Annual Report

Fiscal Year 2021

Department of the Inspector General

Office of the Medicaid Inspector General

Dear Governor Hutchinson, Attorney General Rutledge, President Pro Tempore, Senator Hickey, Speaker of the House, Representative Shepherd, the Division of Legislative Audit, and Legislative Council,

On behalf of the Office of the Medicaid Inspector General, I am pleased to present this report of our activities for State Fiscal Year 2021. 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 fee-for-service Providers and serves in an oversight capacity for the special investigative units of the Dental Managed Care Organizations (MCOs) and the Provider-Led Arkansas Shared Services Entities (PASSEs).

This year has been exceptional. We began this fiscal year during a global pandemic public health emergency as a result of COVID-19. During the pandemic, Arkansas Medicaid adjusted care delivery to ensure beneficiaries received the care they need while allowing Medicaid providers flexibility to focus on reduction of virus spread and maintain necessary precautions.

As a result, OMIG adjusted our manner of program integrity oversight. OMIG continued audit activities during the COVID-19 pandemic by adjusting audit activities. Medicaid providers received additional time to provide records and responses to audit inquiries. Most of the audits were conducted by desk review, however two audits resulted from suspicion of criminal activity, thus those warranted onsite audits. OMIG worked closely with the Arkansas Department of Human Services to review the temporary changes to Medicaid billing and system edits that had been implemented. These changes allowed for expansion of telemedicine services, along with services necessary to address COVID-19 and the needs of the Medicaid population during this time. OMIG continues to collaborate with local, state, and federal entities to protect and safeguard the Medicaid Trust Fund.

We also are realizing the results of the recent implementation of the managed care models in Arkansas Medicaid with the Dental MCOs and the PASSEs. These managed care models are required to conduct program integrity reviews through their special investigative units. OMIG conducts quarterly meetings with each organization for review of their efforts to fight fraud, abuse, and waste. In addition to the quarterly reporting and meetings we have regular interactions and trainings with the MCOs and PASSEs. Previously, OMIG routinely conducted high numbers of audits of both behavioral health and developmental disability providers. However, with the implementation of the PASSE model, OMIG's oversight role has adapted accordingly, and these numbers have declined and OMIG's superintendency has shifted to focus more on qualitative factors. To that end, OMIG is not reporting on the PASSEs' audit numbers, recoveries, or recoupments.

Respectfully,

Elizabeth Thomas Smith

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OMIG Audit Activities

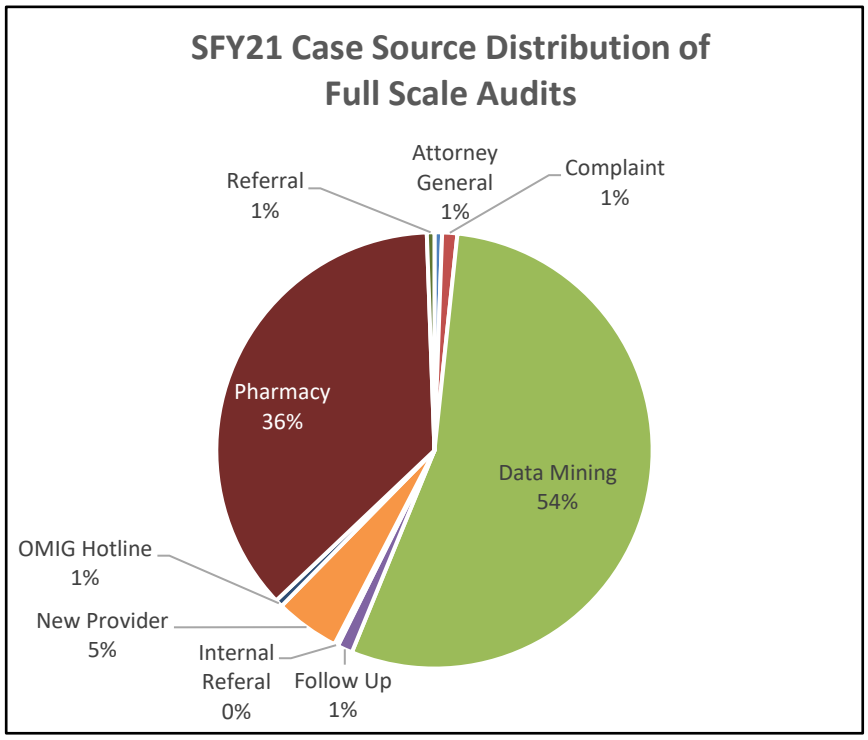
During SFY21 Medicaid audits continued, but there were many changes due to difficulties associated with the Public Health Emergency (PHE). While OMIG has always strived to work with a Provider during the course of an audit, that need was never greater than during the past year. Most audits were conducted via desk review and on-site audits were limited only to cases of suspected criminal activity where a desk audit would not suffice. Some Providers reduced their hours due to quarantine and a lack of staff, while other Providers were nearly overwhelmed with the increased use of telehealth services and the additional medical care required due to COVID-19. OMIG worked with each Provider as needed, routinely granting additional time for Providers to gather and produce records. In a few cases, audits had to be postponed for months due to a temporary business closure or because a Provider or its staff suffered from COVID-19. Oftentimes, audits were delayed upon Provider request for several weeks to allow Providers the additional time. The number of audits performed during the year was reduced as a result of these and other factors.

