Annual Report
Fiscal Year 2022

Department of the Inspector General

Office of the Medicaid Inspector General

Message from the Medicaid Inspector General

I am pleased to present the Office of the Medicaid Inspector General Annual Report for State Fiscal Year 2022. Created to prevent, detect, and investigate fraud, waste, and abuse in Arkansas Medicaid, OMIG serves the statutorily required Medicaid program integrity function. OMIG performs auditing and investigative activities to identify fraud and recover improperly expended funds. OMIG further enhances the integrity of the Medicaid program by review of the Arkansas Department of Human Services policies and program activities and by making recommendations. Suspected allegations of fraud are referred for criminal prosecution by OMIG to the Attorney General's Medicaid Fraud Control Unit, as well as to federal, state, and local law enforcement.

OMIG's greatest impact in FY22 was a referral to the Medicaid Fraud Control Unit of the Office of the Attorney General regarding improper activities of a PASSE for community investment projects and behavioral health provider stabilization payments. This referral resulted in a settlement of $8M in restitution to the Arkansas Medicaid program.

Administrative actions taken by OMIG doubled in FY22. OMIG suspended 46 providers for credible allegations of fraud, excluded 40 providers for criminal convictions or other wrongdoing, and terminated five providers from the Arkansas Medicaid Program, for a total of 91 sanctions. Our investigative division developed a process to receive timely notification from medical licensing and certification boards regarding actions taken affecting a license or certification. When a provider's license or certification is affected by board activity often that results in the need to suspend, exclude or terminate from Arkansas Medicaid. OMIG's action prevents claims from being improperly paid as a result of the board action.

There was also an increase in audits this year. Field audits were conducted specifically for cases that required an in-person investigation. Over the past two years, we learned that we could perform a great deal of valuable work through data analytics prior to or even without conducting an onsite audit. When performing onsite audits, this background work allows for a reduction in the number of days in the field per audit than in previous pre-pandemic years. We had fewer costs incurred for travel and lessened the burden on providers and audit staff by streamlining the onsite field audits. The number of desk audits also increased to 55 desk audits and the pharmacy contract auditors conducted 155 desk audits this year. OMIG's letter campaigns reached over 1,200 providers and recovered improperly paid claims. Our "recoupment" letter campaigns have proven to be an efficient mechanism of recovery whereby the provider is notified of the impending recoupment and given an opportunity to respond. All providers receive training on corrective action and how to avoid improper payments in the future.

The traditional program integrity methods of provider auditing and education for fee-for-service Providers have continued and are now complemented by OMIG's enhanced oversight of the Dental Managed Care Organizations (DMOs) and the Provider-Led Arkansas Shared Services Entities (PASSEs). OMIG conducts quarterly meetings and has regular interactions with the special investigation units of each of the managed care organizations to enhance their efforts to fight fraud and abuse. OMIG has worked closely with DHS in revision of the PASSE and DMO contracts to ensure compliance with CMS regulations. OMIG continues to collaborate with local, state, and federal entities to protect and safeguard the Medicaid Trust Fund.

