Office of Medicaid Inspector General

Annual Report
October 1, 2016

Elizabeth Smith, Medicaid Inspector General

Office of the
Medicaid Inspector General

323 Center Street, Ste. 1200 · Little Rock, AR 72201
501-682-8349 · Fax: 501-682-8350

Greetings,

It is my pleasure to present the Office of the Medicaid Inspector General (OMIG) Fiscal Year 2016 report outlining my first year as Medicaid Inspector General for Arkansas. I am proud of our work during my first year, we were able to recover more state matching funds for the state of Arkansas, increase fraud referrals, recommend and implement valuable changes to the Medicaid Provider manual regarding Group Psychotherapy and develop new initiatives with a small number of tenured staff members and an increasing number of new staff. I have worked to retool and reallocate our staff in order to be more effective and efficient. This report details OMIG's FY16 activities and initiatives. I'll highlight a few of the new initiatives this year.

In the fall of 2015, OMIG received a report from AdvanceMed, our Zone Program Integrity Contractor from CMS identifying vulnerability in our Medicaid Program for Group Psychotherapy. Arkansas was identified as spending far more than the other states, and our billing policies did not have annual limits. In January 2016, I recommended DHS make changes to the Group Psychotherapy billing policy. Two of the changes I recommended have been approved and are scheduled to take effect on October 7, 2016. Other changes have been submitted for comment and approval. Not only will these changes increase our integrity to the program, they will also allow for necessary cost savings.

The Provider Awareness Letter initiative is another of my most proud endeavors. One of my goals in this position has been to work with the providers in order to ensure integrity in the Medicaid program. While there is fraud in the system, most providers do intend to perform their duties with integrity. Receiving a letter identifying the provider as a statistical outlier for Medicaid billing encourages the provider to review their billing practices, encourages self-reporting, and increases appropriate billing practices which generates avoided costs from future inappropriate billings.

In Fiscal Year 2016, OMIG made significant strides in the recovery of School District state matching funds for school-based therapies. OMIG found instances when school districts

had failed to submit proper Medicaid payments. OMIG recovered these funds and sent over 500 letters to school districts and providers to bring about awareness and compliance with billing school-based therapies.

Other significant initiatives and reviews in 2016 included: Emergency Transportation Billing; Physician and Advanced Practice Nurse billing; Hospital In-Patient One-Day Stay reviews; and review of the Dental and Optometry programs. In each of these initiatives and reviews, OMIG worked with DHS and the respective provider groups to determine whether recommendations for reform within the program would be necessary.

I appreciate your interest in OMIG's efforts to combat fraud, abuse, and waste in the Medicaid program. Integrity in our Medicaid Program is of utmost importance and can only be achieved through coordination and cooperation with Medicaid providers, legislators, our federal partners, the Medicaid Fraud Control Unit of the Attorney General's office, the Department of Human Services, and my office. Ensuring Medicaid dollars are spent appropriately will increase our integrity as well as reduce the amount of fraud, abuse, and waste in our program. Together we can achieve these goals.

Sincerely,

Elizabeth Thomas Smith
Medicaid Inspector General

TABLE OF CONTENTS

Introduction

Arkansas Office of the Medicaid Inspector General Mission Statement

The mission of the Office of Medicaid Inspector General (OMIG) is to prevent, detect, and investigate fraud, waste, and abuse within the medical assistance program. This mission is achieved through auditing Medicaid providers and medical assistance program functions; recovering improperly expended funds; and referring appropriate cases for criminal prosecution. OMIG works closely with providers and the medical assistance program to prevent fraud, waste, and abuse.

Creation and Statutory Authority

The Office of the Medicaid Inspector General fulfills the federal program integrity requirement to ensure compliance, efficiency, and accountability within the Medicaid program by detecting and preventing fraud, waste, and abuse under 42 CFR §455 *et al.* Prior to 2013, the program integrity function was housed within the Department of Human Services (DHS), Division of Medical Services (DMS). In order to maximize recovery of improper Medicaid payments and create a more efficient and accountable structure, the state's process for detecting and combating Medicaid fraud and abuse was reorganized and streamlined by Act 1499 of 2013. The Act created the "Office of Medicaid Inspector General," a new state agency, by consolidating the program integrity positions from DMS with two new positions of Medicaid Inspector General and its chief counsel to perform the Medicaid fraud detection, prevention, and recovery functions into a single office effective July 1, 2013. *See Ark. Code Ann. §20-77-2501.*

Pursuant to Ark. Code Ann. §20-77-2501, the Office of the Medicaid Inspector General, (OMIG) shall: (1) Prevent, detect, and investigate fraud and abuse within the medical assistance program; (2) Refer appropriate cases for criminal prosecution; (3) Recover improperly expended medical assistance funds; (4) Audit medical assistance program functions; and (5) Establish a medical assistance program for fraud and abuse prevention.

On June 20, 2015, Governor Asa Hutchinson appointed Elizabeth Smith as Medicaid Inspector General for the State of Arkansas. Prior to this appointment, Inspector General Smith

served as chief legal counsel to Governor Hutchinson. Smith has practiced law for over twenty years, including eight years as associate general counsel for the University of Arkansas for Medical Sciences, two years as an assistant attorney general, two years as an associate for Mitchell Williams Selig Gates and Woodyard representing health care providers, and seven and a half years as deputy prosecuting attorney for the 6th Judicial District of Arkansas.

Annual Report Statistics and Information

According to Ark. Code Ann. §20-77-2509, the Office of the Medicaid Inspector General shall submit a report summarizing the activities of the Office of the Medicaid Inspector General to the Governor, the President Pro Tempore of the Senate, the Speaker of the House of Representatives, Division of Legislative Audit, Legislative Council, and the Attorney General no later than October 1 of each year.

The report shall include, the number, subject, and other relevant characteristics of: (A) Investigations initiated, and completed, including without limitation outcome, region, source of complaint, and whether or not the investigation was conducted jointly with the Attorney General; (B) Audits initiated and completed, including without limitation outcome, region, the reason for the audit, the total state and federal dollar value identified for recovery, the actual state and federal recovery from the audits, and the amount repaid to the Centers for Medicare & Medicaid Services; (C) Administrative actions initiated and completed, including without limitation outcome, region, and type; (D) Referrals for prosecution to the Attorney General and to federal or state law enforcement agencies, and referrals to licensing authorities.

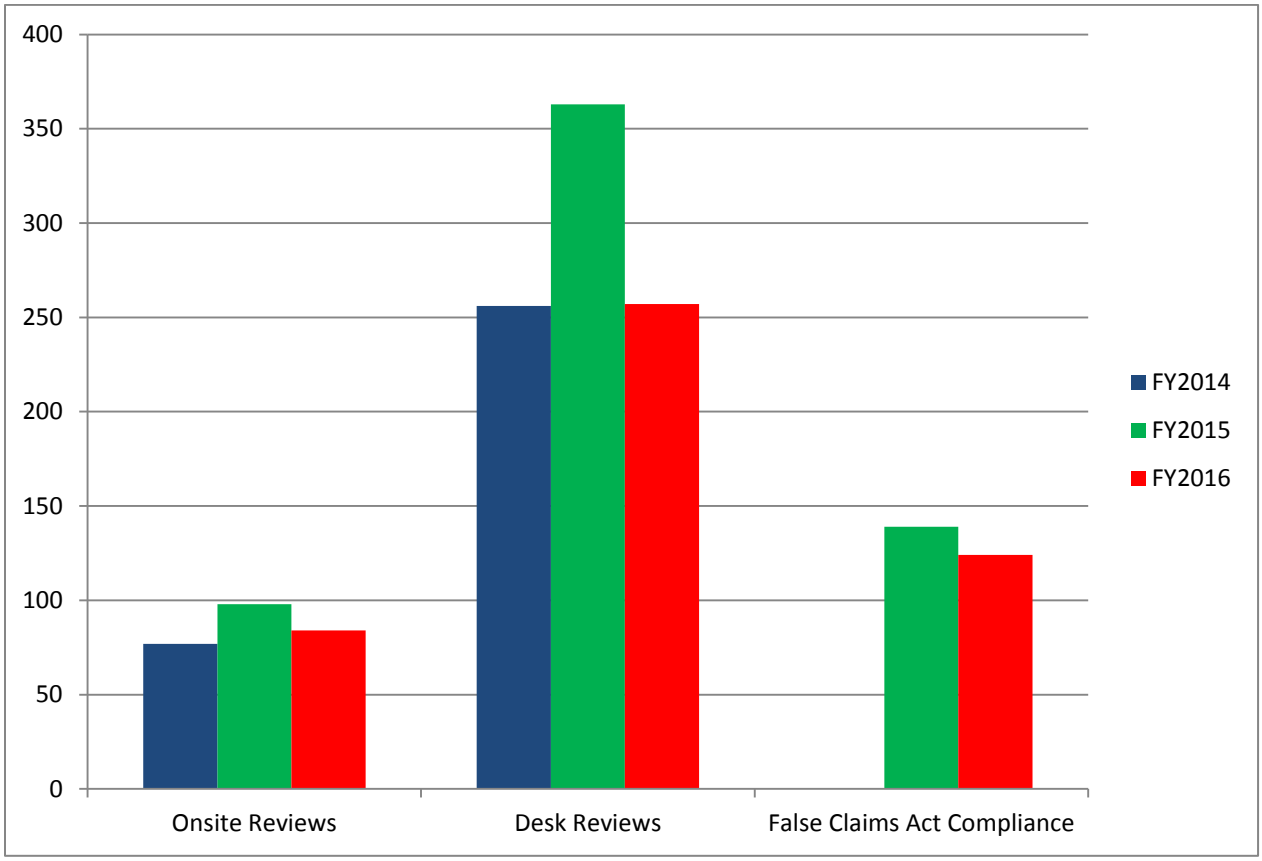
This Annual Report contains statistics, data, and information from Fiscal Year 2016 (July 1, 2015 to June 30, 2016) from the Office of the Medicaid Inspector General and is submitted pursuant to Ark. Code Ann. §20-77-2509.

