Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Arkansas Comprehensive Program Integrity Review

Final Report

May 2008

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INTRODUCTION

CMS's Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Arkansas Medicaid Program. The onsite portion of the review was conducted in May 2007 at the offices of the Arkansas Division of Medical Services (DMS). The MIG review team also visited the offices of the Medicaid Fraud Control Unit (MFCU), the Medicaid fiscal agent, and the Division of Legislative Audit.

This review focused on the activities of the Program Integrity Section (PI Section), which is responsible for Medicaid program integrity. The report addresses regulatory compliance issues, vulnerabilities, and noteworthy practices. The review team identified five areas of non-compliance with Federal regulations during its review. Three of these areas were identified in previous CMS program integrity reviews conducted in 2002 and 2003.

- 42 CFR § 1002.3(b) requires State Medicaid agencies to notify HHS-OIG of any actions it takes to deny a provider application or to limit an individual's or entity's ability to participate in the Medicaid program.

- 42 CFR § 455.104 provides that State Medicaid agencies must require providers to disclose specific ownership and control information relating directly to the provider and concerning any subcontractors in which the provider has direct or indirect ownership of 5 percent or more.

- 42 CFR § 455.105(b) provides that State Medicaid agencies must require providers to disclose information on the ownership of subcontractors with whom the provider has significant business transactions. Such information must be reported to the State or to the Secretary of the U.S. Department of Health and Human Services (HHS) upon request.

- 42 CFR § 455.106 provides that State Medicaid agencies must require providers to disclose the identity of any owner, agent, or managing employee convicted of a health-care related criminal offense. When apprised of such information, the Medicaid agency must report it to the HHS-Office of the Inspector General (HHS-OIG) within 20 working days.

- 42 CFR § 455.15(b) requires State Medicaid agencies to refer suspected cases of recipient fraud to an appropriate law enforcement agency.

The State indicated that it had corrected or was taking actions to correct all areas of non-compliance and vulnerability. The State's response to the draft report is included as Attachment A to this final report.

THE REVIEW

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and noteworthy practices;
3. Help Arkansas improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Arkansas' Medicaid Program

The DMS within Arkansas' Department of Health and Human Services (DHHS) administers the Arkansas Medicaid Program. As of April 30, 2007, the program served nearly 757,000 recipients. Over 80 percent of the recipients were enrolled in a primary care case management (PCCM) program. Under this program, primary care physicians are paid a monthly case management fee to serve as gatekeepers. In contrast to risk capitation arrangements involving managed care organizations, all billings in the PCCM program are run through Arkansas' fiscal agent, Electronic Data Systems, Inc. (EDS), in the same manner as fee-for-service (FFS) billings. The State had enrolled 27,873 providers in the Medicaid program as of April 30, 2007. The only providers operating outside this framework are transportation providers in the state's Non-Emergency Transportation (NET) program and medical providers enrolled to serve a small expansion population under Arkansas' Health Insurance Flexibility Act (HIFA) waiver program.

Medicaid expenditures in Arkansas for the State fiscal year (SFY) ending June 30, 2006 totaled $2,159,707,414. In SFY 2006, the Federal share of the cost of medical services was 73.77 percent. DMS processed an average of 27.3 million claims per year over the period SFY 2004 through 2006. Approximately 98 percent of these claims were submitted electronically.

Program Integrity Section

Within the Arkansas DMS, the organizational component dedicated to the prevention and detection of provider fraud is the PI Section. At the time of the review, the PI Section had approximately 20 staff and two supervisors reporting to the Section Chief. The review team noted that five of the 20 non-supervisory positions in the section were vacant. The Section is divided into two units: one conducts field audit reviews and the other performs surveillance and utilization review activities and is involved in the Medicaid Payment Error Rate Measurement Program. The PI Section receives substantial assistance from two Medicaid contractors: EDS, which serves as the Medicaid fiscal agent in Arkansas and performs data mining functions; and the Arkansas Foundation for Medical Care (AFMC), the State's quality improvement organization, which undertakes claims analysis, fraud research, and targeted medical reviews. The table below presents the total number of investigations, sanctions, identified overpayments, and amounts recouped in the past three SFYs as a result of program integrity activities.