Respectfully,

Elizabeth Thomas Smith

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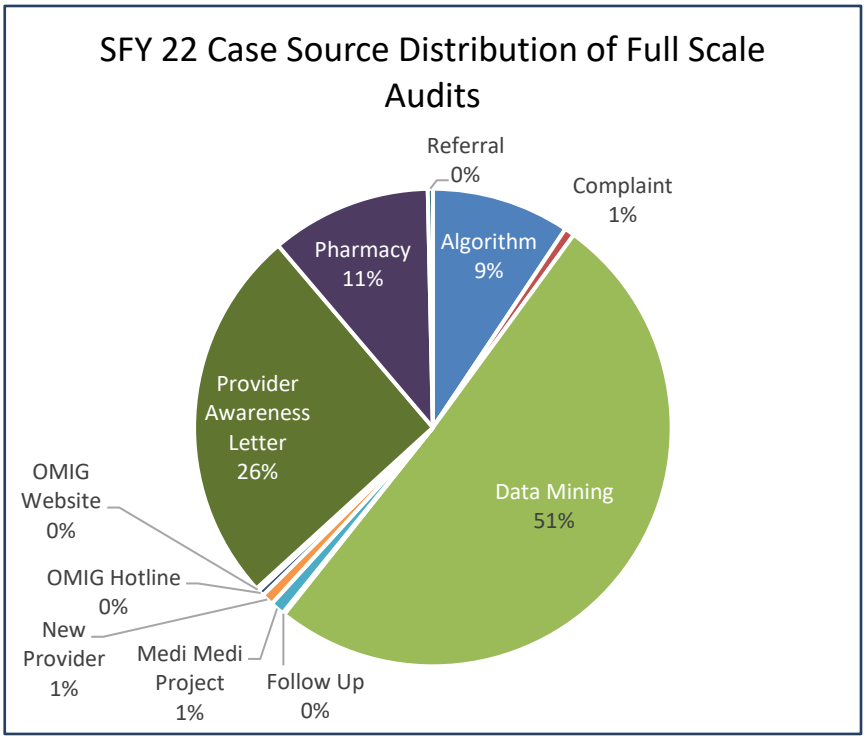
OMIG Audit Activities

The number of OMIG Audit activities significantly increased this year over the past two years to a total of 1,598 separate activities. In guarding for abuses in the Medicaid system, OMIG continues to use professionally trained auditors, coders, data analysts, and medical professionals to perform the activities. We rely heavily upon data analysis capabilities to detect practices of fraud, waste, or abuse. Complaints and referrals are reviewed by our data analysis team prior to investigation or audit.

While continuing to ensure compliance with Medicaid regulations and enhance Medicaid program integrity, OMIG expanded its reach to providers through Recoupment Letters sent to Medicaid Providers identifying improperly paid claims. The nature of these claims required no medical record review to determine whether the claim would need to be recouped, the provider was simply notified of the fault and the funds recouped. OMIG also sent Provider Awareness Letters requesting the provider conduct a self-audit. OMIG focused on growing recoveries while reducing provider burden and reliance on OMIG resources.