Inversely, although the audit numbers were reduced, OMIG saw an exceptional increase in the fraud, waste, and abuse activity identified within audits and reported through complaints. Data analysis generally accounts for at least two-thirds of the source of audits. During SFY21, however, an increase in complaints as the source for audits lowered the reliance upon data alone. Data analysis was responsible for only 54% of all audits opened for the fiscal year, whereas the OMIG Investigations Unit referrals to audit tripled from the previous year.

In guarding for abuses in the Medicaid system, OMIG uses a multi-faceted audit approach with professionally trained auditors, coders, and medical professionals. We rely heavily upon data analysis capabilities to detect practices of fraud, waste, or abuse. Typically, 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. OMIG sent fewer recovery letters during SFY21 due to the PHE to reduce provider burden. However, OMIG will pursue the recovery letters again in SFY22.

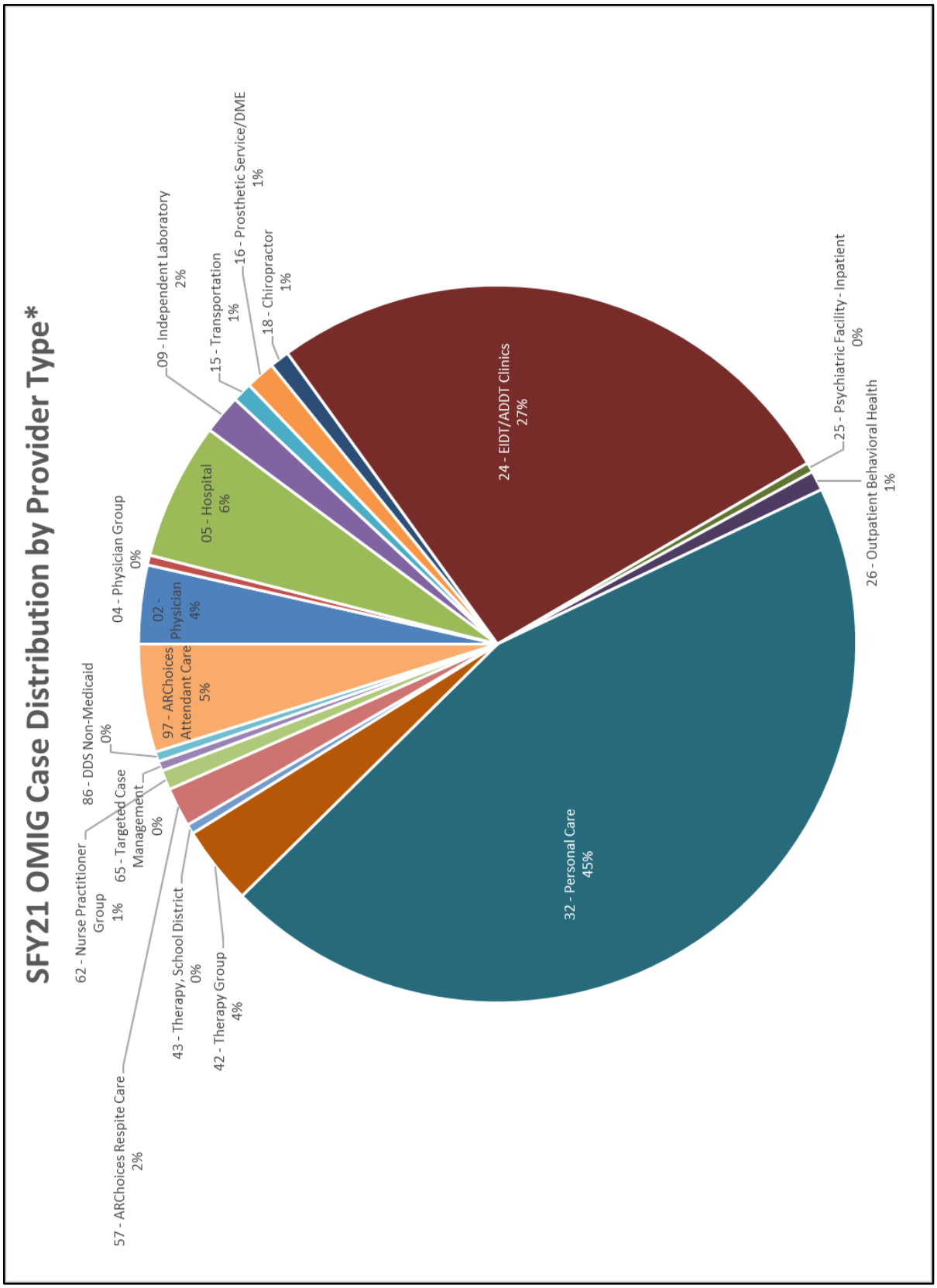
In SFY21, the number of on-site audits, desk audits, provider self- audits, and False Claims Act Compliance Reviews totaled 481 separate events or cases, as shown in the following charts. OMIG places special emphasis on reviewing high- risk and new providers for compliance, as illustrated in the distribution of provider types reviewed in SFY21 as seen on the next page.

