# Department of Health and Human Services

# Centers for Medicare & Medicaid Services

# Center for Program Integrity

# Arkansas Focused Program Integrity Review

# Oversight of Medicaid Personal Care Services

# September 2025

# Final Report

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# I. EXECUTIVE SUMMARY

## Objectives

The Centers for Medicare & Medicaid Services' (CMS) conducted a focused program integrity review of Arkansas's Medicaid Personal Care Services (PCS) program to assess the state's program integrity oversight efforts for Fiscal Years (FY) 2020 – 2022. This focused review specifically assessed the state's compliance with CMS regulatory PCS requirements within 42 CFR Parts 440 and 441. A secondary objective of this review was to provide the state with feedback, technical assistance, and educational resources that may be used to enhance program integrity in the delivery of these services.

To meet the objectives of this focused review, CMS reviewed information and documents provided in response to the CMS PCS review tool provided at the initiation of the review. CMS also conducted in-depth interviews with the State Medicaid Agency (SMA) and evaluated program integrity activities performed by selected agencies under contract to provide PCS to Medicaid beneficiaries.

This report includes one CMS finding(s) resulting in one recommendation(s), identified during the focused review.

## Findings and Recommendations

Findings represent areas of non-compliance with federal and/or state Medicaid statutory, regulatory, sub-regulatory, or contractual requirements. CMS identified one finding that creates risk to the Arkansas Medicaid program related to PCS program integrity oversight. In response to the finding, CMS identified **one** recommendation that will enable the state to come into compliance with federal and/or state Medicaid requirements related to PCS program integrity oversight. The recommendation includes the following:

*State Oversight of PCS Program Integrity Activities and Expenditures*

> **Recommendation #1:** In accordance with § 455.20, Arkansas should develop and implement a process, including written policies and procedures, to conduct beneficiary verifications for PCS furnished by provider agencies and individual Personal Care Attendants (PCAs) in the self-directed program.

## Observations

Observations represent operational or policy suggestions that may be useful to the state in the oversight of its Medicaid PCS program. CMS identified **no** observations related to Arkansas's PCS program integrity oversight. While observations do not represent areas of non-compliance with federal and/or state requirements, observations identify areas that may pose a vulnerability or could be improved by the implementation of leading practices.

# II. BACKGROUND

## Focused Program Integrity Reviews

In the Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, CMS set forth its strategy to safeguard the integrity of the Medicaid program.[1] This plan encompasses efforts to ensure that states are adhering to key program integrity principles, including the requirement that state Medicaid programs have effective oversight and monitoring strategies that meet federal standards.

As a part of these efforts, CMS conducts focused program integrity reviews on high-risk areas in the Medicaid program, such as managed care, new statutory and regulatory provisions, non-emergency medical transportation, telehealth, and PCS. These reviews include onsite or virtual state visits to assess the effectiveness of each state's program integrity oversight functions and identify areas of regulatory non-compliance and program vulnerabilities. Through these reviews, CMS also provides states with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid.

## Medicaid Personal Care Services

Medicaid PCS are services provided to eligible beneficiaries that help them to stay in their own homes and communities rather than live in institutional settings, such as nursing facilities. The PCS benefit is provided according to a state's approved plan, waiver, or demonstration and are optional Medicaid services, except when medically necessary for children eligible for early and periodic screening, diagnostic, and treatment (EPSDT) services. PCS are categorized as a range of assistance provided to persons with disabilities and chronic conditions to enable them to accomplish activities of daily living (ADLs) or instrumental activities of daily living (IADLs). An independent or agency-based PCA may provide ADL services, which include eating, bathing, dressing, ambulation, and transfers from one position to another, and IADL services, which include day-to-day tasks that allow an individual to live independently but are not considered necessary for fundamental daily functioning, such as meal preparation, hygiene, light housework, and shopping for food and clothing.