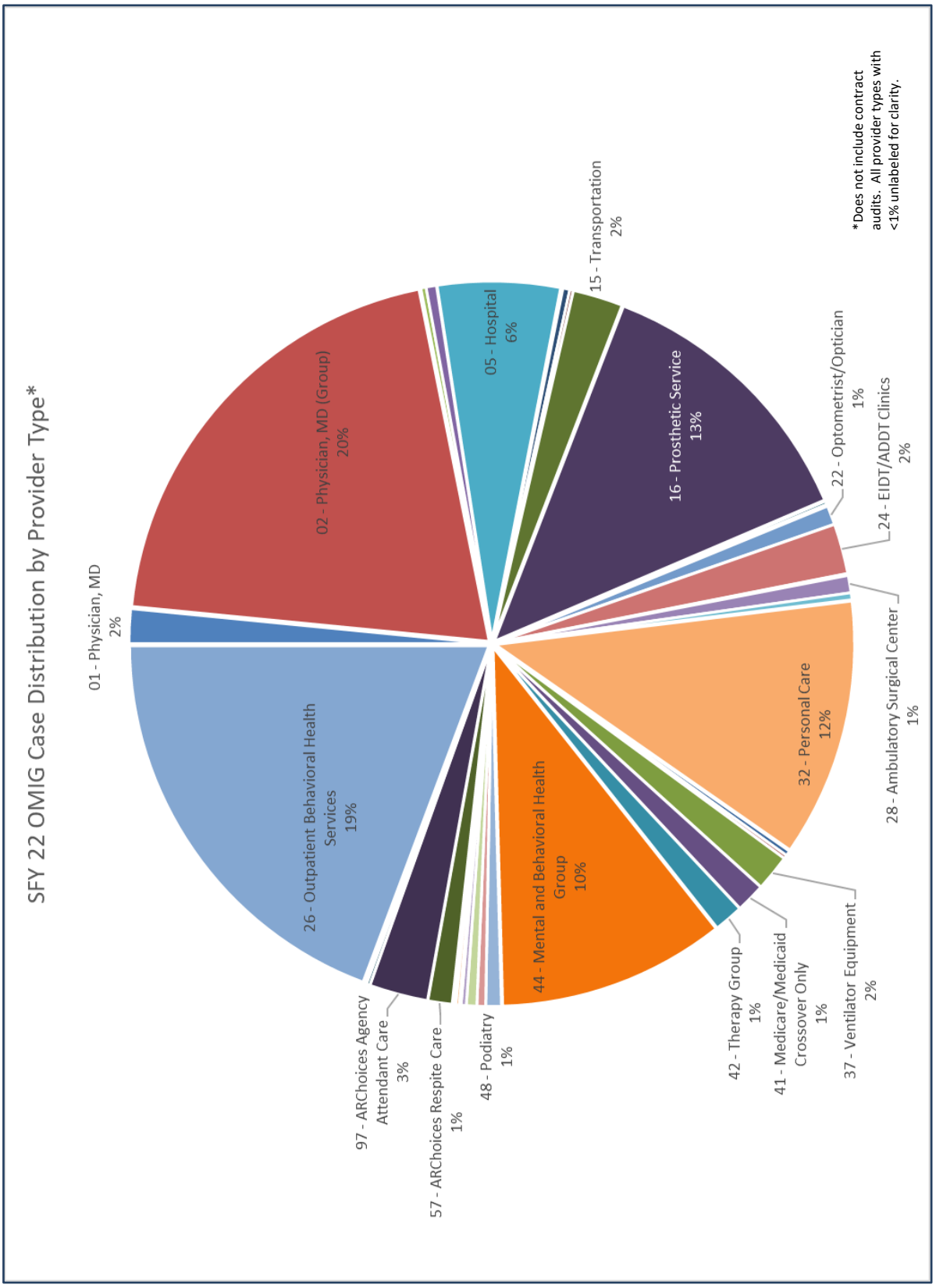
Traditional service-to-billing audits often require providers to submit large volumes of medical records for review by OMIG auditors which can be burdensome on providers as well as OMIG auditors taking weeks to complete. This type of auditing continues to be necessary in many instances, specifically for high-risk providers and when billing appears proper through data analysis. OMIG also places special emphasis on reviewing new providers, who have been in business billing Medicaid for six months, we take this opportunity to ensure compliance with Medicaid policy and to provide training. OMIG conducted more audits of Physicians and Behavioral Health Providers than last year. Home and Community Based services which include Personal care, Respite Care, and Attendant Care providers, continued to be a focus for audits and fraud referrals. The distribution of provider types reviewed in SFY22 is illustrated in the chart on the next page.



Summary of Audit Activities

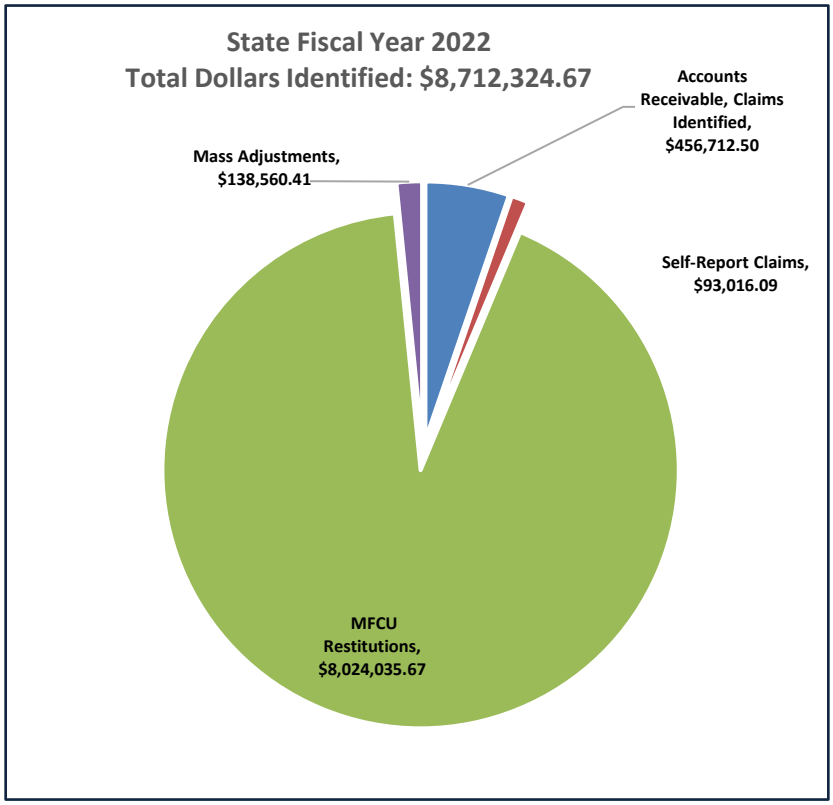
Onsite Audits	5
Provider Awareness Letters	374
Desk Audits	55
False Claims Act Reviews	135
Contractor Audits	173
Recoupment Letters	856
TOTAL	**1,598**

