with the special investigative units (SIU) of the Medicaid dental managed care organizations and the Provider-led Arkansas Share Savings Entities. By meeting quarterly and maintaining contact with the SIUs, OMIG is better able to identify and target fraud, waste, and abuse.

OMIG also receives complaints regarding potential beneficiary fraud. Upon receipt of a complaint involving beneficiaries, a preliminary assessment is performed and information is gathered. If the compliant involves collusion between a beneficiary and medical provider, OMIG will continue the investigation and preparation of referral to the AG's MFCU. However, if the issue involves only a beneficiary, the matter will be referred to the Department of Human Services for investigation. In State Fiscal Year 2020, OMIG referred 44 cases of suspected recipient fraud to DHS for determination of recipient eligibility. When Beneficiary eligibility fraud is identified, those cases are then referred to law enforcement for prosecution.

Program and Policy Review

Electronic Visit Verification

The 21st Century Cares Act required State Medicaid Agencies to implement electronic visit verification (EVV) for all PCS and home health services requiring provider in-home visits by January 1, 2021. OMIG has worked closely with the Department of Human Services in oversight of the procurement process and in finalizing appropriate contract deliverables. A robust EVV program can be used to regulate and prevent improper billing and Medicaid fraud to better serve Medicaid recipients. OMIG anticipates EVV will strengthen existing Program Integrity measures in the home and community-based services. The additional data provided through EVV will further identify fraud, waste, and abuse in these programs and will help to protect these vulnerable Medicaid recipients who are dependent upon these valuable services.

Dental Managed Care Oversight and Collaboration

Delta Dental of Arkansas and Managed Care of North America Dental (collectively, MCOs) serve as the dental benefits managers for the Arkansas Medicaid/CHIP program, providing dental services to Medicaid recipients. OMIG acts in an oversight role for program integrity to bolster transparency and accountability by imposing and clarifying requirements meant to reduce fraud, waste, and abuse. OMIG continues to monitor quarterly reports and act as a liaison between the organization and MFCU. For Fiscal Year 2020, while the MCOs only recouped $11,503.59, an additional $93,942.49 was identified for recoupment and is still outstanding. Fifteen hotline tips were received, and one recipient was referred to OMIG for fraud. Additionally, 15 investigations were opened.

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

The Provider-led Arkansas Shared Savings Entities (PASSEs) serve as the full-risk benefits managers for Tier 2 and Tier 3 behavioral health recipients, as well as all developmentally disabled recipients. As with the dental MOCs, each PASSE has its own SIU. The PASSE contract also requires the same quarterly reporting related to fraud, waste, and abuse. OMIG is responsible to oversee and ensure that each PASSE follows the program integrity rules in place just as with the dental MCOs. OMIG meets quarterly with each PASSE compliance department to discuss the reports and their efforts to combat fraud waste and abuse.

For Fiscal Year 2020, quarterly reports submitted to OMIG show the PASSEs terminated nine providers, received 47 hotline tips, opened 77 investigations, and identified $6,976,121.00 potential erroneous payments as a result of billing errors, third-party liability, self-reports, and business edits in the processing system.

Program and Policy Review

COVID-19 and Telemedicine Review

In response to the Public Health Emergency for the COVID-19 pandemic declared on March 11, 2020, OMIG began an extensive review and monitoring program of Arkansas Medicaid claims geared to identify fraud, waste, and abuse related to pandemic billing system changes.

During the weeks following the Public Health Emergency declaration, OMIG began working in collaboration with the Department of Human Services to relax system edits to allow for payment of services via telemedicine and various new procedure codes created in response to the COVID-19 pandemic.

After the relaxation of system edits and addition of COVID testing and evaluation procedures, OMIG has designed data analysis projects to monitor the spend on these relaxed and new procedures. These data analysis projects include, but are not limited to:

- Telemedicine procedures with a specific focus on Evaluation and Management Office Visits, Behavioral Health services, and Physical, Occupational, and Speech Therapy services;
- COVID-19 testing codes, including duplicate testing on the same date of service and batch billing with other laboratory procedures;
- COVID-19 evaluation codes; and
- Well Check procedures for Early Intervention Day Treatment (EIDT) and Adult Developmental Day Treatment (ADDT) providers.

Contract Reviews

One aspect of the OMIG mission is to review contracts funded by Medicaid. The goal in assessing each contract is to ensure compliance with performance-based contracting standards, to review DHS internal controls, and to determine whether DHS takes corrective action when vendors are not in compliance with their contracts.