OMIG Audit Activities



Summary of Audit Activities	
Onsite Audits	2
Desk Audits	51
Provider Self Audits	43
False Claims Act Reviews	125
Contractor Audits	130
Recoupment Letters	130
TOTAL	**481**

OMIG Audit Activities



Medicaid Provider Self Reports

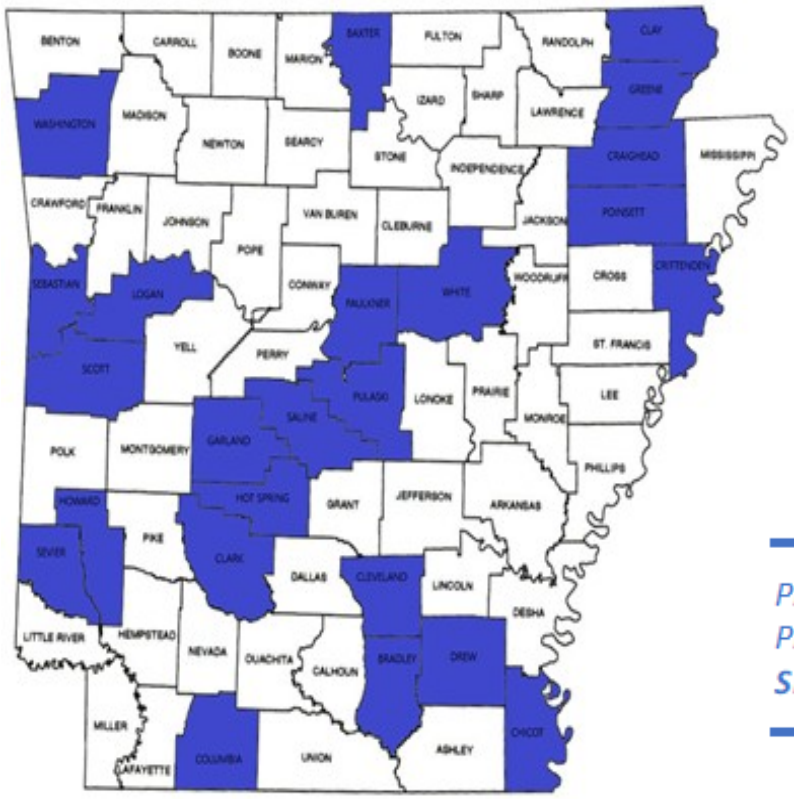
OMIG has always relied on Medicaid Providers filing self-reports. Many Providers' self-reports have been driven by OMIG's Provider Awareness Letters (PALs) which give notice to specific Providers that data analysis has discovered what appear to be overpayments. In SFY21, OMIG sent 43 PALS notifications as opposed to more than 150 the previous year. While we reduced the number of self-reports, Medicaid Providers remained on the alert for overpayments and self-reported a total of $40,880.32 as improper payments received in error from the Arkansas Medicaid program. OMIG's self-report procedure enhances elimination of fraud, waste, and abuse, while using a less burdensome manner of ensuring program integrity than audit and 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