OMIG Audits, Reviews, and Investigations

Fiscal Year 2016 Total Audits/Review (July 1, 2015 to June 30, 2016)

Onsite Audits	**84**
Desk Audits	**257**
False Claims Act Compliance Reviews	**124**
MIC Review	**2**
Provider Awareness Letters*	**42**
Crossover Recoupment Letters*	**1033**
	1542

*New initiatives for Fiscal Year 2016

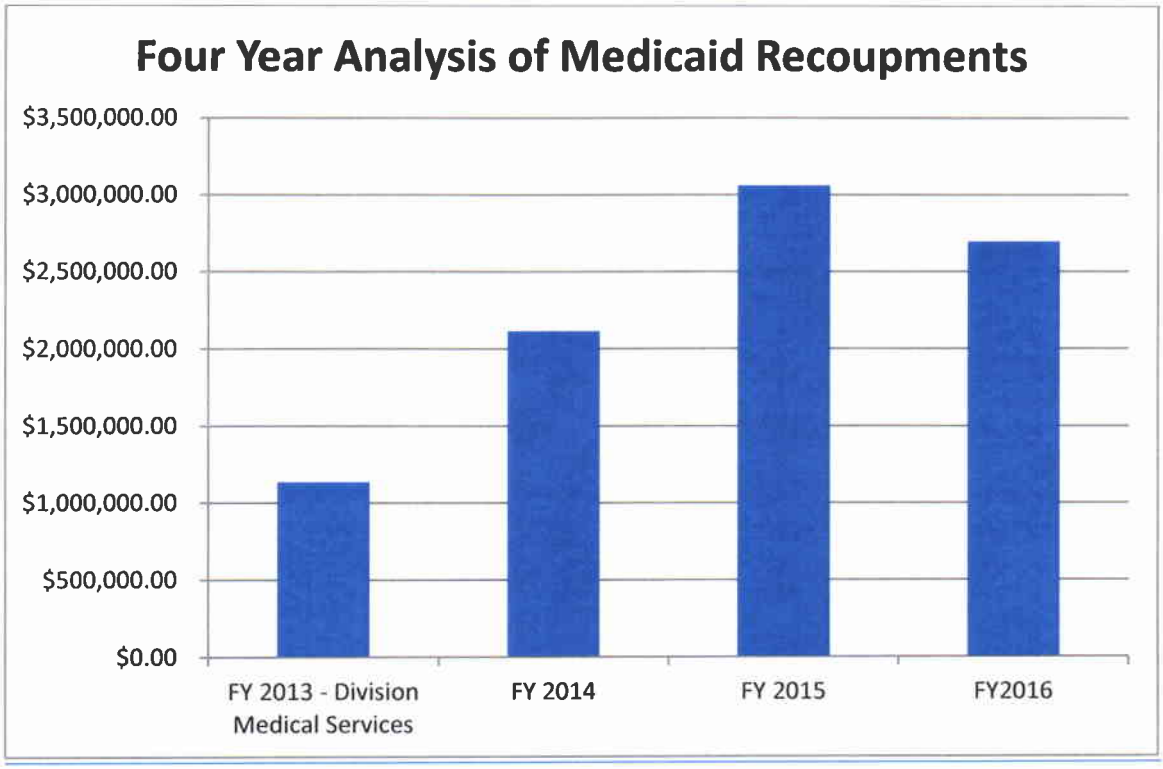


OMIG Recoveries/Recoupment

Recoveries and Recoupments from (July 01, 2015 to June 30, 2016)

Fiscal Year 2016 Recoveries of Overpayments by OMIG **$2,697,074.40**

The graph below indicates OMIG Medicaid recoupments for Fiscal Years 2013 through 2016.



In Fiscal Year 2016 OMIG recovered more in state funds then in previous years. The additional amount of state funds recovered was based on recoupments of state matching funds from school districts, an increased amount of criminal restitution payments from cases referred to the Arkansas Attorney General's Office, and recoveries of claims paid for Herceptin. These initiatives resulted in a higher net total of state Medicaid funds in Fiscal Year 2016.

OMIG initiatives include overpayments that are identified and reported to the Department of Human Services (DHS) and Hewlett Packard Enterprises, company responsible for processing Medicaid payments. The Office of the Medicaid Inspector General will continue to improve methods of recovering state funds.

OMIG Administrative Actions

Pursuant to Ark. Code Ann. §20-77-2106, OMIG may pursue civil and administrative actions against and individual or entity that engages in fraud, abuse, or illegal or improper acts within the medical assistance program. Administrative actions include a number of provider sanctions that result from audits, investigations, and reviews by OMIG.

Fiscal Year 2016 OMIG Statistics

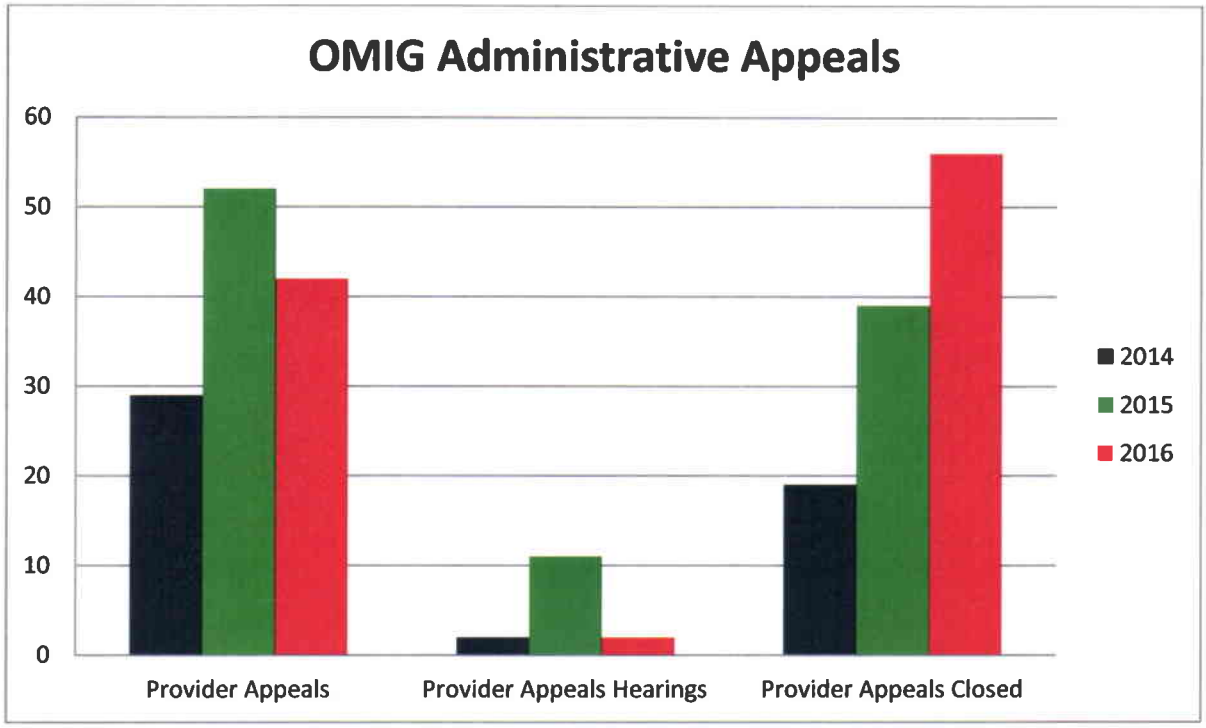
• Provider suspensions from the Medicaid Program	15
• Provider exclusions from the Medicaid Program	38
Total Administrative Actions	**53**

OMIG Administrative Appeals

Administrative appeals occur when Medicaid providers request appeals of OMIG findings after an audit or administrative action occurs. Medicaid providers are entitled to appeal all findings and sanctions pursuant to the Arkansas Medicaid Fairness Act, Ark. Code Ann. §20-77-1702, and pursuant to the Arkansas Medicaid Manual §160.000 et seq.

• Fiscal Year 2014 Provider Appeal Requests	29
• Fiscal Year 2015 Provider Appeal Requests	52
• **Fiscal Year 2016 Provider Appeal Requests**	**42**
• Appeal Requests Closed in Fiscal Year 2015	39
• **Appeal Requests Closed in Fiscal Year 2016**	**56**

- **Total Negotiated Settlement Amount for Appeals** **$746,223.41**



OMIG Referrals of Fraud and Prosecutions

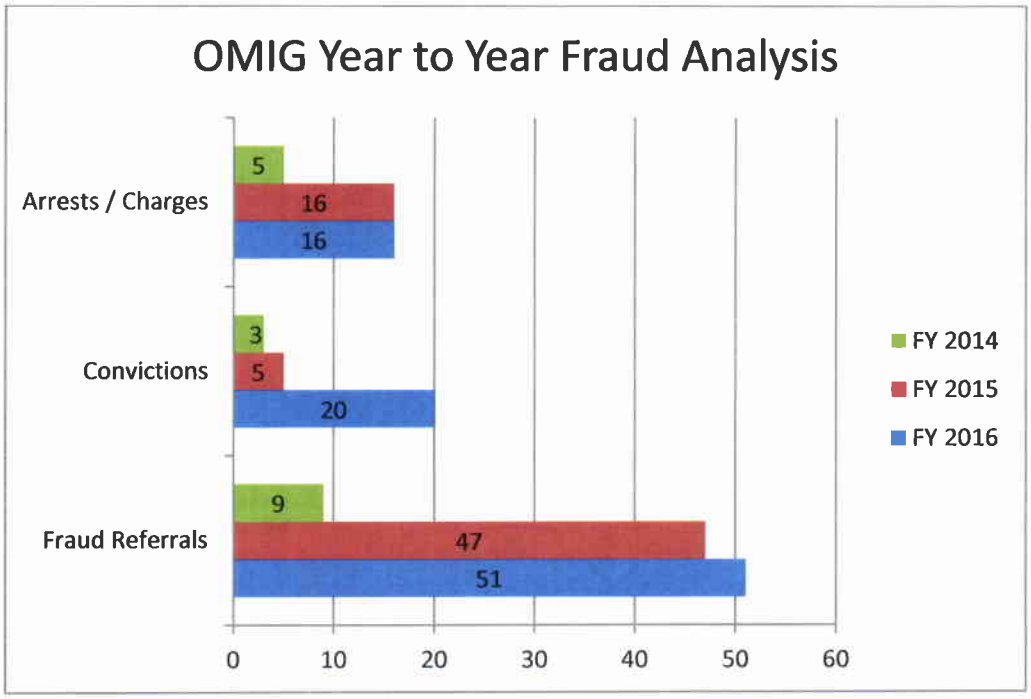
Arkansas Attorney General's Medicaid Fraud Control Unit

Pursuant to Ark. Code Ann. §20-77-2106, the Medicaid Inspector General shall work with the Medicaid Fraud Control Unit (MFCU) of the Office of the Arkansas Attorney General, prosecuting attorneys, and law enforcement agencies. The Medicaid Inspector General refers audit investigations to MFCU when there is a credible allegation of fraud. *See 42 CFR §455.23.*

In Fiscal Year 2016, fifty-one (51) Medicaid provider investigations were referred for consideration to the Medicaid Fraud Control Unit of the Attorney General's Office. In Fiscal Year 2015, OMIG referred forty-seven (47) cases.