In Fiscal Year 2020, OMIG reviewed 100 Medicaid-financed contracts. Examples of those agreements include, among others, a competency evaluation program and registry service for medical professionals and two separate data analysis contractors to provide reports, models and projections to the Arkansas Medicaid Program.

Controlled Prescription Drug Review

OMIG examines prescriber and dispensing practices through use of data analytics by comparing multiple opioid prescriptions within the same Medicaid household, performing link analysis of high prescribers with recipients and pharmacies, and identifies excessive prescribing

practices. The Optum pharmacy contractor conducts audits of identified pharmacies and OMIG reviews prescriber behavior. OMIG works closely with the DHS pharmacy division in review of provider prescribing practices, policy review, and in sharing tools and techniques to assist in identifying issues related to opioid misuse. OMIG assists and supports investigations for federal law enforcement agencies, the Arkansas Department of Health, DHS, the Arkansas Pharmacy Board, Long Term Care Providers, and stakeholders.

OMIG continued to serve on the Opioid Task Force comprised of state and federal law enforcement agencies, state and federal agencies overseeing provision of health care, and private insurance providers. This group meets biannually to collaborate and share information regarding Opioid initiatives, data analysis trends, and provide best practices to tackle this ever-growing problem. OMIG also continues its role on the Prescription Drug Overdose Advisory Workgroup organized by the State Drug Director.

In addition to the Task Force and Workgroup, OMIG spoke to the Advanced Opioids Investigations Classes for Law Enforcement regarding utilization of OMIG as a law enforcement partner. This was a new course offered during SFY20 through the collaborative efforts of the Arkansas State Police, State Drug Director, and other state and federal agencies to assist law enforcement officers in the investigations of opioid-related deaths.

OMIG receives support on a federal level in combatting the overuse and abuse of controlled substances through the Unified Program Integrity Contractor (UPIC). The UPICs were created by CMS to combine the functions formerly performed by Medicaid Program Integrity Contractors (MIC) and Zone Program Integrity Contractors (ZPIC) into a single contractor defined by geographic regions.

The UPIC is contracted to perform Medicare and Medicaid program integrity reviews and assistance to enhance state program integrity functions. Arkansas lies within the Southwestern UPIC jurisdiction along with Colorado, Oklahoma, Mississippi, Missouri, New Mexico, and Texas and is served by Qlarant Integrity Solutions.

In SFY20, Qlarant also initiated reviews to closely scrutinized high prescribers, as well as pharmacies dispensing high numbers of opioids. Their review of ten of those prescribers, and ten pharmacies is currently still in progress. Qlarant also provides data analysis support and policy research supporting fraud investigations.

Contractor Program Integrity Activities

Optum Pharmacy

In State Fiscal Year 2020, OMIG continued its partnership with Optum to conduct pharmacy audits by reviewing documentation on 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 appropriately.

As a result of the collaboration with OMIG, Optum selected 197 Pharmacy providers to audit in State Fiscal Year 2020. 184 audits were selected as a desk and 13 were conducted as an onsite. There was a total of 12,623 records requested for Optum to review and incorporate into the audit, totaling a paid amount of $3,536,891.47. Of the 163 audits that were completed at the time this report was prepared, Optum has identified a total of 1,864 claims with a finding of improper payment or a specific caution being reported to the provider for future education and corrected changes to implement. As a result, a total of $805,463.74 has been identified for recoupments.

Due to the unprecedented events of the pandemic occurring throughout the country in the later part of the fiscal year, the pharmacy audit program made necessary modifications to adapt to the circumstances. Optum incorporated multiple layers of communication to each of the pharmacies requiring documentation submission, and extensions were provided to those pharmacies with limited staff and limited access to the files. The planned onsite audits were then performed as a desk audit. These examples are just a few key changes that Optum and OMIG quickly integrated into the process and will continue to assess and alter as needed throughout the course of this national health emergency.

During State Fiscal Year 2020, Optum continues to report fraud referrals to OMIG as they are identified through the pharmacy audit program with credible allegations of fraud. Optum also continues to support and collaborate with OMIG on cases that are currently under investigation with MFCU. This partnership provides subject matter expertise where it is most beneficial to produce the strongest evidence.

Optum Fraud and Abuse Detection System (FADS)

Optum hosts the Medicaid Enterprise Decision Support System that contains the Fraud and Abuse Detection System (FADS). This software system provides a suite of data extraction tools that OMIG uses to prevent and detect fraud, waste and abuse. The tools in FADS include: Peer Group Profiling, Spike Detection, Query and Report Writing, and Claim Browse and Search.