OMIG Audit Activities



OMIG Recoveries and Recoupments

OMIG Identified Dollars for Recovery



The total amount of Medicaid funds identified for recovery in SFY22 by OMIG activities is $8,712,324.67. 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 (MFCU). 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. While the amount identified for recovery is greater this fiscal year than last year, the large amount recovered by MFCU from overpayment to one of the PASSEs creates a bit of an anomaly. Regardless, the amounts identified and recovered continue to reflect the effectiveness of the program.

OMIG Collections

In SFY22, $8,864,594.03 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 span 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 2022 OMIG Dollars Recovered

Accounts Receivable Claims	$643,915.36
Self-Report Claims	$58,082.59
Restitution and False Claims	$8,024,035.67
Mass Adjustments and Reversal	$138,560.41
TOTAL	**$8,864,594.03**

Fraud Investigations

OMIG receives leads for investigation from audits, complaints received through the OMIG fraud hotline, self-reports by Medicaid providers, referrals from outside agencies, and referrals from law enforcement including MFCU. OMIG also uses data analytics to identify fraud consistent with national and federal program integrity trends. In SFY22, one hundred sixty (160) cases were opened for fraud investigation, with five (5) cases still open and active at this time. Twenty (20) fraud investigations were referred to MFCU with fourteen (14) of those providers being suspended for a credible allegation of fraud.

OMIG continues to provide oversight and work closely with the Special Investigative Units (SIU) of the Medicaid Management Care Organizations (MCOs), including the Dental Managed Care Organizations (DMOs) and the Provider-led Arkansas Share Savings Entities (PASSE). In SFY22, OMIG received a total of twenty (20) referrals of potential fraud, waste, or abuse from the MCOs: sixteen (16) referrals from the PASSEs and four (4) referrals from the DMOs. Through this cooperative relationship, OMIG and the MCOs are better able to identify, target and eliminate fraud, waste, and abuse within the Medicaid program.

Upon receipt of a complaint involving a beneficiary, a preliminary assessment is performed, and information is gathered. If the complaint involves collusion between a beneficiary and a Medicaid provider, OMIG will continue the investigation and prepare a referral to MFCU. However, if the issue involves only a beneficiary, the matter will be referred to either the Arkansas Department of Human Services or the U.S. Office of Inspector General Social Security Administration Fraud, Waste, or Abuse Division for investigation depending on the type of benefits the beneficiary receives. In SFY22, OMIG referred fifty-three (53) cases of suspected Medicaid beneficiary fraud to DHS.