In Fiscal Year 2016, the Attorney General's office charged sixteen (16) individuals with Medicaid fraud based upon Program Integrity Unit and/or Office of the Medicaid Inspector General referrals. Additionally, the Attorney General's office obtained twenty (20) convictions

for Medicaid fraud based upon investigations prompted by Program Integrity Unit and/or Office of the Medicaid Inspector General referrals. Referrals in Fiscal Year 2016 resulted in five convictions of Medicaid fraud. Others referred are still open or pending referrals with the Attorney General's Office.



Upon referral of a potential case to MFCU, OMIG may not issue an audit report or pursue recoupment until the MFCU action is resolved. However, OMIG does track the original questioned costs of all MFCU referrals.

- Total original questioned cost for Fiscal Year 16 MFCU referrals: **$885,264.34**
- Total Restitution for Fiscal Year 16 fraud referrals: **$66,691.22**

Arkansas Attorney General False Claims Cases

The Arkansas Medicaid Fraud False Claims Act, codified at Ark. Code Ann. § 20-77-901, et. seq., states that a person shall be liable to the State of Arkansas, through the Attorney General, for a civil penalty or restitution if he or she knowingly makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under the Arkansas Medicaid program.

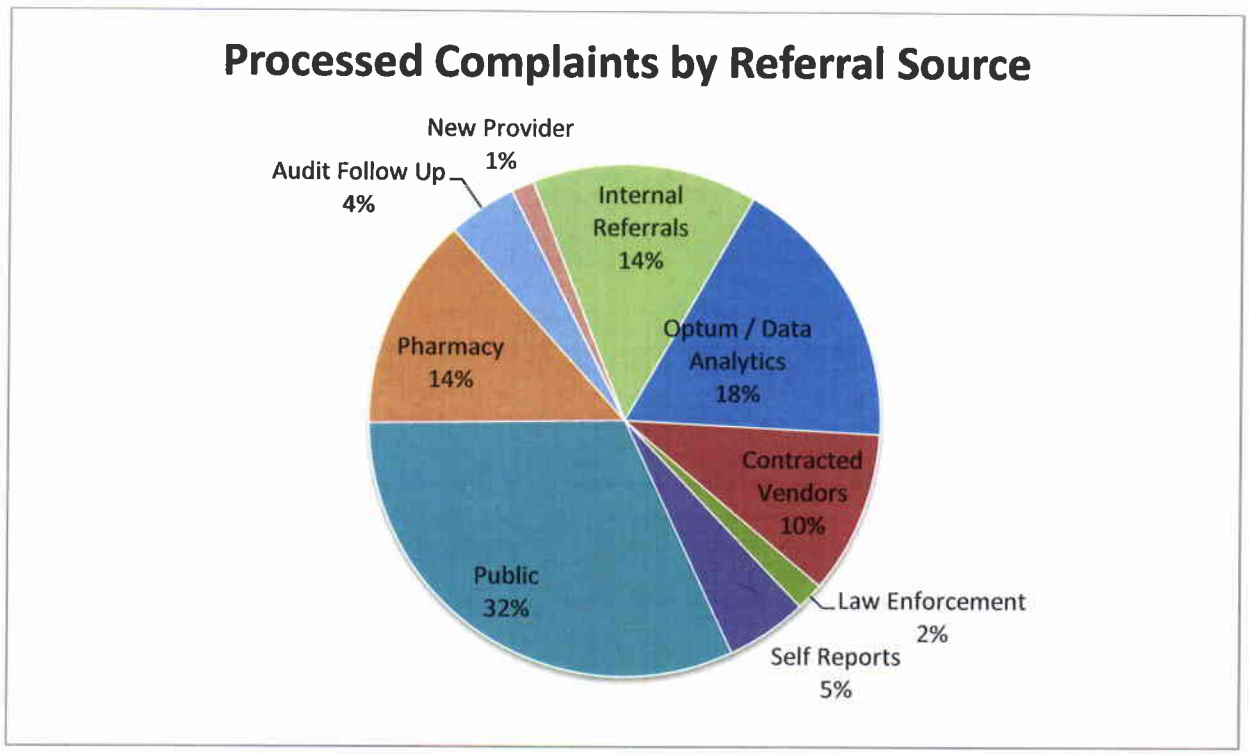
In Fiscal Year 2016, the Medicaid Fraud Control Unit of the Arkansas Attorney General (MFCU) settled four cases that were originally lawsuits filed under the state's false claims act which were originally referred to them by OMIG after the completion of an audit. Total Attorney General settlement amounts for OMIG cases resulted in $719,365.74 in settlements.

Other Fraud Referrals

In addition to referrals of suspected fraud to the Arkansas Attorney General's office, OMIG shall also make referrals and coordinate efforts with other federal, state, and local law enforcement agencies. *See Ark. Code Ann. §20-77-2106(2)*. OMIG will continue to coordinate efforts and make referrals to the appropriate law enforcement agencies when criminal fraud is suspected or uncovered during an audit or investigation. In Fiscal Year 2016, OMIG referred four cases to federal law enforcement agencies for criminal investigation.

OMIG Complaint and Referral Statistics

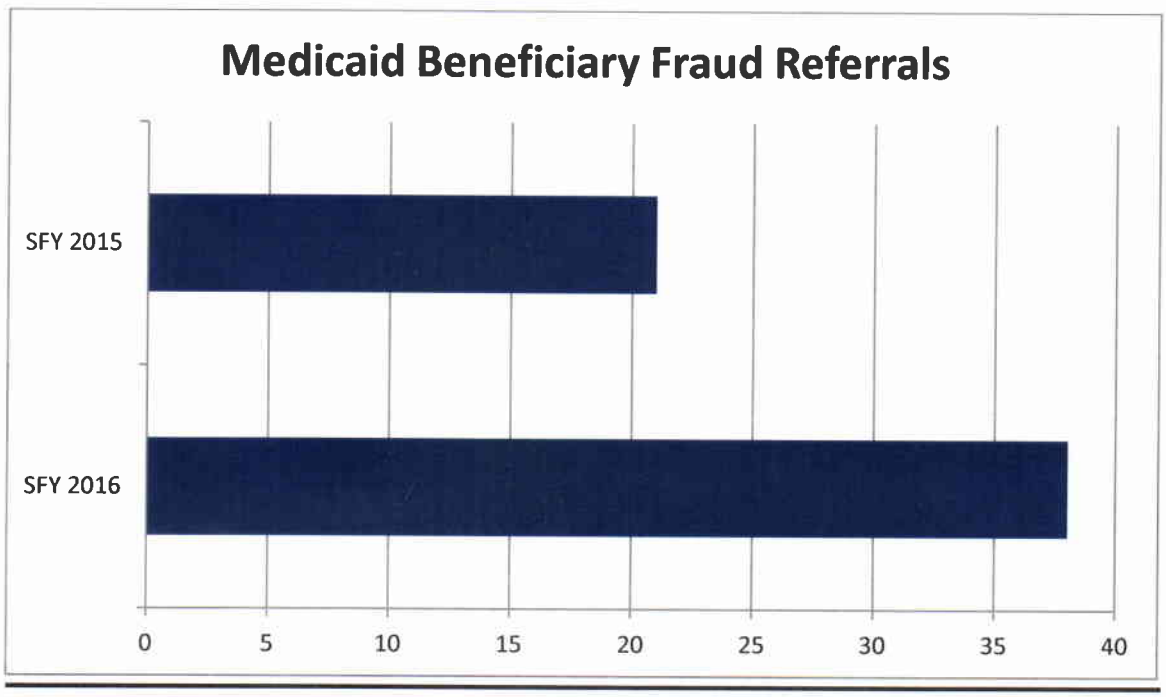
In Fiscal Year 2016, OMIG processed 623 complaints and referrals originating from multiple sources. In Fiscal Year 2016, OMIG created three new referral categories: New Provider, Pharmacy, and Self-Reports. Additionally, changes in the referral assignment process resulted in the break out of internal referrals, which includes all other state agencies, and Audit Follow Up which represents additional OMIG review based on previous audit or review findings.



In Fiscal Year 2016, through the use of data analysis, OMIG focused reviews based on identified spikes in new provider claims. While the Optum / Data Analytics figures mirror FY 2015 figures, other categories such as Internal Referrals, New Provider and Audit Follow Up include cases resulting in part from the increasing use of data analytics tools.