During Fiscal Year 2020, new algorithms were developed and tested through the FADS partnership, and existing algorithms were further tuned and edited to add Managed Care data

fields. These additional fields will help to identify improper claims within the PASSE and Dental Managed Care claims. The new algorithms are as follows:

- Excessive Billing of Blood Glucose Monitors and Diabetic Testing Supplies
- Inappropriate Quantities of Medical Supplies
- Oxygen Concentrator without Respiratory Testing
- Suspicious Claims Submissions

Initiatives

Provider Awareness Letters (PALs)

OMIG has been recognized as a national leader in innovation for Program Integrity practices. OMIG is continually building upon and expanding its focus on provider outreach and education by developing strategies that create the greatest return on investment and reducing provider burden while increasing program integrity. Provider Awareness Letter (PAL) Initiatives continue to serve as a valuable mechanism to effectively correct behaviors across a range of provider groups and identify areas for improvement in the Medicaid program. Cost avoidance opportunities continue to develop while identifying cost-effective ways to maximize the use of agency resources to detect and combat fraud, waste, and abuse. Rather than OMIG conducting full scale audits of these providers, the letters allow OMIG to utilize fewer resources to reach more providers efficiently, creating a positive return on investment. The FADS Peer group profiling tool is used to identify providers who deviated significantly from their peers for potentially aberrant billing behaviors. To verify the billing pattern is improper and to establish a baseline, OMIG audits the most egregious. After review of the audit results, PALs are sent to the remaining outlier providers asking for a self-review of those claims. OMIG expects the provider to self-disclose improper payments, return those funds, and correct the billing behavior going forward which results in cost avoidance. When a provider response does not meet expectations, a full-scale audit is performed in order to verify OMIG's assumptions.

- **False Claims Act Compliance**

OMIG completes False Claims Act Compliance Reviews annually of all providers who receive at least $5 million dollars in Medicaid reimbursement per Federal Fiscal Year to ensure compliance with §6032 of the Deficit Reduction Act, and Social Security Act, §1902(a) (68). These providers are required to develop a compliance plan which includes internal control policies and procedures for detecting and preventing fraud, waste, and a discussion of the rights of whistleblowers. OMIG performed 97 False Claims Act Compliance Reviews during State Fiscal Year 2020.

- **Modifier 25**

Modifier 25 is a code added to a medical claim for an Evaluation and Management (E/M) service that indicates the provider performed an additional distinct service different from the original service. To appropriately utilize Modifier 25, the second service rendered by the practitioner must be medically necessary and require that the patient would have to return for another visit if left unaddressed. In Fiscal Year 2020, OMIG designed a data analysis project that profiled physician utilization of Modifier 25 in their billing practice. The focus of this study was to identify performing providers with outlier billing for E/M procedures utilizing Modifier 25. Through this data analysis project, OMIG identified 220 physicians who appeared to be outliers among their peers for usage of Modifier 25 to bill Evaluation and Management (E/M) Services. OMIG sent

letters to each provider notifying them of their outlier status. OMIG plans a follow-up review of these providers in Fiscal Year 2021 and will evaluate the response to this education letter at that time.

Recoupment Letters

Provider Recoupment Letters are submitted when OMIG is confident that an improper claim has been submitted and resulted in an overpayment. In these instances, there is no fraud suspected and no system edit in place to avoid these claims, OMIG notifies the provider of the issue and that the claims will be subject to recoupment.

Provider recoupment letters that were submitted in State Fiscal Year 2020:

- Duplicate Refraction
- Home and Community Based Services Billing and Inpatient Services Billing Overlap
- Professional and Professional Crossover Duplicates

■ Duplicate Refraction Procedures

As mentioned in the cost avoidance section, OMIG performed a lookback review for compliance with prior fiscal years' education on billing duplicate refraction procedures. OMIG identified multiple instances in which vision providers submitted duplicate refraction exam claims by submitting a refraction procedure on the same date of service as a comprehensive ophthalmological exam, which includes refraction.

The Visual Care-Arkansas Medicaid Provider Manual states that HCPCS code S0620 and S0621 may be billed when a routine ophthalmological examination includes a refraction exam performed for a new or established patient. The CPT code 92015 may be billed for determination of refractive state but must be performed alongside a medical exam. As HCPCS codes S0620/S0621 and CPT code 92015 both cover refraction exams, it is improper for a provider to bill both codes for the same beneficiary on the same date of service.