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 an agency with proper jurisdiction and investigative authority. In SFY22, OMIG referred thirty-six (36) cases to outside agencies to further investigate the reported issue

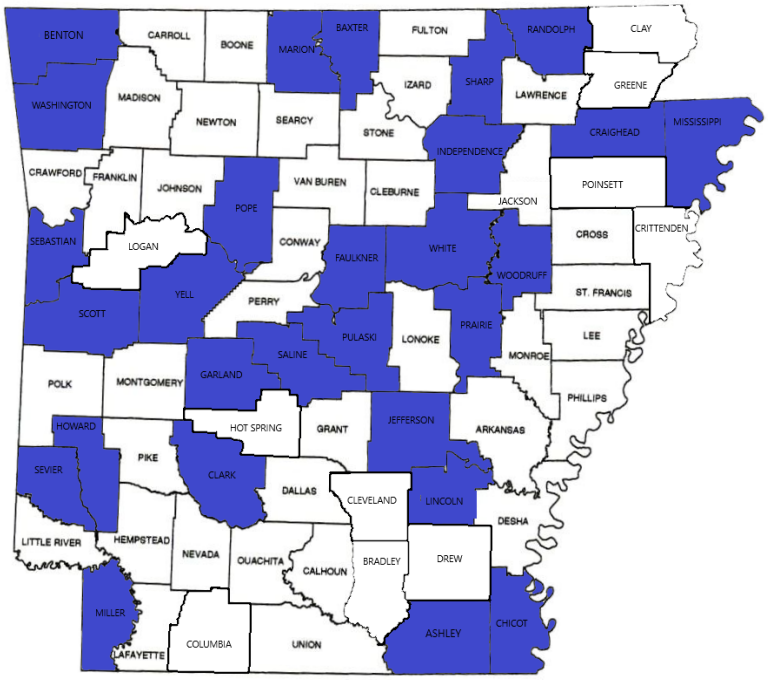
Administrative Actions

Suspensions, Exclusions, and Terminations

OMIG stops Medicaid payments to Medicaid Providers who are suspected of fraud, abuse, and improper billing activity by taking administrative action against the individual or entity provider. Administrative actions include suspension from payment, exclusion from participation, or termination from the Medicaid program. Suspension from payment is required upon identification of a credible allegation of fraud. At the conclusion of the investigation, the provider will either be excluded or reinstated depending on the outcome of the investigation. Regardless of the circumstances, each provider is afforded legal due process to appeal OMIG's decision in a hearing before an Administrative Law Judge.

The number of provider sanctions nearly doubled this year in large part due to an increase in fraud investigations. During this fiscal year, OMIG suspended forty-six (46) Medicaid providers, excluded forty (40) Medicaid providers, and terminated five (5) Medicaid providers for a total of ninety-one (91) Administrative actions, compared to fifty-one (51) last year. OMIG sanctioned Medicaid Providers in twenty-eight (28) Arkansas counties. The map below shows the counties in which sanctions were taken.

OMIG's investigative team made a concerted effort this year to obtain and utilize information from other jurisdictions to identify Arkansas Medicaid Providers who had been sanctioned in other states. Where the sanction would prevent the provider from participating in the Arkansas Medicaid Program, those providers were then excluded or suspended because of the out of state sanction. OMIG also sanctioned three (3) providers located in Texas, one (1) provider located in Pennsylvania, one (1) provider located in Oklahoma, and one (1) provider located in Kentucky.



Provider Suspensions	*46*
Provider Exclusions	*40*
Provider Terminations	*5*
SFY 2022 Total	***91***

Medicaid Self-Reports

In 1998, the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS) published the Provider Self-Disclosure Protocol to establish a process for persons to voluntarily identify, disclose, and resolve instances of potential fraud involving the federal health care programs (as defined in section 1128B(f) of the Social Security Act (the Act), 42 U.S.C. 1320a–7b(f)). This Protocol is designed to provide guidance and procedures to report an overpayment discovered by a health and human services program provider who has identified evidence of an overpayment by a health and human services program due to a mistake or potential fraud by a provider. Self-disclosure by a provider allows for that provider to potentially avoid prolonged investigation and litigation, and the exorbitant costs associated with each.

OMIG has encouraged Medicaid providers to file self-reports utilizing the self-report procedure located on our website. The procedure enhances elimination of fraud, waste, and abuse, while offering Medicaid providers a mechanism to reduce their legal and financial exposure through compliance. Self-report is open to all Medicaid providers, whether individuals or entities, and is mutually beneficial for both the State of Arkansas and the providers involved.