Table 1

State Fiscal Year	Number of Preliminary & Full Investigations	Number of State Administrative Actions or Sanctions	Amount of Overpayments Identified	Amounts Recouped (includes past settlement collections)
2005	86	N/A	$ 113,419.73	$ 170,350.20
2006	78	39	$ 76,061.76	$ 168,341.72
2007 (July to May)	25	11	$ 83,953.75	$ 26,472.47

Methodology of the Review

In advance of an onsite visit, the review team requested that Arkansas complete a comprehensive review guide and supply documentation in support of its answers to the review guide. The review guide included such areas as provider enrollment, claims payment and post-payment review, managed care, Surveillance and Utilization Review Subsystem (SURS), and the MFCU. A four-person review team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of May 21, 2007, the MIG review team visited the DMS offices as well as the MFCU, the Medicaid fiscal agent, and the Division of Legislative Audit. The team met at length with the Chief Program Administrator for Field Audit and PERM, who is effectively the PI Section Chief, as well as with numerous managers, executives, and staff, the MFCU, the Medicaid fiscal agent, and the Division of Legislative Audit.

Scope and Limitations of the Review

This review focused on the activities of the PI Section, but also considered the work of other components and contractors responsible for a range of complementary functions, including provider enrollment, data mining, and legal support. While the review team observed and commented in this report on one regulatory issue involving recipient fraud, its main concern was the prevention and detection of provider fraud in the Medicaid program.

Arkansas operates a combination State Children's Health Insurance Program (SCHIP) program, part Medicaid expansion and part stand-alone program under Title XXI of the Social Security Act. The stand-alone portion of the program was not included in this review. However, the Medicaid expansion portion of the SCHIP program operates under the same PCCM model and FFS billing and provider enrollment policies as Arkansas' Title XIX program. The same findings, vulnerabilities, and noteworthy practices discussed in relation to the Medicaid program also apply to the Medicaid portion of the SCHIP program.

Unless otherwise noted, DMS provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that DMS provided.

RESULTS OF THE REVIEW

In 2002 and 2003, CMS conducted reviews of Arkansas' program integrity operations. The first of these reviews found 11 instances of regulatory and statutory non-compliance. Many of these areas of non-compliance reflected core operational problems, such as the absence of a system for tracking complaints and the inability to generate preliminary investigations and develop appropriate cases for referral to the MFCU. While several compliance issues remain, the 2003 follow-up review showed the beginnings of progress in most areas of non-compliance. The 2007 review showed that the State continues to make progress. The review team also found noteworthy practices in the Arkansas program.

A. NOTEWORTHY PRACTICES

Utilization of Contractors' Data Capabilities
The PI Section compensates for limited staff resources by using data mining services and claims analysis provided by the State's fiscal agent, EDS, and quality improvement organization, AFMC. EDS maintains a data warehouse, holding seven years of claims data, which can be used to rank providers, generate other standard reports or develop customized reports. Two EDS staff members at the DMS office generate reports for PI Section staff using Business Objects software. AFMC also utilizes its own data mining software in retrospective reviews of claims and services and has on several occasions identified overpayment situations for DMS.

Analyses of Improper Billings
The PI Section has undertaken a time dependent analysis of mental health providers who are suspected of billing for simultaneously providing different kinds of services in different places. The PI Section has laid the basis for possible future recoupment actions by initiating similar analyses of overlapping provider billings in several of Arkansas' home and community-based services waiver programs.

B. REGULATORY COMPLIANCE ISSUES

The State does not comply with Federal regulations related to required disclosure and notification activities and appropriate referral of suspected recipient fraud. Three of these findings were identified during the 2002 and 2003 CMS program integrity reviews.

DMS does not report actions it takes on provider applications for participation in the program to the HHS-OIG
The regulation at 42 CFR § 1002.3(b) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program. Adverse actions include the denial or termination of participation in the program, including when an

owner or managing employee has been convicted of a criminal offense related to the Medicare, Medicaid, or Title XX programs. DMS does not report to HHS-OIG any adverse actions it takes on provider applications.

Recommendation: Submit appropriate reports to HHS-OIG regarding adverse actions that DMS takes on any provider's application for participation.

DMS does not meet Federal disclosure requirements concerning the ownership and control of providers and subcontractors (Repeat Issue)

Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. Arkansas' provider enrollment forms do not capture the names of individuals who own or have controlling interests in disclosing entities or providers or related subcontractors, their relationships, or the identity of other disclosing entities in which these individuals have an ownership or controlling interest. In the Medicaid Alliance for Program Safeguards (MAPS) reviews in 2002 and 2003, CMS determined that Arkansas did not comply with this regulation. While DMS has incorporated the required ownership and control information in its State Medicaid Manual (section 142.410), the provider application still does not request this information.

Recommendation: Modify enrollment packages to request the information required to be disclosed under § 455.104(a). Prior to enrolling providers and routinely thereafter, DMS must search under names that are disclosed for possible HHS-OIG exclusions.