In State Fiscal Year 2020, OMIG identified additional improper claims subsequent to the first educational opportunity. The review revealed 27 providers who billed these procedures improperly. OMIG sent recoupment letters to those vision providers and identified a total recoupment of $2,330.40. In FY17, 65 providers billed these codes improperly, this reduction indicates success of OMIG's educational activities and decrease in improper payments.

■ Home and Community Based Services Inpatient Overlap

Personal Care services are historically known as an arena for Medicaid fraud. Over the past few years, OMIG has performed focused reviews of the Home and Community Based Services policies

as well as provider billing behavior. OMIG has educated providers and worked with DHS on implementation of safeguards. This year, OMIG continued its review of personal care services using data analysis to identify claims paid for Home and Community Based Services (HCBS) during the same time those Medicaid Beneficiaries were treated in an Inpatient Facility from July 1, 2018 to December 31, 2019. When a Medicaid Beneficiary is in a hospital or other inpatient facility, Home and Community Based Services obviously are not necessary and not reimbursable. In some instances, HCBS claims are submitted by mistake, however billing for services not provided constitutes fraud. While the reimbursement for these hourly services is low, this population of recipients is vulnerable to Medicaid fraud. HCBS services are typically provided in the home with little direct oversight. OMIG sent 219 recoupment letters to HCBS providers based on this review. During fiscal year 2020, OMIG recovered $46,170.48 as a result of this initiative and referred 2 personal care providers to MFCU for fraud.

- **Professional and Professional Crossover Duplicate Claims**

In State Fiscal Year 2020, OMIG conducted a data analysis review of paid Medicaid professional claims that are identical to professional crossover claims with matching recipients, dates of services, procedure codes, and billing providers. When covered services are provided to a dual-eligible recipient, it is improper to submit a professional claim to Medicaid in addition to a crossover claim for Medicare cost-sharing. The dates of service reviewed were January 1, 2018 through August 30, 2019. OMIG sent an initial batch of letter to 18 providers based on this review. To date, OMIG has requested $5,536.10 for recoupment as a result of this initiative. OMIG plans to continue this recoupment initiative in State Fiscal Year 2021 based on the success of the initial letter campaign.

Provider Community Engagement & Staff Enrichment

Conferences & Workshops

The Inspector General and other OMIG personnel have conducted presentations and provided training at multiple conferences and seminars throughout the year. These appearances include the Arkansas Association of Professional Coders, the Medicaid Integrity Institute, the Arkansas Developmental Disabilities Provider Association, AFMC Workshops, Opioid Training for Law Enforcement, the Healthcare Fraud Prevention Partnership, and other healthcare-related groups and state agencies. In addition, OMIG personnel have also participated in online webinars related to behavioral health billing and the PASSEs.

OMIG will continue to provide training and assistance to Medicaid providers and staff as part of the overall mission to educate and identify fraud, waste, and abuse in the Arkansas Medicaid Program. OMIG's educational outreach has enhanced Medicaid Program Integrity compliance, and increased provider self-reports of improper payments.

NAMPI

In August 2019, Medicaid Inspector General Elizabeth Smith spoke at the National Association for Medicaid Program Integrity (NAMPI) conference in Atlanta, GA. In conjunction with the Arkansas Attorney General's Medicaid Fraud Control Unit (MFCU) Deputy Director, she presented a program integrity cross-training and discussed how states can more effectively collaborate with their own MFCUs. In that presentation, Medicaid Inspector General Smith highlighted the variety of ways in which teamwork and communication between the organizations enhances the ability to identify and prosecute Medicaid fraud.

Continuing Education

Throughout the year, OMIG staff has attended local and national conferences pertaining to program integrity, Medicaid policy, cost avoidance, vendor contracts, and Arkansas Medicaid programs. OMIG staff members continue to attend training courses and other symposiums held by the Center for Medicare and Medicaid Services' Medicaid Integrity Institute (MII). These courses are provided to qualified state employees and are 100% funded by the federal government through the Department of Justice.

In State Fiscal Year 2020, 13 OMIG personnel attended and completed 14 courses at the MII. One OMIG employee successfully achieved certification as a Program Integrity Professional and completed training in fundamental coding, auditing, investigating, program integrity, and coding evaluation and management. This certification and training strengthens the credibility of our staff and aids in communication among auditors, data analysts, investigators, and other medical professionals. The collaboration and knowledge shared during these courses enhances Medicaid program integrity by providing innovative ideas and tools to assist in detection and prevention of fraud, waste, and abuse in the Medicaid program.