States administer their Medicaid programs within broad federal rules and according to requirements of the specific authority approved by CMS. Pursuant to 42 CFR Part 440, states can choose to provide PCS for eligible beneficiaries through their state plan, a waiver, or a Section 1115 demonstration. Because PCS are typically an optional benefit, they can vary greatly by state and within states, depending on the Medicaid authority used to cover the benefit. Under federal statute and regulations, PCS must be approved by a physician or through some other authority recognized by the state. Beneficiaries receiving PCS cannot be inpatients or residents

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf

of a hospital, nursing facility, intermediate care facility for the developmentally disabled, or institution for mental disease. Services can only be rendered by qualified individuals who have met certain training and enrollment requirements, as designated by each state.

# III. Overview of the Arkansas Personal Care Services Program and the Focused Program Integrity Review

Arkansas administers Medicaid PCS to eligible beneficiaries under the Section 1905(j) state plan authority and Section 1915(c) Home and Community-Based Services (HCBS) waiver authorities. The DHS offers both agency-based and participant-directed PCS options. Detailed descriptions of the Arkansas Medicaid PCS programs and their applications can be found in Appendix C.

In FY 2022, Arkansas's total Medicaid expenditures were approximately $8.6 billion,[2] providing coverage to approximately 1,004,558 beneficiaries.[3] Arkansas's Medicaid expenditures for PCS totaled approximately $69.5 million, and 7,241 beneficiaries received PCS. Appendix C provides enrollment and expenditure data for the PCS population in Arkansas.

The Department of Human Services' (DHS) Division of Medical Services (DMS) is responsible for the administration of the Arkansas Medicaid program. The OMIG is the state agency tasked with oversight of program integrity-related functions, including those related to PCS. The PCS program is administered and monitored by DHS in conjunction with OMIG. Arkansas maintains a collaborative and coordinated effort between DHS and OMIG.

In September 2023, CMS conducted a focused program integrity review of Arkansas's PCS program. This focused review assessed Arkansas's compliance with regulatory requirements at 42 CFR Parts 440, 441, 455, and 456, as well as Sections 1915(c) and 1915(j) of the Social Security Act (the Act). As a part of this review, CMS conducted interviews with state staff involved in the administration of PCS to validate the state's program integrity practices, as well as with key personnel within three[4] PCS agencies. The Magnolias of Little Rock was selected to participate in this Arkansas program integrity review but elected not to provide all the requested documents and did not attend the scheduled interview session. After the conclusion of the agency interviews, CMS staff were advised by the Medicaid Fraud Control Unit (MFCU) and DHS that The Magnolias of Little Rock had voluntarily closed two weeks prior to the scheduled CMS interview. CMS also evaluated the status of Arkansas's previous corrective action plan, developed by the state in response to a PCS focused review conducted by CMS in 2018, the results of which can be found in Appendix A.

During this review, CMS identified a total of one recommendation and one observation. CMS

[2] https://www.kff.org/medicaid/state-indicator/total-medicaid-spending

[3] https://www.kff.org/other/state-indicator/medicaid-and-chip-monthly-enrollment

[4] Four PCS providers were originally selected by CMS to participate in the review; however, one agency, The Magnolias of Arkansas, declined to participate and had reportedly gone out of business prior to the review.

also included technical assistance and educational resources for the state, which can be found in Appendix B. The state's response to CMS' draft report can be found in Appendix D, and the final report reflects changes CMS made based on the state's response.

This review encompasses the six following areas:

A. **State Oversight of PCS Program Integrity Activities and Expenditures** – States share responsibility with CMS for ensuring that state and federal dollars are used to deliver health care services consistent with efficiency, economy, and quality to eligible individuals and are not misused for fraud, waste, or abuse. States must meet various statutory and regulatory requirements, such as program integrity safeguards in 42 CFR Parts 455 and 456, to maintain effective oversight of their Medicaid programs.

B. **Electronic Visit Verification (EVV) for PCS –** Pursuant to Section 12006(a) of the 21st Century Cures Act, all states were required to implement an EVV system for PCS by January 1, 2020. Failure to meet this requirement results in incremental Federal Medical Assistance Percentage (FMAP) reductions of up to 1 percent, unless the state has both made a "good faith effort" to comply and has encountered "unavoidable delays."