DMS does not meet Federal disclosure requirements concerning large business transactions (Repeat Issue)

The regulation at 42 CFR § 455.105(b) requires that upon request, providers furnish to the State or HHS information about certain business transactions with wholly owned suppliers or any subcontractors. Arkansas' provider enrollment agreements do not require such disclosures. In the MAPS reviews in 2002 and 2003, CMS determined that Arkansas did not comply with this regulation. Although DMS inserted a disclosure requirement on business transactions in State Medicaid Manual (section 142.420), the provider application still does not request this information.

Recommendation: Modify enrollment packages to incorporate the appropriate business transaction language.

DMS does not meet Federal regulations requiring the disclosure of criminal conviction information in its provider enrollment packages (Repeat Issue)

The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify HHS-OIG whenever such disclosures are made. Again, while the State Medicaid Manual references this requirement (section 142.430), the DMS provider enrollment packages do not solicit this criminal conviction information. In the MAPS reviews in 2002 and 2003, CMS determined that Arkansas did not comply with this regulation. The omission in turn prevents Arkansas from forwarding information on providers, owners, and managing employees to HHS-OIG within 20 working days, as is required by the regulation.

Recommendation: Modify enrollment packages to request managing employee criminal conviction information for all provider types. Refer that information to the HHS-OIG as required.

DMS does not refer all cases of recipient Medicaid fraud to the appropriate law enforcement authorities

The Federal regulation at 42 CFR § 455.15(b) requires State Medicaid agencies to refer suspected cases of recipient fraud to an appropriate law enforcement agency. During the interview with the Arkansas DHHS Office of Chief Counsel (OCC), the Chief Deputy Counsel mentioned that while significant cases of suspected recipient fraud are sent to prosecuting attorneys in the county of residence, DMS no longer refers recipient fraud cases with an estimated dollar value of less than $500. The latter cases are handled internally within DMS. When DMS verifies fraudulent behavior, it will impose such sanctions on recipients as restricting them to the use of a specific pharmacy or, in egregious cases, excluding them from Medicaid.

OCC's Chief Deputy said that the reason for this policy is that county prosecutors routinely turn away any referral that stands to recoup less than $500. The use of selective referrals puts DMS out of compliance with the regulation.

Recommendation: Report all cases of suspected recipient fraud to county law enforcement authorities.

C. AREAS OF VULNERABILITY

The review team also identified three areas of vulnerability in Arkansas' practices related to disclosure, verification of licensure, and limitation of out-of-state providers' enrollment.

Not capturing managing employee information on its provider enrollment forms
Under 42 CFR § 455.101, a managing employee is defined as "a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency." Arkansas does not solicit managing employee information in its provider enrollment packages. Thus, DMS would have no way of knowing if excluded individuals are working for providers or health care entities in strategic positions, such as billing managers and department heads.

Recommendation: Include managing employee information on all enrollment forms. This information should also be captured in the database maintained by EDS, the State's provider enrollment contractor, to be used to search for exclusions upon enrollment and on a monthly basis.

Not verifying provider licenses during the application process and not limiting the period in which out-of-state providers can continue billing Medicaid
Providers applying to participate in Arkansas Medicaid may enter their information on-line through a web application or file a paper application provided by EDS. Certain additional documentation, such as a copy of the provider's license, tax forms, and evidence of Medicare enrollment, must be mailed in. Out-of-state providers may not be enrolled unless they have provided services to an Arkansas Medicaid recipient and submitted a claim for services. EDS then checks the DMS and OIG websites for State and Federal exclusions and checks for any adverse action notifications from State Medical Boards or the Attorney General's Office. However, copies of provider licenses are only checked to verify that they have not expired. Neither EDS nor DMS undertake any look-behind to determine if in- or out-of-state provider licenses have limitations imposed that were never reported. In addition, once Arkansas allows out-of-state providers to enroll, it permits them to remain in the program and continue billing under the same terms as in-state and border area providers. DMS would only remove an out-of-state provider from active status if it did not bill the Medicaid program for six months. An unscrupulous provider might exploit this loophole.

Recommendation: Require EDS to fully verify in- and out-of-state licenses before enrolling providers in the Medicaid program. Consider limiting the duration in which non-border area, out-of-state providers may remain enrolled in Arkansas Medicaid after the legitimate out-of-area service they provided has been reimbursed.

Not requiring the provider enrollment broker in the Arkansas Safety Net Benefit Program to capture information on owners, officers and managing employees
In October 2006, Arkansas implemented the Arkansas Safety Net Benefit Program, operated under HIFA waiver authority, to increase health insurance coverage for up to 50,000 low-income, working adults and their families through employer sponsored health insurance coverage. At the time of the CMS review, participation totaled around 400.