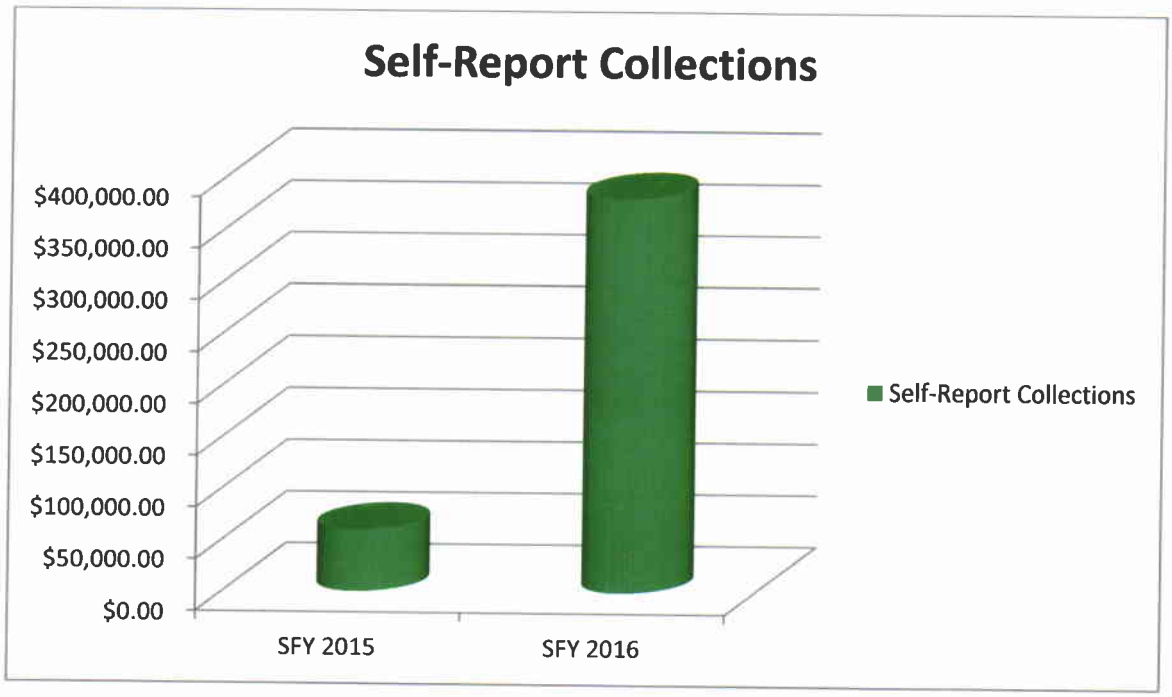
Medicaid Beneficiary Fraud Referrals

OMIG has increasingly become a central point of contact for any perceived Medicaid fraud. This increasing public awareness results in an increase in Medicaid beneficiary fraud allegations. As a result of this increased public awareness, beneficiary fraud referrals during Fiscal Year 2016 totaled thirty eight (38) cases up from twenty one (21) cases in Fiscal Year 2015.



Medicaid Provider Self-Reports to OMIG

OMIG continues to make efforts to form partnerships with Medicaid providers through the self-report procedure. It is anticipated that the self-report procedure will continue to enhance OMIG's efforts to eliminate fraud, waste and abuse while simultaneously offering Medicaid providers a mechanism to reduce their legal and financial exposure. OMIG maintains a system that separately tracks self-reports made to the agency. For the Fiscal Year 2016, OMIG received $380,674.71 from 18 Medicaid providers self-reports.



Part of the self-report procedure requires providers to create and submit to OMIG a Corrective Action Plan (CAP), which addresses the nature of the incident or practice reported, as well as appropriate measures put in place to prevent future occurrences.

OMIG Special Projects and Initiatives for 2016

Introduction

One of OMIG's main points of focus in Fiscal Year 2016 was to expand beyond the traditional program integrity audit and review process and develop new strategies and initiatives to bring reform and savings to the Medicaid program. OMIG special projects and initiatives were successful in generating collections, implementing changes, recommending edits, and creating cost avoidance opportunities. Implementing special projects and initiatives are cost effective, maximizes the use of agency resources to identify fraud, waste, abuse and also creates cost savings opportunities and cost avoidance.

Crossover Claims Initiative

In Fiscal Year 2016, OMIG identified paid Arkansas Medicaid crossover claims in which the paid Medicare claim was later voided or reversed. Crossover payments occur when a beneficiary is eligible for both Medicare and Medicaid coverage. Pursuant to the Arkansas Medicaid 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.

With the help of the Arkansas Zone Program Integrity Contractor, AdvanceMed, and the Medicaid Management Information Systems (MMIS) vendor for Arkansas Medicaid, Hewlett Packard Enterprises, OMIG began to review and analyze over $700,000.00 in Medicaid claims that were identified as potentially subject to void or recoupment based on Medicare crossover voids and reversals.

During the first phase of the Crossover Claims Initiative, OMIG reviews resulted in $47,851.79 being recovered from Medicaid providers. Before the end of Fiscal Year 2016, OMIG submitted the second phase of crossover reviews which recently resulted in an additional $178,810.50 that will be counted towards reversals and collections in the 2017 fiscal year. The third phase will review Hospital billing crossover claims. This phase began in the first quarter of Fiscal Year 2017.

OMIG continues to review and adjust paid Arkansas Medicaid crossover claims in which paid Medicare claims were voided or reversed. OMIG submitted a recommendation to the Division of Medical Services that they review their current Coordination of Benefits Contract to determine if it would be appropriate to receive voided and reversed crossover claims data.

Since OMIG began the Crossover Claims Initiative, other state Medicaid programs have contacted Arkansas and AdvanceMed to learn about the Crossover Claims Initiative and review their own state policies and claims process regarding crossover claims.

School District State Matching Funds

Funding for the Medicaid program is shared between the federal and state government. Arkansas is responsible for paying a portion of all reimbursed Medicaid claims, otherwise known as the state match payment. School districts must pay the state match for Medicaid covered services that are provided as part of the student's Individualized Education Program (IEP), regardless of whether the school district or a contracted provider bills for the claim.

OMIG began researching and analyzing data and information over concerns that some school districts were not paying the state match for school-based services. School districts receive a quarterly match statement identifying the state match amount to be paid by the school

district. OMIG's review identified numerous circumstances where school districts failed to reimburse the Medicaid program for school-based service claims.

OMIG's review identified $272,547.32 of match payments that were not made due to improperly billed claims. OMIG recouped this amount in full. As this amount was "state-only" funds, the entire recoupment amount was returned to the Arkansas state Medicaid fund.

For Fiscal Year 2017, OMIG has continued the School District Matching Funds Initiative by submitting 556 Provider Awareness Letters to school districts and LEA coordinators, and is working to provide information and education to school districts and their contracted therapists on the requirements for billing Medicaid claims for school-based services. OMIG will also monitor future state match fund payments by school districts and LEA coordinators to measure any increased reporting of school-based therapy services based on the OMIG's awareness and education efforts.

Emergency Transportation Billing

In Fiscal Year 2016, OMIG received a referral regarding transportation providers billing exclusively Advanced Life Support (ALS) procedures for all ambulance transportation claims. OMIG created a peer group data claims study to analyze high rates of ALS billing amongst transportation providers and identified the top outliers for high rates of ALS billing. OMIG selected a number of providers for audit, and sent Provider Awareness Letters to an additional 16 outliers who showed to have high-risk behavior. These letters explained the methodology of the peer group data claims study, the provider's status as an outlier among their peers, and also requested that the provider self-report and submit a recoupment for all identified overpayments.

OMIG's audits of these transportation providers identified $24,789.10 in questioned costs that were found to be a result of improper claims. Of the questioned costs identified, $18,969.30 has been claimed for recoupment by the end of Fiscal Year 2016 and the additional $5,819.80 is expected to be recouped in Fiscal Year 2017 resulting in 100% recoupment of questioned costs for these audits. Additionally, OMIG received a 100% return response from the Provider Awareness Letters (16 out of 16 providers), and an additional $13,754.79 in self-reports was recouped due to the self-report requests.

OMIG was invited by the Arkansas Ambulance Association to present at their annual EMS Expo in April. OMIG provided education regarding this billing practice and discussed the methodology of the peer group study for this initiative. OMIG will continue to use data analytics to monitor the identified outlier providers in FY2017 to ensure that their billing behavior patterns will continue to normalize and fall more into line with those of their peers. The initiative not only resulted in $32,724.09 in recouped claims, a cost avoidance review by Optum of the providers' billing practice after being contacted by OMIG revealed that provider's compliance with Medicaid regulations has improved resulting in cost avoidance of more than $600,000.00 to the Arkansas Medicaid program.

Analysis of Physician and Advanced Practice Nurse Billing

During the course of a medical claims review conducted by Medical Audit and Review Solutions (MARS), Medicaid patient records revealed many instances where office visits were performed by Advanced Practice Nurses (APN), yet billed to Medicaid indicating that a physician performed the service or treatment.

OMIG conducted a review and analysis of the billing practices for patient office visits by physicians and APNs. The Common Procedure Terminology (CPT) codes reviewed include

99201 – 99205 and 99211 – 99215. OMIG reviewed the Arkansas policies and payment schedules and compared them to other state Medicaid programs that operate a fee-for-service payment schedule, and states that are similarly situated to Arkansas. OMIG also reviewed the Medicare program and payment schedules and performed a comparative analysis. OMIG drafted and submitted a report to the Arkansas Department of Human Services that provides the results of OMIG's analysis of the Arkansas billing practices as well as recommendations for changes to the Arkansas Medicaid program.

OMIG continues to monitor this issue and has performed various reviews in order to ensure that Medicaid regulations are being followed. A cost avoidance review by Optum of one specific provider's billing practice after being contacted by MARS revealed compliance with Medicaid regulations resulting in cost avoidance of more than $27,000.00 to the Arkansas Medicaid program.

Hospital Inpatient One-Day Stay Reviews

During the course of Fiscal Year 2016, OMIG worked with Health Integrity, the Medicaid Integrity Contractor (MIC), to review and audit hospitals that bill Arkansas Medicaid for one-day in-patient services. Based on the review by Health Integrity, OMIG recouped $96,584.63 from six hospitals. Currently Health Integrity is working to submit an additional hospital review for consideration.

After the reviews by Health Integrity, OMIG submitted 13 Provider Awareness Letters containing specific claims data, requesting the hospitals to perform a self-audit. OMIG is requesting that each hospital review the claims and payments, to conduct an internal audit or review, submit any improper overpayments, and prepare a corrective action plan to ensure compliance with Medicaid policies.

To date, seven of the thirteen hospitals have completed the review and the remaining hospitals are in the review process. The seven hospitals that have completed the review have returned a total of $98,633.98 in overpayments to OMIG. As part of the initiative, each hospital is asked to submit a corrective action plan to ensure future compliance.

The Hospital Inpatient One-Day Stay initiative should lead to more specific compliance and cost avoidance moving forward in the Arkansas Medicaid program.