C. **Provider Enrollment and Screening –** CMS regulations at § 455.436 require that the SMA conduct database checks to verify the exclusion status of the provider, persons with an ownership or control interest, and agents and managing employees on the Department of Health and Human Services Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE); the System for Award Management (SAM); the Social Security Administration's Death Master File (SSA-DMF); and the National Plan and Provider Enumeration System (NPPES) upon enrollment and reenrollment, and check the LEIE and SAM no less frequently than monthly. In accordance with § 455.434, PCS agencies or attendants that enroll in Medicaid as providers are also subject to federal screening requirements found at § 455.410.

D. **State Oversight of Self-Directed Services –** States may elect to cover self-directed PCS under a Section 1915(j) waiver, which allows participants or their representatives to exercise choice and control over the budget, planning, and purchase of self-directed PCS. CMS regulations at 42 CFR 441 Subpart J govern the use of this option.

E. **State Oversight of Agency-Based PCS Providers** – Beneficiaries may receive services through a personal care agency that oversees, manages, and supervises their care. Agency-based PCS are available under state plan or waiver authority. In accordance with §§ 441.302 and 441.570, the SMA must assure that certain necessary safeguards have been taken to protect the health and welfare of individuals furnished services under the program and assure the financial accountability for funds expended for PCS provided through wavier or state plan authority.

F. **PCS Agency Oversight of Staff and Attendants –** As defined by § 440.167, PCS services must be provided by an individual who is qualified to provide such services,

unless defined differently by a state agency for purposes of a waiver granted under part 441, subpart G. The conditions of participation for home health aides participating in PCS programs are further detailed at §484.80. In accordance with these standards, state law often requires PCS agency staff and attendants to be subject to enhanced screening and credentialing procedures at the date of hire and annually thereafter. As part of this review, CMS interviewed several PCS agencies to determine if they are exercising appropriate oversight of the quality and integrity of services provided to beneficiaries under the care of their agency, in accordance with state standards.

# IV. RESULTS OF THE REVIEW

## A. State Oversight of PCS Program Integrity Activities and Expenditures

States share responsibility with CMS for ensuring that state and federal dollars are used to deliver health care services consistent with efficiency, economy, and quality to eligible individuals and are not misused for fraud, waste, or abuse. States must meet various statutory and regulatory requirements, such as program integrity safeguards in 42 CFR Parts 455 and 456, to maintain effective oversight of their Medicaid programs.

As required by § 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and beneficiaries. In addition, Section 1902(a)(30) of the Act and federal regulations at 42 CFR Part 456 require the state plan to provide for the establishment and implementation of a statewide surveillance and utilization control program that provides methods and procedures to safeguard against unnecessary or inappropriate utilization of care, services, and excess payments. States often meet these requirements through implementation of a surveillance and utilization review subsystem (SURS) within the Medicaid Management Information System (MMIS) and/or discrete SURS Units that are a part of larger program integrity efforts.

In Arkansas, OMIG is primarily responsible for Medicaid Program Integrity activities. The OMIG is tasked with conducting suspected fraud investigations and/or conducting data mining to detect aberrant trends. The OMIG employs a multi-faceted audit approach utilizing auditors, coders, and medical professionals who use data analysis to detect fraud, waste, and abuse. The OMIG sends data-driven recovery letters requesting providers to conduct a self-audit and return Medicaid funds accordingly. The OMIG also pursues administrative actions against individuals and entities engaging in fraud, abuse, and improper billing practices. Administrative actions include suspension, exclusion, or termination from the Medicaid program. When OMIG suspects criminal actions, a referral is made to the MFCU, at which time the law requires the provider to be suspended under most circumstances. Depending on the outcome of the criminal matter, OMIG will then either exclude or reinstate the provider. The OMIG also pursues suspension, exclusion, or termination as a sanction outside of criminal matters in cases where a provider continually abuses Medicaid. A monitoring tool utilized by OMIG is required for agency-directed PCAs to perform client site visits at a minimum of every 62 days. In addition, the agency is required to maintain service plans and review PCAs' service logs for accuracy and

completeness. In further program integrity efforts, OMIG works closely with the special investigative units of the Medicaid managed care organizations and the Provider-Led Arkansas Shared Savings Entities (PASSE). Additionally, in Arkansas, the Division of Provider Services and Quality Assurance (DPSQA) monitors IndepedentChoices, a self-directed PCS program. Detailed information on post-payment actions taken as a result of PCS provider audits can be found in Appendix C.