During SFY21, OMIG pursued administrative actions against individuals and entities engaging in fraud, abuse, and improper billing practices. As a result, OMIG suspended 19 Medicaid providers and excluded 26 Medicaid Providers. The map below depicts the suspensions and exclusions by county in which the Medicaid Provider is located. OMIG excluded Medicaid Providers in 24 Arkansas counties and 2 Providers located in Texas for State Fiscal Year 2021.

Under state and federal laws, OMIG has the responsibility of investigating potential Medicaid fraud, waste, and abuse. When credible evidence of fraud is found, OMIG is required to refer those cases to the Arkansas Attorney General's Medicaid Fraud Control Unit (MFCU) for criminal investigation. In most circumstances, OMIG must suspend payment of Medicaid reimbursement to the referred individuals and/or entities. The suspension of payment prevents further depletion of Medicaid funds once fraud is suspected. When MFCU has completed the investigation, if a criminal conviction or civil settlement is obtained, OMIG will place the Provider on the DHS Exclusion List. By being excluded, the Provider (and often closely related parties) are prohibited from participating in any DHS program, including all contracts, grants, licenses, certifications, and agreements involving appropriated funds.



Provider Suspensions	*19*
Provider Exclusions	*26*
SFY 2021 Total	***45***

Fraud Investigations

In SFY21, the OMIG Investigations Unit saw a remarkable 45% increase in the number of cases it reviewed. OMIG receives leads for investigation from audits, public complaints received through the OMIG fraud hotline, self-reports by Medicaid Providers, referrals from outside departments, and referrals from law enforcement including the Attorney General's MFCU. The past year's increase was fueled by many things, including complaints by Medicaid beneficiaries regarding telehealth services billed but not performed. Another reason for the increase was due to the new Electronic Verification Visit (EVV) system, which requires personal care aides and home health aides to electronically clock in and out while at the beneficiary's home. The system led to both beneficiaries and the Medicaid Provider agencies making complaints that the aides were simply driving by and clocking in and out and thereby billing Medicaid for services not rendered. The complaints regarding excessive laboratory billing also increased the numbers.

Overall, OMIG's Investigation Unit opened and investigated 93 cases for fraud, with one case still open and active at this time. As a result of the investigations, OMIG internally referred 27 cases for audit. It also referred 25 cases to MFCU for potential criminal prosecution as compared to 12 cases referred to MFCU the previous year.
During SFY21, the OMIG investigation team continued to work closely with the Medicaid Dental Managed Care Organizations (Dental MCOs) and the Provider-led Arkansas Shared Savings Entities (PASSEs). Delta Dental of Arkansas and Managed Care of North America Dental serve as the dental benefits managers for the Arkansas Medicaid/CHIP program, providing dental services to Medicaid recipients. Each Dental MCO is required to maintain its own Special Investigations Unit (SIU), and is contractually obligated to investigate fraud, waste, and abuse internally. The Dental MCOs provide a quarterly report to OMIG and DHS. The organizations then meet individually with OMIG to discuss cases, trends, and issues.

Arkansas Total Care, Empower Healthcare Solutions, and Summit Community Care are the full- risk benefits managers serving as the PASSEs for Tier 2 and Tier 3 behavioral health recipients, as well as all developmentally disabled recipients. As with the Dental MCOs, each PASSE has its own SIU. 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.