90853 Group Psychotherapy

The 90853 Group Psychotherapy Initiative has been one of the most successful and rewarding initiatives since the creation of the Office of the Medicaid Inspector General. With the assistance of the Arkansas Zone Program Integrity Contractor, AdvanceMed, and utilizing Optum FADS tools and analytics, OMIG launched a comprehensive review of an identified service and billing outlier in the Arkansas Medicaid Behavioral Health program. The AdvanceMed analysis showed Arkansas was a significant outlier in both the utilization and payment for Group Psychotherapy.

Table 1 - Summary of Medicaid Group Psychotherapy Payments by State 2013 – 2015

State	Procedure Code	Dual Eligible Recipients	% of Total Recipients	Dual Eligible Claims	% of Total Claims	Paid for Dual Eligible Recipients	Total Paid	% of Total Paid for Dual Eligible Recipients
AR	90853	2,920	7.1%	365,349	17.7%	$23,982,449	$147,961,241	16.2%
AL	90853	1,644	13.0%	29,537	21.0%	$1,080,362	$8,287,294	13.0%
GA	90853	362	4.3%	2,455	3.1%	$88,393	$3,395,819	2.6%
MS	90853	677	5.0%	5,858	2.6%	$155,505	$7,784,924	2.0%
LA	90853	130	2.4%	596	1.9%	$7,653	$504,348	1.5%
TN	90853	124	1.2%	923	1.2%	$18,502	$1,781,068	1.0%
WV	90853	11	0.4%	44	0.2%	$616	$452,913	0.1%

Note: Most current data available varies by state, ranging from June 2015 for Tennessee to December 2015 for Arkansas

Table 2 - Group Psychotherapy Reimbursement Policy Comparison by Program

State (Medicaid)		Procedure Code	Payment per Unit	Units (Minutes)	Number of Participants	Daily Unit Limit	Yearly Unit Limit
AL		90853	$23.00	90	2-10	1	12
AR		90853	$13.80	15	2-12 (18 or Older) 2-10 (Under 18)	6	None
GA		90853	$28.92	60	10 (maximum)	4 (< age 21)	24 (<age 21)
						1 (>= age 21)	12 (>= age 21)
LA		90853	$22.05	60	No policy	1	24
MS		90853	$22.44	"Per service"	2-12 (18 or older) 2-10 (Under 18)	2	40
TN		90853	N/A	N/A	N/A	N/A	N/A
WV	Prior to 7/1/15	90853	$18.65	75-80	12 (maximum)	N/A	N/A
	After 7/1/15	90853	$18.65-$19.58	60-80	None	Varies by MCO from no limit to 2	N/A
Medicare - Novitas		90853	$25.01	45-60	10 (maximum)	N/A	N/A

The analysis led to concerns that the existing payment policy for 90853 Group Psychotherapy billing code created vulnerability in the Medicaid program for fraud, waste, and abuse. The reports and studies prompted OMIG to create a plan of action to address the program vulnerability. The plan included multiple meetings with Arkansas Medicaid, the Division of Behavioral Health, and other state agencies. OMIG made presentations to the Legislative Health Care Task Force, the Governor's office, and other groups. OMIG also met with Medicaid providers and the Arkansas State Hospital. Ultimately, OMIG made the following recommendations to the Arkansas Medicaid Program to reform the 90853 RSPMI procedure code:

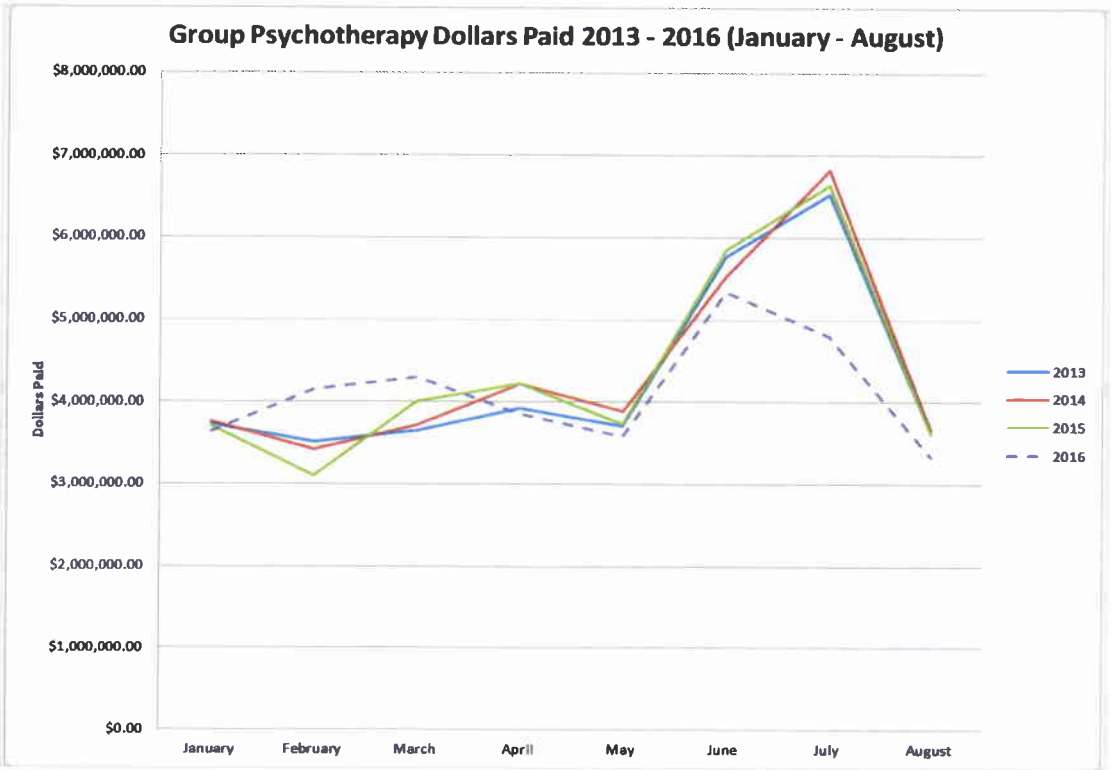
- limit the number of units that could be billed on a daily basis from 6 units to 4 units;
- to set a cap on the number of sessions that could be performed in a year; and
- reduce the fees schedule from $13.80 to $10.00 per 15 minute unit.

Based on a review and analysis of previous billing and payments of 90853 Group Psychotherapy, the OMIG recommendations would not only provide necessary limitations and safeguards against fraud, waste, and abuse, it could also save the Arkansas Medicaid Program up to $35 million dollars a year if implemented.

OMIG claims analysis indicated that bringing awareness, meeting with the contracted vendor for prior authorization, and making the recommendations led to cost avoidance in the last quarter of the 2016 fiscal year. Based on data available to OMIG at the time of this report, the chart below shows a decline in 90853 Group Psychotherapy billing from April 2016 through August 2016 by more than $3,000,000.00.

Group Psychotherapy (90853) Dollars Paid January through August

	2013	2014	2015	3 Year Average (2013 - 2015)	2016	Difference	% Change
January	$3,723,447.06	$3,764,138.19	$3,705,541.86	$3,731,042.37	$3,638,714.03	$92,328.34	-2%
February	$3,511,360.29	$3,425,417.15	$3,096,549.30	$3,344,442.25	$4,151,450.13	($807,007.88)	24%
March	$3,645,833.77	$3,718,961.72	$4,004,674.94	$3,789,823.48	$4,301,962.72	($512,139.24)	14%
April	$3,920,269.43	$4,223,257.14	$4,220,527.80	$4,121,351.46	$3,852,940.48	$268,410.98	-7%
May	$3,701,323.09	$3,889,701.73	$3,732,252.14	$3,774,425.65	$3,574,586.28	$199,839.37	-5%
June	$5,774,539.51	$5,531,424.58	$5,850,128.67	$5,718,697.59	$5,338,599.48	$380,098.11	-7%
July	$6,526,639.30	$6,817,609.42	$6,636,820.30	$6,660,356.34	$4,802,779.27	$1,857,577.07	-28%
August	$3,619,870.65	$3,661,911.47	$3,618,446.85	$3,633,409.66	$3,330,383.93	$303,025.73	-8%
TOTALS:	$34,423,283.10	$35,032,421.40	$34,864,941.86	$34,773,548.79	$32,991,416.32	$1,782,132.47	-5%



In September of 2016, two of OMIG's recommendations submitted for promulgation were passed by legislative committees. The reforms regarding unit times expected to go into effect in October of 2016. OMIG anticipates a significant impact, savings, and most importantly, true program integrity to the Arkansas Medicaid Behavioral Health program. The reforms regarding rate reduction have been submitted for public comment.

Provider Awareness Letters

During Fiscal Year 2016, OMIG sent Provider Awareness Letters to providers whose billing practices were identified as high risk and potentially aberrant. The letters were sent with the intent of improving integrity within the Medicaid program by educating providers on observed billing trends and giving them the opportunity to self-report overpayments.

OMIG utilized claims data to identify providers that would receive an awareness letter. Claims data was analyzed through peer group studies which focused on specific billing behaviors of a specific type of provider. Peer group studies provide a statistical comparison of providers in a defined peer group which can be utilized to identify statistically significant outliers by user-defined billing behavior patterns. Providers whose billing deviated significantly from those in their peer group were further analyzed and ranked according to their risk profile as defined in the peer group study.

OMIG audited top outliers identified in the peer group studies that were reviewed as part of this initiative. OMIG then selected additional providers with a similar risk profile, and those providers received a provider awareness letter which explained the peer group study, the provider's status as an outlier, and requested that the provider perform an internal review of the claims identified in the letter and submit an explanation as to why they were identified as an

outlier. Further, OMIG requested that the provider self-report and submit a recoupment for all identified overpayments.