In SFY22, OMIG received twenty-six (26) provider self-reports which identified a total of $88,131.13 in improper payments received from the Arkansas Medicaid program. OMIG works closely with the self-reporting provider to coordinate any steps necessary to reach an effective and prompt resolution. All providers who self-report must submit a Corrective Action Plan (CAP) including appropriate measures to prevent recurrence of identified issues.

Program and Policy Review

Dental Managed Care Oversight and Collaboration

Delta Dental of Arkansas and Managed Care of North America Dental (DMOs) continue to serve as the dental benefits managers for the Arkansas Medicaid/CHIP program, providing dental services to Medicaid recipients. Each DMO has their own Special Investigative Unit (SIU) and is contractually obligated to investigate fraud, waste, and abuse internally and report to OMIG on a quarterly basis. 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 the quarterly reports and act as a liaison between the organizations and MFCU. For SFY22, the DMOs reported recoupments totaling $187,900.72, and three (3) provider referrals for suspected fraud.

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 the Provider-led Arkansas Shared Savings Entities (PASSEs) for Tier 2 and Tier 3 behavioral health recipients, as well as all developmentally disabled recipients. CareSource of Arkansas is the newest PASSE and began enrolling members in January 2022. As with the DMOs, each PASSE has its own SIU. The PASSE contract also requires quarterly reporting related to fraud, waste, and abuse. For SFY22, the PASSEs reported a collective total of $1,741.202.42 and 19 provider referrals for suspected fraud. OMIG is responsible to oversee and ensure that each PASSE is investigating fraud, waste, and abuse in compliance with program integrity regulations. OMIG meets quarterly with each PASSE to evaluate the reports and review efforts to combat fraud, waste, and abuse. In June 2022, OMIG conducted training on the implementation and reporting of these efforts. Compliance and SIU personnel from all four PASSEs attended the in-person event. In addition, OMIG notifies the PASSEs and DMOs about all suspensions and exclusions so the MCOs can mirror the state's actions.

Electronic Visit Verification Duplicate Payments

The 21st Century Cures 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. 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.

Program and Policy Review

Contract Reviews

Another statutory requirement for OMIG is the 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 SFY22, OMIG reviewed one hundred and two (102) Medicaid contracts totaling over four billion dollars.

Arkansas Contracts Audited by OMIG SFY 2022

Type of Procurement	Number of Contracts	7 Year Cost Allocation
Request for Proposal (RFP)	11	$ 3,739,764,244
Invitation for Bid (IFB)	35	$ 525,127,806
Competitive Bid (CB)	11	$ 6,215,955
Intergovernmental	15	$ 386,171,797
Special Procurement	5	$ 71,215,285
Request for Qualifications (RFQ)	6	$ 3,062,793
Cooperative Contract	7	$ 14,374,520
Other	12	$ 21,160,757
Total	**102**	**$ 4,767,093,157**

OMIG performs both comprehensive audits and more focused audits of DHS contracts. In performing a comprehensive audit, OMIG reviews bid solicitation documents, bid solicitation responses, adherence to performance-based contracting standards, actual cost analysis, qualifications of the vendor, and DHS' monitoring of the contract. 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 SFY22, OMIG performed comprehensive audits of fifteen (15) contracts and focused audits on all remaining contacts.

Contractor Program Integrity Activities

Optum Pharmacy

In SFY22, Optum continued 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 and supervised by OMIG.

In SFY22, Optum conducted one hundred fifty-nine (159) pharmacy audits, four (4) of which were onsite. The pharmacy claims were selected for audit by using multiple algorithms that Optum ran on a regular schedule. Multiple types of specific issues were identified with these algorithms: incorrect package-size, duplicate claims, lack of medical necessity, incorrect days' supply, excessive quantity, incorrect software conversion of units billed, incorrect compounds, wrong beneficiary, invalid prescriber, and improper services after death.