OMIG serves the oversight role for program integrity to bolster transparency and accountability by clarifying and monitoring requirements meant to reduce fraud, waste, and abuse. To increase communication with the Dental MCOs and PASSEs, OMIG instituted a Provider Alert File which immediately notifies the Dental MCOs and PASSEs when a Medicaid Provider is suspended, excluded, has had an adverse action regarding their license, as well as Providers exhibiting high risk billing behavior. The SIUs investigate matters within their organizations and send referrals to OMIG when fraud or abuse is suspected.

Through this cooperative relationship, OMIG and the Managed Care Organizations are better able to identify, target, and eliminate fraud, waste, and abuse within the Medicaid program.

Fraud Investigations

OMIG also receives complaints regarding potential beneficiary fraud. Since OMIG is limited to pursuing administrative actions against Medicaid Providers, any complaint against a Medicaid beneficiary is reviewed for referral. Upon receipt, an OMIG investigator conducts a preliminary assessment and gathers information. If the complaint involves collusion between a beneficiary and Medicaid provider, OMIG will complete the investigation and refer the case to the AG's MFCU for possible criminal prosecution. However, if the issue involves only a beneficiary, the matter will be referred to the Department of Human Services. In SFY21, OMIG referred 98 cases of suspected Medicaid beneficiary fraud to DHS for determination of eligibility, more than double the number of cases from the previous year.

Occasionally, OMIG receives complaints which are outside of OMIG's investigative authority but require further review or investigation. OMIG works closely with other investigative agencies to ensure that each complaint is referred to the state or federal agency with proper jurisdiction and investigative authority. In SFY21, OMIG referred 18 cases to outside investigative agencies to further investigate the reported issue, including the federal Office of Inspector General, the Federal Bureau of Investigation, the Social Security Administration, and Arkansas's Adult Protection Services, among several others.

Program and Policy Review

Electronic Visit Verification

The 21st Century Cares Act required State Medicaid Agencies to implement electronic visit verification (EVV) for all personal care service agencies and home health services requiring provider in-home visits. 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. As noted above, there has been an increase of fraud reports based on EVV. 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.

COVID-19 and Telemedicine Review

In response to the PHE 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. This monitoring has continued through SFY21.

During the weeks following the emergency declaration, OMIG worked 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 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

Another statutory requirement is OMIG's review of all 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.

Contracts can be created either by the State Office of Procurement or an authorized Procurement Officer in the specific agency. In either case, the Agency is responsible for monitoring adherence by the Vendor and determining the effectiveness of the Contract.

In SFY21, OMIG reviewed eighty-eight Medicaid contracts.

Arkansas Contracts Audited by OMIG SFY 2021

Type of Procurement	Number of Contracts	7 Year Cost Allocation
Request for Proposal (FB)	12	$1,181,668,679
Invitation for Bid (IFB)	24	$406,123,397
Competitive Bid (CB)	9	$19,085,733
Intergovernmental	14	$906,835,367
Small Order (SO)	3	$7,697,200
Special Procurement	3	$67,050,916
Request for Qualifications (RFQ)	5	$3,574,208
Other	18	$16,493,815
Total	88	$2,608,529,315

OMIG performs both comprehensive audits and more focused audits of DHS contracts. In performing a comprehensive audit, OMIG reviews the procurement document, all responses to the procurement document, adherence to performance-based contracting standards, actual cost analysis, qualifications of the vendor, and monitoring of the contract by DHS. With focused auditing, OMIG reviews more selective portions of a contract such as procurement method, contract extensions series, objective and scope, payment method, payment estimate, amendments, and reasons for amendments. During SFY21, OMIG performed comprehensive audits of sixteen (16) contracts and focused audits on all remaining contracts.

Program and Policy Review

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 identifying 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.

In SFY21, 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 continued its role on the Prescription Drug Overdose Advisory Workgroup organized by the State Drug Director.

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.