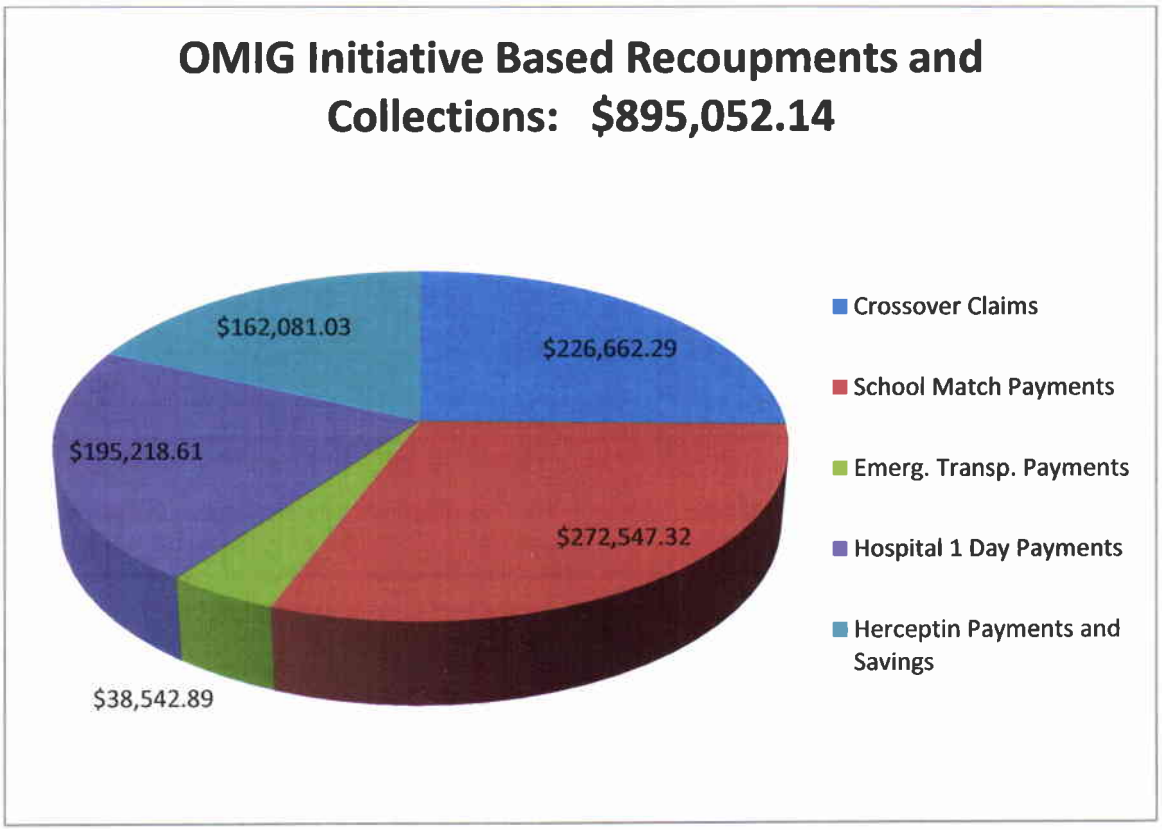
OMIG provider awareness letters alerted providers to potential improper billing resulting in improved compliance with Medicaid policy and cost avoidance. OMIG sent forty-two (42) Provider Awareness Letters during the last two quarters of Fiscal Year 2016. The Provider Awareness Letters focused on excessive billing of stainless steel crowns for children, advanced life support for emergency transportation, improper billing of hospital inpatient stays, and duplicative billing of fundus photography.

HHS/OIG Herceptin Recoupment Review

In July of 2015, the Health and Human Services, Office of the Inspector General (OIG), issued a report demanding that the Arkansas Medicaid Program submit a repayment of $165,623.85 based on overpayments for the drug Herceptin for a three-year time period from July 1, 2010 through June 30, 2013. Before the state submitted payment for the federal share of $128,776.00, OMIG reviewed the findings and determined the report was inaccurate.

The review by OMIG revealed that 81 of the 143 claims (48%) has been billed and paid correctly within the Arkansas Medicaid system totaling $79,196.32 of the repayment demanded. In addition, OMIG identified 10 of the 143 claims that have either not been billed correctly by the providers or Medicaid actually owes to the providers were it to be billed correctly. This is an additional $20,458.56 that Arkansas does not owe the federal government. OMIG ascertained that only 52 of the claims could be possible appropriate recoupments for a total of $65,968.97. This is only 40% of what OIG requested be recouped.

This review by OMIG prevented the Arkansas Medicaid Program from improperly refunding over $128,000.00 in federal matching funds and also recouping an additional $33,305.03. The total impact of the initiative was $162,081.03 net savings and recoupment for the State Medicaid Program.



OMIG Medi-Medi Partnership

OMIG is making use of all available resources to fight fraud, waste, and abuse in the Arkansas Medicaid Program. In particular, OMIG is participating in the Centers for Medicare and Medicaid Services funded Medicare-Medicaid Data Matching Program known as the 'Medi-Medi Data Match Program.' The Medi-Medi Program has provided insight into the complete impact of providers who bill both programs, and the program offers analytic and investigative

resources to supplement those already available to OMIG. As a participant in the Medi-Medi Program, OMIG has access to the Medicare data for all Arkansas recipients that are receiving services in both the Medicare and Medicaid programs. The Medi-Medi Program is administered by Medicare's Zone Program Integrity Contractor. AdvanceMed for Arkansas' zone. This allows OMIG to monitor Arkansas providers who are enrolled as both a Medicaid and Medicare provider. This specifically permits OMIG to monitor the following:

- Services that are being billed to both Medicaid and Medicare
- Services that should be billed to Medicare as the primary payor instead of Medicaid
- Services that are being billed to Medicaid during a Medicare inpatient stay

OMIG staff worked with Medi-Medi Program contractors on various projects in Fiscal Year 2016, including a joint audit. OMIG staff also worked closely with the Medi-Medi Program contractors on a number of proactive studies, including the development of three separate initiatives: comparative analysis to other states of group psychotherapy expenditure, review of voided crossover claims, and improperly billed dual eligible recipient claims. OMIG and AdvanceMed have monthly Medi-Medi program management conference calls. In these monthly calls both OMIG and AdvanceMed share proactive data studies, program updates and policy changes, updates on ongoing Medi-Medi projects, and current investigation activities.

OMIG participates in biannual meetings with the Medi-Medi Health Care Task Force. This meeting includes the Medicare Zone Program Integrity Contractor, local and federal law enforcement, the FBI, Arkansas Attorney General's Medicaid Fraud Control Unit, the United States Attorney's Office, and various private insurance agencies.

OPTUM DSS Partnership

The Optum Decision Support System (DSS) Fraud and Abuse Detection System (FADS) which contains the Surveillance and Utilization and Review Subsystem (SURS), fraud and abuse detection, and program integrity functions, went live Fiscal Year 2015 on February 3, 2015. Optum's FADS solution features a suite of tools designed to help manage fraud and abuse investigations ranging from detection to collection. It allows users the ability to research aberrant behaviors while identifying only a minimum of false positives. The FADS component and data extraction tools create a comprehensive Program Integrity solution which includes:

- FADS Peer Group Profiling
- FADS Fraud Algorithms
- FADS Provider Activity Spike Detection
- FADS Browse and Search Capability
- FADS Professional Claims Scoring Model
- FADS Case Tracking
- OPTUM Pharmacy Reviews and Edits
- MARS Reviews and Audits

FADS Peer Group Profiling

Peer Group Profiling provides a statistical comparison of providers in a defined peer group which can be utilized to analyze provider behavior. Providers are grouped together by common characteristics that are user-defined, and studies can be easily modified to focus results to a specific subpopulation of providers. The OMIG Data Analytics Team utilizes this tool as an indicative test to identify high-risk areas prone to fraud, waste, or abuse in the Arkansas Medicaid program. Peer group profiles can be written for any behavior that is identifiable in claims data, and OMIG often creates peer group profiles proactively to analyze exposure in the Arkansas Medicaid Program to various aberrant billing practices. OMIG can utilize these peer group profiles to analyze program spending, review peer-to-peer comparative analysis of billing

behaviors, and even compare recipients by user-defined behavior patterns. In Fiscal Year 2016, the OMIG Data Analytics Team began an initiative utilizing peer group profiling to send Provider Awareness Letters to providers with high risk profiles and potentially aberrant billing behaviors. Optum's peer group profiling has helped shape this initiative by providing meaningful statistical analysis and a ranked list of providers based upon the degree of abnormal behavior. This makes identifying providers with high-risk profiles quicker and easier than ever before. OMIG currently has 233 different peer group profiles available in the study library that focus on a number of different Medicaid programs.

FADS Fraud Algorithms

Through bi-weekly working sessions with OMIG, Optum develops for the State of Arkansas customized algorithms to identify potential areas of fraud, waste, and abuse. This is a collection of comprehensive algorithm strategies that employ advanced technologies to detect suspicious fees for service claims, non-compliance with Medicaid policy, and complex healthcare, fraud, abuse, and waste. The algorithms are systematically available (refreshed quarterly) providing the most recent and up-to-date data for the user to select claims for further review. There are currently eight algorithms in production, and OMIG is scheduled to receive one new algorithm per quarter for a total of four new fraud algorithms per year.

FADS Provider Activity Spike Detection

The Provider Activity Spike Detection is a batch process that runs after each data load to detect significant increases or decreases in provider activity. A provider's current week of activity is compared to the previous week for the most recent twenty-six weeks based on the first date of service. An online report displays the suspicious increases or decreases in the number of

claim lines, dollars paid, and the distinct number of beneficiaries serviced based on thresholds defined by the provider. New providers are also reported within this process.

FADS Browse and Search Capability

The Browse and Search Capability allows OMIG access to claims data that is grouped according to claim type based on claim header or based on detail designation. It can be used for both provider and beneficiary data. Users can browse or search tables using sorts, filters, or a combination thereof. The OMIG Data Analytics Team utilizes this tool to provide verification and in-depth analysis to peer group profiling and algorithm results. Additionally, this tool returns results quicker than writing a query against the database.

FADS Professional Claims Scoring Model

The Professional Claims Scoring Model is a predictive scoring model that is built by Optum to analyze claims and provider billing in the Arkansas Medicaid program. This tool utilizes a multivariate, unsupervised scoring approach to estimate the likelihood of overpayment on each line item of professional services claims. The model utilizes provider and recipient claims history to measure against a series of known indicators of potential overpayment on professional services claims. The variables are analyzed by a scoring methodology that produces an overpayment risk score based on the combination of the metrics. The OMIG Data Analytics Team utilizes the model to quickly identify providers who are at a high risk of overpayment, and also as a verification tool to ensure quality results from peer group profiles and algorithms.