The pharmacy audit program continued the necessary modifications put into place at the outset of the public health emergency. In SFY22, pharmacies continued to face challenges because of COVID-19. While most pharmacies were able to open their lobbies to the public, some pharmacies were again forced to temporarily close their lobbies. Some pharmacies are still struggling with staffing shortages. To that end, Optum continued to use multiple layers of communication with pharmacies requiring documentation submission, such as deadline extensions and conducting desk audits instead of onsite audits. These examples are just a few key changes that Optum and OMIG carried over from the previous fiscal years in response to the COVID-19 crisis.

During SFY22, Optum reviewed a total of 7,308 records which totaled a paid amount of $14,871,132. A total of 1,702 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 $2,998,109 has been identified for recoupments, which is a significant increase from the last two fiscal years.

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 SFY22, 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:

- Paid Encounters with Invalid MCO Enrollment - Reviews paid encounter data to compare with beneficiary MCO enrollment dates and report instances where the beneficiary was not enrolled with the MCO payor when the services were rendered. The algorithm may also detect instances where the beneficiary has overlapping MCO payor assignments resulting in duplicate payments.
- Attendant Care, Respite Care, Personal Care Impossible Days - Detects performing providers who bill an excessive number of hours per date of service for attendant care, respite care, and personal care. The hours billed may be distributed across multiple claims by the same provider.
- 90-day Surgical Global Period Billing - Identifies provider summary payment information for surgical 90-day global period procedure codes identified in the Surgical Global Reference Report that should already be included within the surgical global period per Centers for Medicare and Medicaid Services guidelines.

Other key activities conducted through the FADS partnership include:

- Virtual training in October 2021 for seven (7) OMIG employees and one (1) employee with the Arkansas Attorney General's Office.
- At OMIG's request, the Optum FADS team created a provider detail report specific to Home and Community Based Services (HCBS) with Electronic Visit Verification (EVV) data to analyze billing and performing provider HCBS claims which include personal care, attendant care, and respite care. The inclusion of EVV data will continue to strengthen OMIG's program integrity measures through audits and recoupment initiatives to help identify fraud, waste, and abuse in these programs.

■ Unified Program Integrity Contractor (UPIC) Reviews

OMIG continues to receive 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 SFY22, Qlarant initiated reviews of a variety of providers including behavioral health, durable medical equipment (DME), endoscopy labs, as well as general practitioners. These investigations were in addition to ongoing investigations and analytics targeting high Opioid prescribers and pharmacies who fill high quantities of opioids. Additionally, Qlarant also provides data analysis support and policy research supporting fraud investigations.

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. 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, Provider Awareness Letters (PALs) are sent to the remaining outlier providers asking for a self-review of those claims. OMIG directs 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 to verify OMIG's data findings. Provider Awareness Letter campaigns that were conducted in SFY22:

- **False Claims Act Compliance**

Medicaid providers who receive $5 million or more in Medicaid reimbursement must comply with the False Claims Act. These providers are required to develop and implement a compliance plan which includes internal control policies and procedures for detecting and preventing fraud and waste as well as a discussion of the rights of whistleblowers. OMIG is charged to perform an annual review of these providers to ensure compliance with the Act. § 6032 of the Deficit Reduction Act, and § 1902(a)(68) of the Social Security Act. OMIG performed one hundred thirty-five (135) False Claims Act Compliance Reviews during SFY22.

- **Outpatient Behavioral Health Services (OBHS) Monthly Reporting**

All behavioral health providers approved to receive Medicaid reimbursement for services to Medicaid beneficiaries must meet specific qualifications for their services and staff. In addition, providers with multiple service sites must enroll each site separately and list the actual service site on billing claims. Behavioral Health Providers must meet the Provider Participation and Enrollment requirements contained within the OBHS manual to be eligible to participate in the Arkansas Medicaid Program.

Monthly notification to OMIG is not required when the list of covered health care practitioners remains unchanged from the previous submission. OMIG identified outpatient behavioral health providers for an opportunity to review and promote the policy requirements for monthly reporting of staff changes. Three hundred seventy-four (374) PALs were sent to Outpatient Behavioral Health Services providers as a result of this initiative. This letter campaign was intended to educate or remediate these providers on Medicaid enrollment requirements in addition to the designated eligibility criteria for monthly submissions to OMIG.