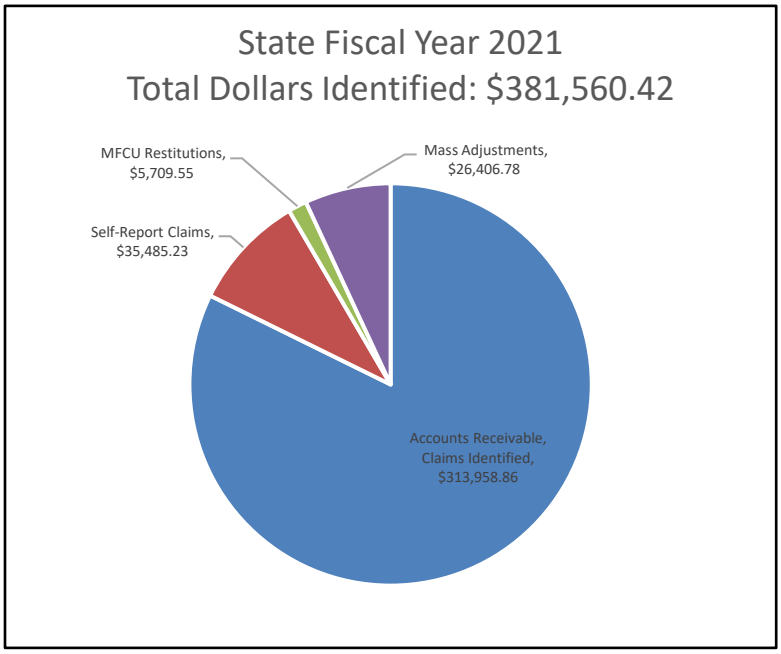
The UPIC is contracted to perform Medicare and Medicaid program integrity reviews and assistance to enhance state program integrity functions. Arkansas lies within the Southwestern UPIC jurisdiction along with Colorado, Oklahoma, Mississippi, Missouri, New Mexico, and Texas and is served by Qlarant Integrity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

In SFY21, Qlarant initiated reviews of hospice, radiology, hyperalimentation, durable medical equipment (DME) providers, as well as prescribers of high numbers of opioids. Qlarant also provides data analysis support and policy research supporting fraud investigations.

OMIG Recoveries and Recoupments

OMIG Identified Dollars for Recovery

The total amount of Medicaid funds identified for recovery in State Fiscal Year 2021 (SFY21) by OMIG activities is $381,560.42. As noted in the chart, OMIG uses various methods to identify improperly paid Medicaid dollars, including: audits, recoupment letters identified as accounts receivable claims, provider self-reports, recoupment letters based on data analysis, and restitution from criminal fraud and civil false claim referrals to the Medicaid Fraud Control Unit. OMIG continues the Provider Awareness Letter initiative and provider educational seminars to impress upon providers the importance of program integrity. These efforts continue to show results.



OMIG Collections

In SFY21, $521,837.09 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 2021 OMIG Dollars Recovered

Accounts Receivable Claims	$342,106.77
Self-Report Collections	$125,875.59
Restitution and False Claims	$27,447.95
Mass Adjustments and Reversal	$26,406.78
TOTAL	**$521,837.09**

Contractor Program Integrity Activities

Optum Pharmacy

In SFY21, 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 by Optum.

As a result of the coordination with OMIG, Optum selected 130 pharmacy providers to audit in SFY21. These 130 providers were chosen for audit using multiple algorithms that Optum ran on a regular schedule. For SFY21, data analytics supported the use of the following algorithms: package-size billing errors, near duplicates, kit errors, unreasonable quantity tabs and capsules, insulin billing errors, inhalers and nasal products, injectable medication billing errors, parent/child billing errors, topical optic and ophthalmic errors, services after death, and compounds.

All 130 pharmacy audits were selected as desk audits. There was a total of 8,363 records requested for Optum to review and incorporate into the audits, totaling a paid amount of $7,362,293.14. As of the publication of this report, 85 audits have been completed. A total of 1,132 claims were identified 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 $264,507.02 has been identified for recoupments.

The pharmacy audit program continued the necessary modifications put into place at the outset of the public health emergency. Optum continued to use multiple layers of communication to each of the pharmacies requiring documentation submission. Additionally, Optum continued to allow for deadline extensions to those pharmacies with limited staff and access to the files. Any planned onsite audits were performed as a desk audit. These examples are just a few key changes that Optum and OMIG carried over from the previous fiscal year in response to the COVID-19 crisis.