Other program integrity activities are conducted by the DHS contractor, Optum. Optum hosts the Medicaid Enterprise Decision Support System that contains the Fraud and Abuse Detection System (FADS). This software system provides a suite of data extraction tools that OMIG uses to detect and prevent fraud, waste, and abuse for PCS.

In Arkansas, these oversight and monitoring activities are met through the coordinated efforts outlined in the Memorandum of Understanding (MOU) between DHS, OMIG, and the MFCU. The MOU lists the overall cooperation, duties, responsibilities, reporting, access to data, and oversight between these three agencies. The agencies meet at least quarterly to discuss referrals and to discuss investigations into alleged Medicaid fraud. In addition, OMIG and the MFCU meet on an ad hoc basis to share information and collaborate. As outlined in the MOU, when DHS receives a complaint of Medicaid fraud, waste, or abuse from any source, or identifies any questionable practices, DHS will refer the complaint to OMIG who conducts a preliminary investigation to determine whether there is a sufficient basis to warrant a full investigation and prepare a fraud referral. If the findings of the preliminary investigation give OMIG reason to believe that an incident of Medicaid provider fraud or abuse has occurred, OMIG will refer the case to the MFCU. The MFCU will assess OMIG's referral to determine whether further investigation is appropriate. When MFCU accepts or declines a case, MFCU notifies the referring agency of the acceptance or declination of the case. The OMIG routinely reports suspected fraud to MFCU through a formal process established between the two agencies that complies with §§ 455.13-17.

However, CMS noted that OMIG has a budget of 22 program integrity positions within the agency, and of those budgeted positions, there are ten vacancies. In addition, the OMIG only has one position that investigates PCS for fraud, waste, and abuse. Further, CMS noted that during the review period the state reported a very low number of suspected fraud referrals to the MFCU, payment suspensions, and overpayment recoveries identified and recovered.

**CMS also noted that Arkansas's contracted Financial Management Services Agency (FMSA), Palco, is not tasked with performing beneficiary verifications as part of their contractual responsibilities. The state indicated that it has not issued any Explanation of Medicaid Beneficiary Medical Benefits (EOMB) verifications during the review period for PCS furnished through either provider agencies or by individual PCAs in self-directed programs.**

> **Recommendation #1:** In accordance with § 455.20, Arkansas should develop and implement a process, including written policies and procedures, to conduct beneficiary verifications for PCS furnished by provider agencies and individual PCAs in the self-directed program.

## B. Electronic Visit Verification (EVV) for PCS

EVV is used to verify that PCS visits occurred and can be performed through a number of methods, including, telephonic and GPS-enabled applications. Pursuant to Section 12006(a) of the 21st Century Cures Act, all states were required to implement an EVV system for PCS by January 1, 2020.

Currently, Arkansas utilizes an EVV system, provided by the vendor Fiserv, for in-home scheduling, tracking and billing for PCS providers. Arkansas has opted to use an open vendor model and allows providers the option to use either the state selected EVV system, AuthentiCare, or a third-party vendor that meets certain state and federal requirements. Fiserv acts as the data aggregator for the PCS providers' alternate EVV systems. Arkansas Medicaid Provider Manual Section I describes the various elements to be verified by the EVV system to meet the federal requirements and establishes utilization standards for provider agencies to electronically verify home visits and verify that clients receive the services for which Medicaid is being billed. All PCS agencies interviewed reported the use of EVV during the review period. PCS provided to a student in a public school is not subject to the EVV requirement because it does not involve an in-home visit. Arkansas implemented their current EVV in January 2021 and is in compliance with Section 12006(a) of the 21st Century Cures Act.

CMS did not identify any findings or observations related to these requirements.

## C. Provider Enrollment and Screening

CMS regulations at § 455.436 require that the SMA conduct database checks to verify the exclusion status of the provider, persons with an ownership or control interest, and agents and managing employees on the HHS-OIG's LEIE, SAM, SSA-DMF, and NPPES upon enrollment and reenrollment, and to check the LEIE and SAM no less frequently than monthly. In addition, under § 455.104, disclosing entities must disclose individuals or entities having five percent or more direct or indirect ownership of or controlling interest in the agency.