DMS contracted with NovaSys Health Network to serve as the provider enrollment broker for the Arkansas Safety Net Benefit program. NovaSys credentials and contracts with providers outside the normal Medicaid process in accordance with National Committee on Quality Assurance standards, checks with the State Medical Boards and the National Practitioner Data Bank, and checks for Medicare and Medicaid exclusions before enrolling a provider. The NovaSys process does not capture the requisite information on owners, officers, and managing employees that would satisfy the disclosure of ownership, control, business transactions and criminal conviction information requirements of 42 CFR Part 455, Subpart B.

Recommendation: Require NovaSys to capture information on owners, officers, and managing employees as part of the credentialing process for providers recruited to serve Arkansas' HIFA waiver expansion population.

CONCLUSION

The State of Arkansas has improved its program integrity operations since CMS' 2003 review. The use of contractor data mining services to assist in-house staff and the development of detailed time series analyses to identify abusive provider billing practices are noteworthy. CMS encourages DMS to continue its noteworthy practices and look for additional opportunities to improve overall program integrity.

However, the identification of five areas of non-compliance with Federal regulations is of concern. That three of those issues are repeated from a prior review four years ago is particularly troubling. In addition, three areas of vulnerability were identified in the 2007 program integrity review. CMS encourages DMS to closely examine each of the three areas of vulnerability that were identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will request DMS to provide a corrective action plan for each area of non-compliance and vulnerability within 30 calendar days of the date of the final report letter.

The corrective action plan should address how the State of Arkansas will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps you expect will occur. If correcting any of the findings or vulnerabilities will take more than 90 calendar days from the date of this letter, please provide an explanation for that. If DMS has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of Arkansas on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its noteworthy practices.

Attachment A

Arkansas' Response to Medicaid Integrity Program Review of Program Integrity Procedures

B. Regulatory Compliance Issues

DMS does not report actions it takes on provider applications for participation in the program to the HHS-OIG

Response – Program Integrity will submit appropriate reports to HHS-OIG regarding adverse actions that DMS takes on any provider's application for participation.

DMS does not meet Federal disclosure requirements concerning the ownership and control of providers and subcontractors (Repeat Issue)

Response – We have modified the enrollment package to correct this deficiency. We are in the final stages of negotiating a contract with LexisNexis to verify information provided by the enrollee. Policies are in place addressing this issue. Currently, our Medicaid manuals require disclosure of ownership and control interests of providers and subcontractors. A disclosure form has been created and is being added to the enrollment package. This form contains questions related to ownership and control of providers and subcontractors.

DMS does not meet Federal disclosure requirement concerning large business transactions (Repeat Issue)

Response – We have modified the enrollment package to correct this deficiency. A significant business transaction disclosure form has been created and is being added to the enrollment package to reflect this CFR requirement. Currently, our Medicaid manuals require disclosure of significant business transactions.

DMS does not meet Federal regulations requiring the disclosure of criminal conviction information in its provider enrollment packages (Repeat Issue)

Response – We have modified the enrollment package to correct this deficiency. We will refer the conviction information to the HHS-OIG as required. The Medicaid manuals require disclosure of personnel convicted of criminal offenses related to that person's involvement in any program under Medicaid, Medicare, or the Title XX Services Program. A disclosure form has been created and is being added to the enrollment package. This form contains questions related to criminal convictions as per the CFR requirement.

DMS does not refer all cases of recipient Medicaid fraud to the appropriate law enforcement authorities.

We have developed a system to handle all recipient complaints in which all cases will be reported to appropriate law enforcement authorities.

C. Areas of Vulnerability

Not capturing managing employee information on its provider enrollment forms.

Response – We have modified the enrollment package to correct this vulnerability. The new disclosure form that is being added to the enrollment package addresses this issue. The form asks for managing employee information in order to determine if any excluded individuals are working for providers or health care entities in strategic positions.

Not verifying provider licenses during the application process and not limiting the period in which out-of-state providers can continue billing Medicaid.

Response – Licenses will be verified before enrolling providers. We will look at limiting the duration in which non-border area, out-of-state providers may remain enrolled in Arkansas Medicaid after the legitimate out-of-area service they provided has been reimbursed.

Not requiring the provider enrollment broker in the Arkansas Safety Net Benefit Program to capture information on owners, officers and managing employees.

Response – A meeting was held with our contractor, NovaSys Health Network. We discussed the requirement of capturing information on owners, officers and managing employees as outlined in 42 CFR Part 455, Subpart B. We agreed that Program Integrity would periodically review a sample of their providers that they are enrolling to ensure that they are in compliance with the above regulations. In addition, Program Integrity will also review a sample of enrollees to ensure eligibility.