During SFY21, Optum continued to report fraud identified through the pharmacy audit program. Optum also continues to support and collaborate with OMIG on cases currently under investigation with MFCU. This partnership provides subject matter expertise where it is most beneficial to produce the strongest evidence.

Contractor Program Integrity Activities

■ Optum Fraud and Abuse Detection System (FADS)

Optum hosts the Medicaid Enterprise Decision Support System that contains the Fraud and Abuse Detection System (FADS) through its contract with DHS. 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 SFY21, new algorithms were developed and tested through the FADS partnership, and new and existing algorithms were further tuned and edited to add Dental Managed Care and PASSE data fields. These additional fields are designed to help identify improper PASSE and Dental Managed Care claims.

The new algorithms are as follows:

- Psychotherapy Patient Churn - Detects providers who may be exhausting the yearly maximum allowed psychotherapy benefits for a beneficiary in a short time frame for expedited revenues and thus prevents the beneficiary from receiving further treatment later in the year

- Covid-19 Lab Testing - Focuses on beneficiaries that receive excessive lab testing in conjunction with COVID-19 testing on the same day

- Denied through Fee-for-service and Paid by Managed Care Organization – Reviews denied fee-for-service claims data for claims that have been subsequently paid by the MCO

Other key activities conducted through the FADS partnership include:

- Virtual training in November 2020 for 15 OMIG employees

- At OMIG's request, the Optum FADS team created an online Telemedicine dashboard detailing the number of telemedicine claims and amount paid for any date range. This resulted in a seamless transition from a weekly dashboard to one that could be easily accessed online, thus saving a substantial amount of disk space. Two different online dashboards were created—one to indicate all telemedicine claims with the required modifier attached and another to indicate which claims did not include the required modifier.

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. Although the number of Provider Awareness Letter (PAL) Initiatives decreased during the PHE, OMIG continued to use this tool 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.

Provider Awareness Letter campaigns that were conducted in State Fiscal Year 2021:

- False Claims Act Compliance
- Non-Emergency Transportation Procedures Greater Than 150 Miles

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 125 False Claims Act Compliance Reviews during SFY21.

Non-Emergency Transportation Procedures Greater Than 150 Miles

As a result of the Recoupment Letter campaign created for non-emergency transportation procedure A0120, OMIG sent out a Provider Awareness letter to all providers with claims that were greater than 150 miles on a single date of service. The Medicaid Manual policy explains that services are only covered for "loaded miles" and mileage is calculated based on the odometer reading from the point of pick up to a facility, and then from the facility to return to the drop-off.

In the case of multiple beneficiaries, that mileage is calculated based on the odometer reading for the beneficiary traveling the most distance. Additionally, the route traveled must be reasonable, planned to minimize time, and not include unnecessary extended routes that would increase mileage. For this review, OMIG considered claims for this service from January 1, 2019, through September 30, 2020. Many providers have conducted extensive self-reviews as a precaution from the letter where billing issues were found, and providers self-reported those billing errors. As a result of this letter campaign, OMIG has recovered $5,348.41 to date from this initiative and provider reviews are still ongoing at this 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. The Recoupment Letters are less detailed than a full audit and yet still ensure the integrity of the Medicaid Program.

Provider recoupment letters that were submitted in State Fiscal Year 2021:

- Duplicate COVID testing procedures
- Home and Community Based Services Billing and Inpatient Services Billing Overlap
- Non-Emergency Transportation Greater than 150 miles per Date of Service

■ Duplicate COVID Testing Procedures

As mentioned in the program and policy review section, during SFY21 OMIG performed a data analysis review of duplicate or near duplicate claims paid for COVID-19 testing procedure codes for the same date of service for the same recipient. Procedure codes that were included in this review are U0001, U0002, U0003, U0004, and 87635. OMIG identified multiple instances where providers submitted duplicate COVID-19 procedures for the same patient on the same date of service in error. OMIG sent 20 recoupment letters to Medicaid providers that were identified in this analysis. In total, OMIG has recovered $1,982.70 as a result of this letter campaign and provided valuable education in how to properly bill COVID-19 testing procedures to Medicaid. OMIG will continue to monitor these procedures codes going forward for fraud, waste, and abuse, and will educate providers on proper billing procedures should the need arise.

■ 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.