For agency directed services available under the state plan and Section 1915(c) waiver authorities, responsibility for compliance with § 455.436 is delegated to DHS. CMS confirmed that the DHS has a state policy in place addressing this requirement. For self-directed services available under the IndependentChoices program through the state plan and the ARChoices in Homecare program through the waiver authority, responsibility for provider screening is delegated to the contracted FMSA, Palco. Palco also provides fiscal intermediary and other support services to beneficiaries who choose to self-direct their service.

Numerous agencies, organizations, and other entities may qualify for provider enrollment in the Arkansas Medicaid PCS program. Participation requirements vary among these different types of providers. All owners, principals, employees, and contract staff of a PCS provider agency are required to have a national and state criminal background check according to the Arkansas Code Annotated §§ 20-33-213 and 20-38-101 et seq. The DHS contracts with Gainwell Technologies to enroll PCS providers in the Medicaid program.

PCS providers must meet the provider participation and enrollment requirements and criteria to be eligible for the Arkansas Medicaid program. Section II of the Arkansas PCS Provider Manual describes provider participation requirements, provider enrollment procedures, licensing, certification, and other requirements specific to each PCS provider type.

PCS in public schools are available to eligible beneficiaries under the age of 21. The Medicaid program requirements are the same as PCS delivered in the beneficiary's home. A school district or education service cooperative must be certified as a Local Educational Agency by the Arkansas Department of Education.

The Arkansas Department of Health (ADH) issues licenses for PCS agency providers. The DPSQA certifies the agency after receiving a notification of PCS agency's licensure from the ADH. Individual PCAs are enrolled with Arkansas Medicaid as a rendering provider; however, they are not individually contracted with DHS and cannot submit independent billings.

In accordance with § 455.434, PCS agencies or attendants that enroll in Medicaid as providers are subject to federal screening requirements found at § 455.410. The SMAs must require providers, as a condition of enrollment in Medicaid, to consent to Fingerprint-based Criminal Background Checks (FCBCs) when required to do so under state law, or by the level of screening based on fraud, waste, and abuse risk as determined for that category of provider, in accordance with § 455.450. High risk and moderate risk providers are subject to enhanced screening.

CMS determined that DHS has met federal screening requirements. The state has implemented the screening level provisions, including fingerprinting, based on the assigned level of risk for directly enrolled PCS providers, and has implemented the federal database checks on any persons with an ownership interest, or who is an agent or managing employee. The state contracts with Gainwell Technologies to check the excluded provider lists for all employees/caregivers being paid by Medicaid funds. In addition, the contractor will not make payments to any individual who fails the criminal background check or is listed on the Medicaid or Medicare excluded provider list, and/or the Arkansas Adult or Child Maltreatment Central Registries. Criminal background checks are completed at least once every five years as required. These requirements are verified at initial enrollment, revalidation and reenrollment, and licensure is also verified upon license renewal.

CMS did not identify any findings or observations related to these requirements.

## D. State Oversight of Self-Directed Services

A self-directed PCS state option allows beneficiaries or their representatives, if applicable, to exercise decision-making authority in identifying, accessing, managing, and purchasing their PCS. A state offering a self-directed option must assure that certain necessary safeguards have been taken to protect the health and welfare of individuals furnished services under the program and assure the financial accountability for funds expended for self-directed services in accordance with § 441.464. These safeguards must include prevention against the premature

depletion of the beneficiary directed budget, as well as identification of potential service delivery problems that might be associated with budget underutilization. In Arkansas, the Independent Choices program and the AR Choices in Homecare waiver offer self-directed PCS.

Many self-directed program participants share authority with, or delegate authority to family members or other individuals close to them. The designation of a representative enables minor children and adults with cognitive impairments to participate in self-directed programs. The individual or the legally authorized representative is the employer of record (i.e., common law employer) and has decision-making authority and budget authority over the self-directed services. The employer of record assumes and retains responsibility to recruit, hire, train, manage, and terminate employees.