Initiatives

Recoupment Letters

Provider Recoupment Letters are submitted when OMIG is confident that an improper claim hasbeen submitted and resulted in an overpayment. In these instances, there is no fraud suspectedand 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 SFY22:

- Home and Community Based Services Billing and Inpatient Services Billing Overlap
- Non-Emergency Transportation Greater than 150 miles per Date of Service
- EVV Duplicate Payments
- Crossover Voids

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 performed focused reviews of the Home and Community Based Services (HCBS) policies as well as provider billing behavior. OMIG 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 HCBS during the same time those Medicaid Beneficiaries were being treated in an Inpatient Facility from July 1, 2021, to December 31, 2021. 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 one hundred forty (140) recoupment letters to HCBS providers based on this review during Q4 of SFY22, recovery is anticipated during Q1 of SFY23 after any pending administrative reconsiderations or appeals are exhausted. Recoveries are expected to be completed via claims adjustment and will be reporting during the quarter in which the adjustment occurs.

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

In SFY22, OMIG conducted a focused review of twenty-six (26) 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 one hundred fifty (150) miles on a single date of service. The Medicaid Policy Manual 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 reviewed claims for this service from May 1, 2021, through May 31, 2022. OMIG has recovered $12,889.03 from this initiative and recoveries are still ongoing in SFY23.

- **Electronic Visit Verification (EVV) Duplicate Payments**

Arkansas Medicaid began utilizing the Electronic Visit Verification (EVV) system to verify services provided by Home and Community-Based Care providers in SFY21. After this program went live, OMIG discovered that some providers were receiving duplicate payments by billing claims through both the EVV system through caregiver entry and via traditional billing through the InterChange system. OMIG sought to identify these duplicate payments and recover these overpayments along with educating providers on how to properly bill Medicaid using the EVV system. OMIG sent letters to forty-two (42) providers for this initiative and has recovered $66,562.06 to date as a result of these letters. OMIG continues to monitor this new program and work closely with providers to ensure compliance.

- **Crossover Voids**

Medicare crossover payments occur when a Medicaid client is eligible for both Medicare and Medicaid coverage. Pursuant to the Arkansas Medicaid Provider Manual § 332.300, if any Medicare payment source makes an adjustment that results in an overpayment or underpayment by Medicaid, the provider must submit an adjustment and the Medicaid crossover payment should be recouped or reversed. OMIG has partnered with our Unified Program Integrity Contractor (UPIC), Qlarant, to identify the crossover payments where the Medicare payment had been previously voided or reversed and an existing Medicaid payment still existed. Based on that data analysis, OMIG sent six hundred fifty (650) letters to Arkansas Medicaid providers of Inpatient, Outpatient, Professional, and Durable Medical Equipment services. As a result of this initiative, OMIG has recovered over $138K in overpayments to the Arkansas Medicaid Program.

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 SFY22, 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, 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 2021, Medicaid Inspector General Elizabeth Smith and OMIG Audit Coordinator Michael McNeely spoke at the NAMPI virtual conference. They presented a session entitled "Loopholes Resulting from Covid-19 EVV and Behavioral Health" in which they discussed Arkansas OMIG's audit findings and use of data analytics to changes to Medicaid policy related to Covid-19 for fraud, waste, and abuse.

Continuing Education

Throughout the year, OMIG staff attended more than forty (40) 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 continued to be suspended due to the COVID pandemic, but OMIG staff attended on-line conferences where available.

For SFY22, OMIG's highly-trained professional staff includes:

- Two Registered Nurses (RN), one with double board certifications;
- Five 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
- One Certified Program Integrity Professional.

Provider Community Engagement & Staff Enrichment

In SFY22, OMIG personnel attended and/or completed several Medicaid-related courses by the Medicaid Integrity Institute, NAMPI or other Medicaid-related organizers. Three (3) OMIG employees obtained training in medical coding under the American Medical Association's CPT medical coding system, and one OMIG employee obtained certificate status as a medical coder in SFY22.

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.