FADS Case Tracking

Optum's FADS Case Tracking system maintains an audit case from initiation to completion. The Case Tracking system allows OMIG to effectively organize and manage an audit while maintaining all historic information pertaining to any work conducted on an audit

case. In Fiscal Year 2016, OMIG began further enhancement of the Case Tracking tool to further customize the tool to include a method of maintaining pertinent information regarding the growing number of initiatives and data analysis projects. Initially, the Case Tracking tool was enhanced after implementation to create a separate but similar work space for both OMIG and DHS-SURS to enter and track fraud, waste, and abuse cases. While neither group can view cases entered by the other, DHS-SURS can forward selected case information to OMIG. In Fiscal Year 2016, seventeen cases were referred by DHS-SURS to OMIG during Fiscal Year 2016.

OPTUM Pharmacy Reviews and Edits

OMIG has continued the partnership it began in Fiscal Year 2015 with Optum to conduct pharmacy audits by reviewing documentation on selected pharmacy claims. Optum's analytics team, along with the expertise of a licensed Arkansas pharmacist and pharmacy technician, select pharmacies to perform both desk and on-site reviews. The audit selections are approved by OMIG, and the pharmacies are notified appropriately. In Fiscal Year 2016, 77 pharmacies were audited. Fifty-eight pharmacies were selected for desk review, and 19 pharmacies were selected for onsite review. These audits include amounts identified as valid associated with questionable claims, including but not limited to compound drugs. Thirty six audits and reviews were closed in Fiscal Year 2016. To date, $127,820.24 has been refunded to the Arkansas Medicaid Program.

Some of the most significant work from the OPTUM pharmacy initiative has been the recommendation to the Arkansas Medicaid pharmacy staff to implement edits to the MMIS system to prevent excessive prescriptions and overutilization. During onsite pharmacy audits, Optum's pharmacy team noticed that many pharmacists were waiting 60 to 90 days or more before reversing prescriptions. Medicaid electronically pays pharmacies within seven days of

service. However, the provider manual did not specifically address reversals. Together with OMIG, Optum recommended that the provider manual be modified to require a 14 day reversal policy, which is the industry standard. This policy change became effective on February 1, 2016. A cost avoidance review of claims data indicates that the average number of reversal days has reduced from 36 days to 25 days after the implementation of the new policy.

Another recommendation from the Optum pharmacy initiative was the implementation of an edit to prevent overpayments based on duplicate claims or claims that are refilled too soon. The Optum pharmacy team identified a significant overpayment with regard to duplicate paid pharmacy claims, which were paid twice for either the same or closely related dates of service. The previous process allowed pharmacies to override the Drug Utilization Review (DUR) edit and denial.

OMIG and Optum recommended two edits, which were approved and implemented on February 16, 2016. Prior to the implementation of the new edit, over 22,000 claims were being overridden at the pharmacy level every month. After the implementation of the edit, the number of claims that have been filled after initial denial has been reduced to less than 150 per month.

Optum and OMIG are currently working to quantify the cost avoidance associated with the edits that have been recommended and implemented. An initial calculation by Optum shows a potential savings of close to $1,800,000.00 a year based on the new edits to the Medicaid pharmacy system.

MARS Reviews and Audits

Optum and Medical Audit and Review Solutions (MARS) collaborate to assist OMIG in medical necessity reviews and claim selection of cases identified for further review. During Fiscal Year 2016, OMIG worked closely with MARS to develop and implement an efficient

program through which audits are conducted according to OMIG's policies and procedures. As a collective exchange, OMIG presents cases to MARS requiring physician review or additional case reviews for medical necessity. MARS utilizes analytic algorithms to identify and recommend cases to OMIG for review and audit. A physician peer review process is led by licensed MARS physicians with various specialties to provide clear, unbiased, and evidence-based determinations. In Fiscal Year 2016, MARS opened and completed 24 audits. Optum analysis of the impact of MARS audits and reviews revealed compliance with Medicaid regulations resulting in cost avoidance of more than $1,000,000.00 to the Arkansas Medicaid program.

Performance Narrative

OMIG Cost Avoidance and Deterrence

Although difficult to quantify or measure, cost avoidance and deterrence are important factors for OMIG to consider and review in order to fully determine the impact the agency has on the overall Medicaid program. OMIG strives to increase provider and other stakeholder awareness and its presence through contact, communication, billing and service reviews, program education, and monitoring of the Medicaid program and Medicaid providers.

OMIG has conducted preliminary studies and reviews to evaluate cost avoidance and to determine if the agency's initiatives have an impact on the Medicaid program. Although preliminary and subject to other factors, the studies and reviews have resulted in some statistical reductions in spending by Medicaid providers where OMIG intervention has resulted in administrative actions, MFCU referrals, suspensions, provider education, provider settlements,

and self-disclosures. OMIG's insistence on the submission and completion of Corrective Action Plans by Medicaid providers in order to remedy deficiencies and prevent further improper billing play a significant role in cost avoidance.

OMIG has also focused on preventing inappropriate acts or improper billing and service practices from occurring. The significant increase in Medicaid provider suspensions and referrals for fraud investigation may also play a role in deterrence among Medicaid providers. A key factor in deterrence is OMIG's increased visibility and transparency with providers, education initiatives, encouragement of self-disclosures by Medicaid providers regarding individual bad actors, and increasing awareness and working with law enforcement groups and medical and health care service associations.

False Claims Act Compliance Initiative

OMIG conducted 124 total False Claims Act Compliance Reviews during Fiscal Year 2016. OMIG conducts annual compliance checks to seek a facility's certification to employee education about the False Claims Act. This annual campaign ensures compliance with the Deficit Reduction Act Section 6032 and Section 1902(a)(68) of the Social Security Act regarding the education of false claims recovery to employees.

The Deficit Reduction Act of 2005 established the "Employee Education about False Claims Recovery." The act requires entities that receive or make payments totaling at least $5,000,000 annually during the Federal Fiscal Year approved under Title XIX or under any waiver of such a plan, to provide detailed information to employees about the False Claims Act. This $5,000,000 annual aggregated amount is determined by taxpayer identification number.

The Arkansas Medicaid Provider Manual § 142.800(A)(1) states that a qualifying provider is:

> Any entity, including any Medicaid managed care organization, irrespective of the form of business structure arrangement by which it exists, whether for profit or not for-profit, which receives or makes payments, under a State Plan approved under Title XIX or under any waiver of such plan, totaling at least $5,000,000 annually, regardless of whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

OMIG's False Claims Act Compliance Review during Fiscal Year 2016 prompted first-time qualifying providers to draft required policies and to begin educating their employees about the False Claims Act. False Claims Act Compliance Reviews are now completed annually after the close of the federal fiscal year per the requirements of the Arkansas Medicaid State Plan.

OMIG Personnel Education and Training

Throughout the year, OMIG staff has attended local and national conferences pertaining to program integrity, Medicaid policy, and Arkansas Medicaid programs. OMIG staff and personnel are encouraged to attend federally funded education courses and classes at the Medicaid Integrity Institute, which is located in Columbia, South Carolina. These courses are provided to qualified state employees, and are 100% funded by the federal government.

In August 2016, Elizabeth Smith, Inspector General, made a national presentation at The National Association for Medicaid Program Integrity (NAMPI) 32nd Annual Conference in Baltimore Maryland. The purpose of the conference was to safeguard the fiscal, operational, and program integrity of the Medicaid programs through communication between various agency members across multiple states.

The Inspector General and other OMIG personnel have made numerous presentations and have provided training at multiple conferences and seminars throughout the year including the Arkansas Foundation for Medical Care, Hewlett Packard Enterprises, Community Health Centers of Arkansas, the Arkansas Bar Association and other provider groups and state agencies. OMIG

will continue to provide training and assistance to Medicaid providers, personnel and programs as part of the overall mission to educate and provide assistance to identify fraud, waste, and abuse in the Arkansas Medicaid program.

OMIG EMFAD Initiative

Pursuant to Act 259 of the 2014 Fiscal Session, OMIG is required to establish an Enterprise Fraud Program which utilizes state of the art technology to detect and prevent fraud, waste, abuse, and improper payments within the Arkansas Medicaid Program. OMIG coordinated with both DHS and the Office of State Procurement (OSP) to develop the Enterprise Fraud Program, including issuing a Request for Information (RFI) in 2014 and drafting a Request for Proposal (RFP).

In May of 2015, DHS submitted the required Proposed Advanced Planning Document, (PAPD) for the Enterprise Fraud Program, along with the RFP to CMS. On September 1, 2015, CMS approved the PAPD for the EMFAD initiative.

On November 12, 2015, the RFP for the EMFAD initiative was released. During the first phase of procurement, a large number of questions were submitted by interested vendors. After meetings with the Office of State Procurement, and DMS, OMIG determined it was appropriate to remove the RFP to develop a more comprehensive and specific bid proposal that would provide additional details and information. It was also necessary for OMIG to consider the ongoing developments with the new MMIS set to go live on May 27, 2017, the new Enrollment and Eligibility Framework (EEF), the work of the Open Data Transparency Task Force, and the DHS Enterprise Data Warehouse (EDW).

The OMIG EMFAD program director was hired in April, 2016 evaluated the previous RFP and assessing the current Medicaid and future data systems and program to determine

stability and access issues. This evaluation of current and future systems includes determination of issues related to interfaces for the EMFAD solution.

OMIG is currently utilizing fraud analysis tools made available through the DHS 2013 Procurement of OPTUM DSS FADS. Those tools include predictive scoring for post-payment detection, complex pattern analysis, link analysis, text mining and case tracking. OMIG has recently reallocated positions and hired specialty trained staff to build a professional data analytic team. The OMIG data analytic team provides data reviews of suspected fraud, waste, and abuse in Medicaid.

In order to be good stewards of the Arkansas tax payers' money, OMIG is collaborating with other state agencies to share data analytics software and resources. This collaboration and identification of existing state resources is assisting OMIG to achieve compliance with the EMFAD requirement. Once the new MMIS system is on line, OMIG will be in a better position to determine if there are any outstanding software or system resources needed.

OMIG CONTRACT REVIEW

In September 2015, a Contract Administration division was created within the Office of Medicaid Inspector General. The program defined five specific purposes:

1. Is the Department of Human Services properly monitoring performance of the contract?
2. Is the contractor fulfilling its responsibilities under the contract?
3. Are there deficiencies in the Contract?
4. Does the contract meet Performance Based Contracting standards?
5. Are there duplications with other contracts and programs?