Arkansas ensures these requirements are met through the FMSA which provides each beneficiary receiving self-directed PCS with a case manager to monitor the participant's expenditures. This case manager is tasked with advising the beneficiary on care choices and reporting significant budget variances that may indicate potential fraud or abuse to the OMIG and DPSQA. Initially, all participants are required to undergo orientation and training with the FMSA Supports Coordinator. The purpose of the training is to ensure that program responsibilities will be fulfilled, set up a budget, complete required paperwork, establish a backup plan, and complete required fraud and compliance training. After a participant starts the program, the FMSA Supports Coordinator is required to frequently assess the participant's experience directing their own care. The first six months post-enrollment are a provisional period, in which intense monitoring occurs. During the review period, Palco was the FMSA as well as the Fiscal/Employer Agent which acts as an employer agent for self-directed program participants by performing payroll-related and employer tax reporting functions.

Additionally, the DPSQA conducts regular audits of self-directed data to identify any potential outliers and/or discrepancies. The FMSA is held to performance indicators in the contract and is monitored by DPSQA through daily, weekly, and monthly reporting for compliance with contract requirements and data accuracy. The DPSQA specialists also have access to the FMSA system to verify participant status and payments to providers.

CMS did not identify any findings or observations related to these requirements.

## E. State Oversight of Agency-Based PCS Providers

Beneficiaries can enroll to have their care overseen, managed, and supervised by a personal care agency. Agency-based PCS in Arkansas is available under state plan/waiver authority. In accordance with §§ 441.302 and 441.570, the SMA must assure that certain safeguards have been taken to protect the health and welfare of individuals and to assure the financial accountability for funds expended for agency-based PCS. Arkansas ensures that these requirements are met through prior authorization (PA) of PCS services

PCS claims are submitted to the MMIS by the PCS agencies. The MMIS has a process for reconciling units requested and billed. When a PCS claim is submitted for payment, the

units/dollars paid on the claim are subtracted from the units/dollars authorized on the PA. Once all the prior authorized units/dollars are used, any additional PCS claims will be denied because the units/dollars on the PA are exhausted. The PCAs are enrolled with Arkansas Medicaid as a rendering provider and assigned a unique identifier.

Additionally, PCAs are subject to audits, reviews, and data mining conducted by OMIG to identify any aberrant billing patterns. The OMIG Data Analytics and Initiatives Unit is responsible for managing all aspects of data analysis and data-driven recoveries. For example, data analysts are responsible for creating algorithms, reports, and other proactive data studies that uncover outlying billing as well as possible indications of fraud, waste, and abuse in the Arkansas Medicaid system. Data analysis projects are created through data mining and research using multiple sources including complaints from the OMIG website and fraud hotline, law enforcement, program integrity trainings, conferences, networking events, and collaborative projects with the Unified Program Integrity Contractor and the National Healthcare Fraud Prevention Partnership. The data analysts utilize a Fraud and Abuse Detection System to review providers and their billing practices by performing reviews such as algorithms, peer-grouping studies, provider spike detection, claims risk analysis, and the creation and maintenance of various business-intelligence reports. This unit is also responsible for managing data-driven recoveries of overpayments for OMIG.

CMS confirmed that Arkansas has a MOU in place for suspected fraud referrals that meet federal requirements to ensure the financial accountability for funds expended for agency-based PCS provided through waiver or state plan authority.

CMS did not identify any findings or observations related to these requirements.

## F. PCS Agency Oversight of Staff and Attendants

As defined by § 440.167, PCS must be provided by an individual who is qualified to provide such services, unless defined differently by a state agency for purposes of a waiver granted under part 441, subpart G. The conditions of participation for home health aides participating in PCS programs are further detailed at § 484.36. In accordance with these standards, state law often requires PCS agency staff and attendants to be subject to enhanced screening and credentialing procedures at the date of hire and annually thereafter. As part of this review, CMS interviewed several PCS agencies to determine if they are exercising appropriate oversight of the quality and integrity of services provided to beneficiaries under the care of their agency, in accordance with state standards.

In accordance with state law Arkansas Code Annotated Title 20, Chapters 33 and 38, PCS agency staff and attendants are subject to enhanced screening and credentialing procedures at the date of hire and annually thereafter.