Initiatives

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 January 1, 2020, to July 31, 2020. 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 intentionally 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 100 recoupment letters to HCBS providers based on this review. During fiscal year 2021, OMIG recovered $32,686.24 as a result of this initiative and referred 1 personal care provider to MFCU for fraud.

- **Non-Emergency Transportation Greater than 150 miles per Date of Service**

In State Fiscal Year 2021, OMIG conducted a focused review of 10 providers who were paid for non-emergency transportation billing for procedure code A0120. The focus of this review was for claims that were greater than 175 miles on a single date of service. The Medicaid Manual policy explains that services are only covered for “loaded miles” and mileage is calculated based on the odometer reading from the point of pick up to a facility, and then from the facility to return to the drop-off. In the case of multiple beneficiaries, that mileage is calculated based on the odometer reading for the beneficiary traveling the most distance. Additionally, the route traveled must be reasonable, planned to minimize time, and not include unnecessary extended routes that would increase mileage. For this review, OMIG considered claims for this service from January 1, 2019, through September 30, 2020. As of today, OMIG has recovered $44,854.54 from this initiative.

Provider Community Engagement & Staff Enrichment

Conferences & Workshops

Providing training and assistance to Medicaid providers and their staff is part of the overall mission to educate and identify fraud, waste, and abuse in the Arkansas Medicaid Program. In SFY21, OMIG personnel gave presentations to the National Association for Medicaid Program Integrity (NAMPI), State Information Sharing Session on COVID-19 Testing, the Arkansas Association of Professional Coders, the National Health Care Anti- Fraud Association, the Arkansas Developmental Disabilities Provider Association, AFMC Workshops, and the Healthcare Fraud Prevention Partnership.

Medicaid Inspector General Elizabeth Smith continued to serve as the Region IV representative to CMS' Technical Division Group for Fraud, Waste, and Abuse. In that role, Smith has been involved on a national level in discussions on Medicaid program integrity and brought that information back to Arkansas Medicaid providers.

NAMPI

In August 2020, Medicaid Inspector General Elizabeth Smith and OMIG Program Administrator Brandy Cook spoke at the NAMPI virtual conference. They presented a session on Arkansas OMIG COVID-19 Response in which they discussed Arkansas OMIG's use of data analytics to monitor emergency changes to Medicaid policy for fraud, waste, and abuse. At the same conference, OMIG Audit Coordinator and certified coder Michael McNeely presented Medical Coding Overview for Non-Coders to help enhance the understanding of the billing codes used for submitting Medicaid claims.

Continuing Education

Throughout the year, OMIG staff attended more than 74 courses in continuing professional education. OMIG staff members continue to attend training courses and other symposiums held by the Center for Medicare and Medicaid Services' Medicaid Integrity Institute (MII), NAMPI, State Information Sharing Sessions, and the National Health Care Anti- Fraud Association (NHCAA). Most in-person courses including MII were suspended due to the COVID pandemic, but OMIG staff attended on-line conferences where available. These valuable courses are provided to qualified state employees and are 100% funded by the federal government through the Department of Justice, so future attendance is anticipated.

OMIG has a highly-trained professional staff that includes:

- Two Registered Nurses (RN), one with double board certifications;
- Four Certified Professional Coders (CPC);
- One Licensed Clinical Social Worker (LCSW);
- One Registered Health Information Technician;
- One Surveyor certified by the Commission on Accreditation of Rehabilitation Facilities; and
- Three Certified Program Integrity Professionals.

Provider Community Engagement & Staff Enrichment

In addition, 21 OMIG staff hold doctoral, master's, bachelor's, or other degrees in health care, information technology, data analytics, law, or allied fields.

In State Fiscal Year 2021, OMIG personnel attended and/or completed 11 Medicaid-related courses by the Medicaid Integrity Institute, NAMPI or other Medicaid-related organizers. Two OMIG employees obtained training in medical coding under the American Medical Association's CPT medical coding system. Three OMIG employees are currently enrolled in the American Academy of Professional Coders (AAPC) Professional Medical Auditor class in pursuit of Certified Professional Medical Auditor certificates, and one OMIG employee obtained certificate status as a medical coder in SFY 2021.

Certifications and continuing training strengthen 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.