As part of the review, CMS interviewed three provider agencies: Arkansas Area on Aging, Bentonville School District, and Diamond Personal Care.
Per state requirements, PCAs must complete a 40-hour training course and certification prior to

providing PCS. This includes at least 24 hours classroom training and a minimum of 16 supervised practical training hours provided by or under the supervision of a registered nurse. In addition, the services must be provided by an individual who is qualified to provide such services and who is not a member of the beneficiary's family. School personnel providing billable PCS must be trained and certified by the Division of Elementary and Secondary Education.

According to the Arkansas Code Annotated §§ 20-33-213 and 20-38-103, all owners, principals, employees, and contract staff of a personal care provider are required to have a national and state criminal background check. If the PCA has not been a resident of Arkansas continually for the past five years, then a federal background check with fingerprinting is required. If the PCA can prove five years of residence in the state of Arkansas, then a state background check is sufficient. Criminal background checks must be repeated at least once every five years. Central registry checks must include the Child Maltreatment Central Registry, Adult and Long-Term Care Facility Resident Maltreatment Central Registry, and Certified Nursing Assistant/Employment Clearance Registry. All three provider agencies interviewed reported compliance with background screening and credentialing requirements.

CMS did not identify any findings or observations related to these requirements.

# V. CONCLUSION

CMS supports Arkansas's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified one recommendation and one observation that requires the state's attention.

We require the state to provide a corrective action plan for the recommendation within 30 calendar days from the date of the issuance of the final report. The corrective action plan should explain how the state will ensure that the recommendation has been addressed and will not reoccur. The corrective action plan should include the timeframe for the corrective action along with the specific steps the state expects will take place and identify which area of the SMA is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the corrective action plan, such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of issuance of the final report. If the state has already acted to correct compliance deficiencies or vulnerabilities, the corrective action plan should identify those corrections as well.

The state is not required to develop a corrective action plan for any observations included in this report. However, CMS encourages the state to take the observations into account when evaluating its program integrity operations going forward.

CMS looks forward to working with Arkansas to build an effective and strengthened program integrity function.

# VI. APPENDICES

## Appendix A:

Arkansas's last CMS program integrity review was in March 2018, and the report for that review was issued in December 2018. The report contained five recommendations. During the virtual review in September 2023, CMS conducted a thorough review of the corrective actions taken by Arkansas to address all recommendations reported in calendar year 2018. One of the findings from the 2018 Arkansas focused PI review report has not been satisfied by the state as noted below.

## Findings

1. ***The state should consider issuing Explanation of Medicaid Beneficiary Medical Benefits (EOMB) verifications to beneficiaries receiving PCS furnished by individual PCAs in self-directed programs.***
   **Status at time of the review: Not Corrected**

   Arkansas indicated that the state has not issued any EOMB verifications during the review period for PCS services furnished through provider agencies or by individual PCAs in self-directed programs.

2. ***The state should consider establishing a statewide system that captures information on all PCS providers related to the status/results of necessary background checks, federal database checks and licensing requirements that can be accessed to verify PCS providers' ability to provide services.***
   **Status at time of the review: Corrected**

   Arkansas implemented screening level provisions, including fingerprinting, based on the assigned level of risk for directly enrolled PCS providers and has implemented the federal database checks on any person with an ownership interest or who is an agent or managing employee of the provider as required. The state does check all parties against the federal List of Excluded Individuals and Entities and System for Award Management monthly after enrollment/reenrollment. The state contracts with Gainwell Technologies to check the excluded provider lists for all employees/caregivers being paid by Medicaid funds.

3. ***The state should consider utilizing data analytics to identify potential improper payments related to PCS claims that may require further investigation for fraud, waste and abuse.***
   **Status at time of the review: Corrected**

   Arkansas OMIG has increased its use of data analytics tools to identify providers for audit and investigation.

4. ***The state should consider providing regular training opportunities for PCS providers related to topics (including but not limited to) updates related to PCS program rules and/or guidance, PCS billing requirements, PCS fraud, waste and abuse identification and reporting requirements.***
   **Status at time of the review: Corrected**

   Arkansas will continue to hold monthly provider training related to PCS program rules, PCS billing requirements, PCS fraud, waste, and abuse identification and reporting requirements. In addition, the DPSQA provides annual provider training.

5. ***The state should ensure that the contracting occurs in order to secure an EVV system as a method to verify visit activity for Medicaid-provided PCS as required under Section 12006 of the 21st Century Cures Act. The EVV system should verify the date of service, location of service, individual providing the service, type of service, individual receiving the service, and the time the service begins/ends.***
   **Status at time of the review: Corrected**

   Arkansas has implemented an EVV system to verify visit activity.

**Appendix B:**

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance and educational resources for the SMA.

- Access the Resources for State Medicaid Agencies website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs to address techniques for collaborating with MFCUs.
- Access the Medicaid Payment Suspension Toolkit at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf, to address overpayment and recoveries.
- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts. https://www.riss.net/
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at https://www.cms.gov/hfpp.

## Appendix C:

Table C-1 provides detailed information on the PCS programs available in Arkansas.

**Table C-1. Arkansas Medicaid PCS Programs**

| Program Name/Federal Authority | Administered By | Description of the Program |
|---|---|---|
| State Plan PCS – IndependentChoices | DHS Division of Aging, Adult, Behavioral Health Services (DAABHS) | The state plan PCS program is available to assist Medicaid eligible individuals to perform ADLs and IADLs in their home, place of employment or community. |
| ***Section 1915(c) HCBS Waiver Authorities*** | | |
| ARChoices in Homecare | DHS DAABHS | The purpose of the AR Choices in Homecare waiver is to offer cost-effective, person-centered HCBS as an alternative to nursing home placement to persons aged 21 to 64 years with a physical disability, or 65 and older who require an intermediate level of care in a nursing facility, not a skilled level of care. |
| AR Living Choices Assisted Living | DHS DAABHS | The AR Living Choices Assisted Living waiver program allows individuals to live in apartment-style living units in licensed level two assisted living facilities and receive individualized personal, health, and social services that enable optimal maintenance of their individuality, privacy, dignity, and independence. The environment promotes participants' personal decision-making while protecting their health and safety. The major goal of this program is to delay or prevent institutionalization of these individuals aged 65 or older and individuals with physical disabilities aged 21-64 years who meet a nursing facility level of care. |

**Table C-2. Arkansas PCS Enrollment by Authority**

| | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|
| State Plan PCS – IndependentChoices | 5,935 | 7,241 | 7,226 |
| 1915(c) HCBS Waiver Authority | 4 | 14 | 10 |

**Table C-3. Summary of Arkansas PCS Expenditures by Authority**

| | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|
| State Plan – IndependentChoices | $41,447,458 | $65,276,535 | $69,502,485 |
| 1915(c) HCBS Waiver Authority | $384 | $25,982 | $16,362 |

**Table C-4. Waiver Authority Expenditures by Type**

| 1915(c) HCBS Waiver Authority | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|
| ARChoices in Homecare | | | |
| AR Living Choices Assisted Living | | | |

**Table C-5. Program Integrity Post Payment Actions Taken – PCS Providers**

| Agency-Directed and Self-Directed Combined | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|
| Identified Overpayments | $216,998 | $484,559 | $573,081 |
| Recovered Overpayments | $127,168 | $153,226 | $236,519 |
| Terminated Providers | 62 | 179 | 138 |
| Suspected Fraud Referrals | 28 | 56 | 39 |
| Number of Fraud Referrals Made to MFCU | 7 | 9 | 15 |

**Appendix D:**

# State PI Review Response Form

**INSTRUCTIONS:**

For the draft recommendation listed below, please indicate your agreement or disagreement by placing an "X" in the appropriate column. For any disagreements, please provide a detailed explanation and supporting documentation.

| Classification | Issue Description | Agree | Disagree |
|---|---|---|---|
| Recommendation #1 | In accordance with § 455.20, Arkansas should develop and implement a process, including written policies and procedures, to conduct beneficiary verifications for PCS furnished by provider agencies and individual PCAs in the self-directed program. | | |

Acknowledged by:

Jay Hill__/s/ Director, Division of Aging and Adult Behavioral Services, Arkansas DHS_____

_11/20/2025_____
Date