A five step audit program was developed. Of the 80 contracts identified as Medicaid-related, reviews commenced on 67 contracts with 16 now completed. In fiscal year 2016, the Contract

Administration Division completed the contract reviews of Non-Emergency Transportation and the DMS Navigant CMS-64 Reconciliation Contract.

Non-Emergency Transportation Review (14 contracts)

In Fiscal Year 2016, OMIG published audit findings regarding the contract duties and performance measures for the Non-Emergency Transportation Program. The Arkansas Medicaid Non-Emergency Transportation program provides eligible Medicaid beneficiaries with "medically necessary" transportation to receive a Medicaid covered service provided by an enrolled Medicaid provider. The transportation services are provided through a single transportation broker for each of eleven pre-established regions. The brokers are paid on a per-member per-month (PMPM) basis rather than a fee-for-service. A list of eligible beneficiaries is provided to the brokers by DHS at the beginning of each month. A reconciliation is conducted at the end of each year to account for inaccuracies in the monthly counts, i.e. deaths, terminations, etc. Payments are not to be paid for retroactive eligibility.

OMIG submitted the audit findings and met with DMS staff and personnel to review the audit findings and develop appropriate measures to ensure compliance and prevent overpayments. Based on the meetings and audit findings, DMS implemented new procedures to reduce potential overpayments.

In Fiscal Year 2015, DMS was able to save nearly $2,000,000.00 from the previous year in reconciliation payments based on the implementation of a new utilization factor. In Fiscal Year 2016, DMS was able to reduce the total expenditure for NET payments by nearly $4,300,000.00. These savings were accomplished by applying a fuel adjustment and implementing the new utilization adjustment.

DMS Navigant CMS-64 Reconciliation Contract Review

The State is responsible for a portion of the costs regarding Medicaid and the Children's Health Insurance Program (CHIP). Reports of the CMS-64 (Medicaid Statement of Expenditures for the Medical Assistance Program) and the CMS-21 (Children's Health Insurance Program Statement of Expenditures for Title XXI) are summited quarterly to CMS.

The Legislative Single Audit found numerous errors in the reports that were being submitted. To address these issues, a sole source contract was entered into with the Navigant Consulting company for $190,000. The contractor was to review seven prior quarters of CMS-64 and recommend changes to enhance the State's standard operating procedures for reconciliation of the CMS-64 report. The contract had an initial expiration date of December 31, 2015 with an opportunity to extend to June 30, 2016. As of February 8, 2016, the contract has not been extended.

OMIG Provider Education

OMIG has made a concentrated effort to contact Arkansas provider associations and organizations. OMIG has attended meetings and scheduled presentations with a number of Medicaid provider organizations. OMIG is available to any Medicaid provider or association that has questions or concerns going forward. OMIG continues to provide education through the audit and review process as well as requiring Medicaid providers to submit Corrective Action Plans (CAPs) when deficiencies are substantiated in a Program Integrity Review. Moving forward, OMIG will consider other methods for encouraging provider education including requiring providers to attend training and review courses as part of negotiated settlements.

OMIG regularly participates in provider task force meetings and other provider meetings.

OMIG has placed a greater focus on CAPs, including providing information on its website about preparing and submitting CAPs, and OMIG is making an increased effort to ensure compliance with a provider's CAP response through performing follow- up audits. Field audit personnel are increasingly providing on-the-spot provider education through conducting entrance and exit conferences during on-site audits.

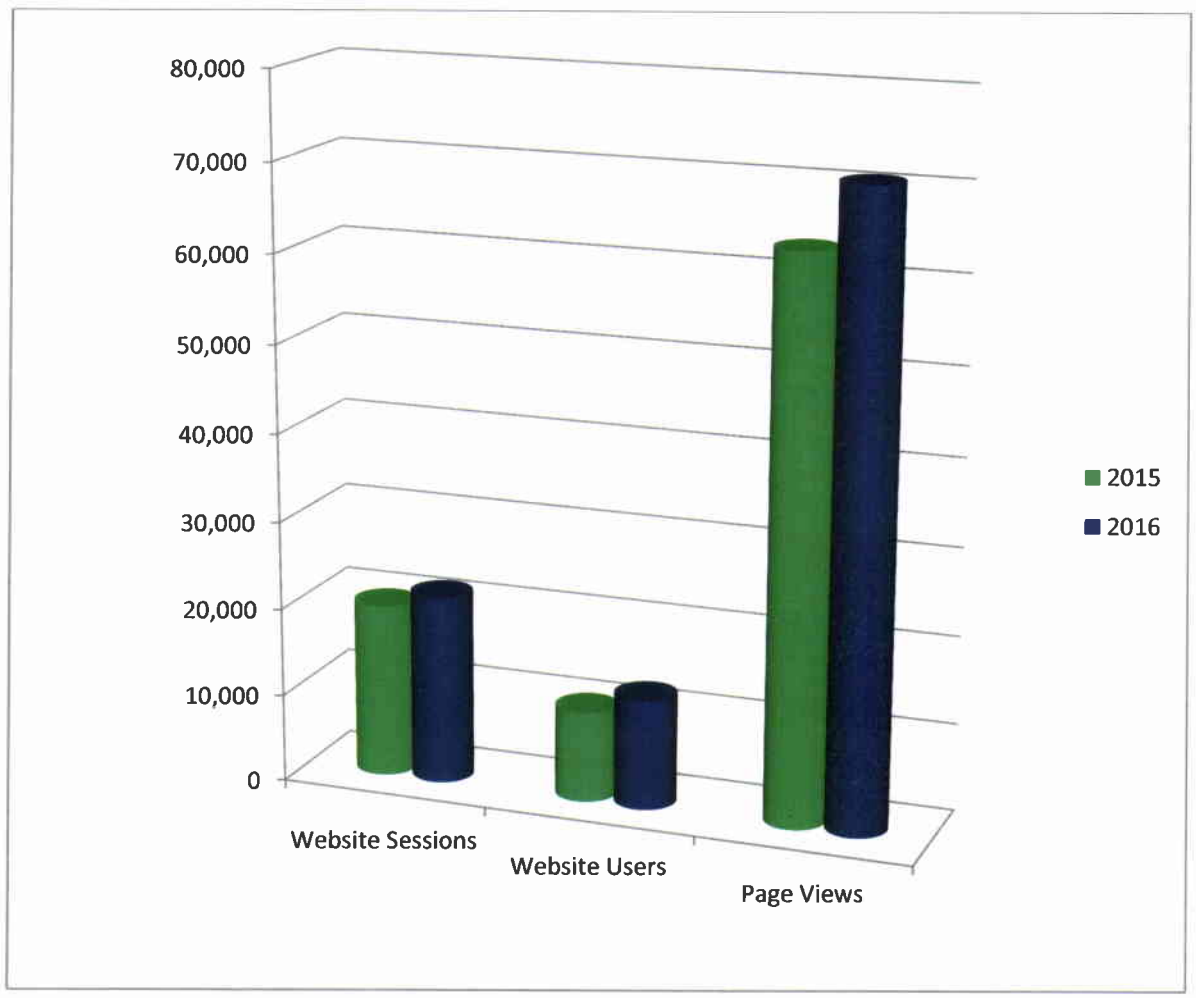
OMIG has added numerous provider resources to its' agency website, including information on audit protocols, self-disclosure protocols, reconsideration, appeals, CAPs, False Claims Act Education compliance, and a statutory compliance program. The provider-specific resources can be found at: http://omig.arkansas.gov/providers.

Provider Resources

OMIG is striving to establish working relationships with providers and provider associations. The OMIG website includes, but is not limited to, Medicaid provider information pertaining to audit protocols, self-disclosure programs, Corrective Action Plans, and contact information. OMIG plans to expand the resources available to providers in Fiscal Year 2016. Medicaid providers now have access to information and resources that were either not previously available to them or difficult to obtain.

OMIG Website Statistical Data

For July 1, 2015 through June 30, 2016, the OMIG website viewer sessions, website users, and individual website page views increased over the previous fiscal year.



Website Analytics for Fiscal Year 2016

Google Analytics

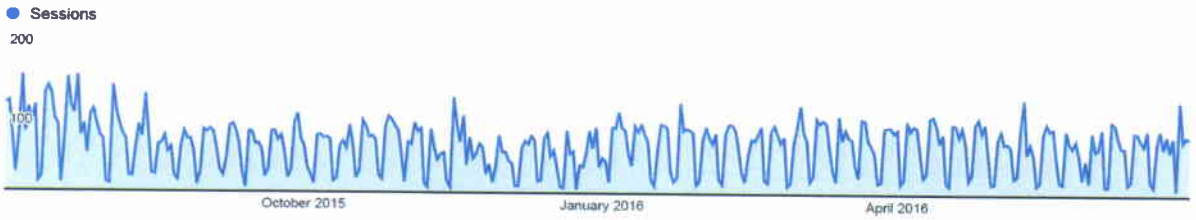
Office of the Medicaid Inspector Gener... Go to this report
All Web Site Data

Audience Overview

Jul 1, 2015 - Jun 30, 2016

All Users
100.00% Sessions

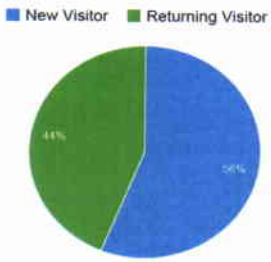
Overview



Sessions	Users	Pageviews
21,532	12,532	70,761

Pages / Session	Avg. Session Duration	Bounce Rate
3.29	00:03:28	47.40%

% New Sessions
55.85%



	Language	Sessions	% Sessions
1.	en-us	18,992	88.20%
2.	(not set)	2,209	10.26%
3.	en	146	0.68%
4.	en-gb	41	0.19%
5.	zh-cn	27	0.13%
6.	es	15	0.07%
7.	fr	12	0.06%
8.	c	10	0.05%
9.	pt-br	9	0.04%
10.	de-de	6	0.03%

Website Analytics for Fiscal Year 2016

Google Analytics

Office of the Medicaid Inspector Gener
All Web Site Data

Go to this report

Location

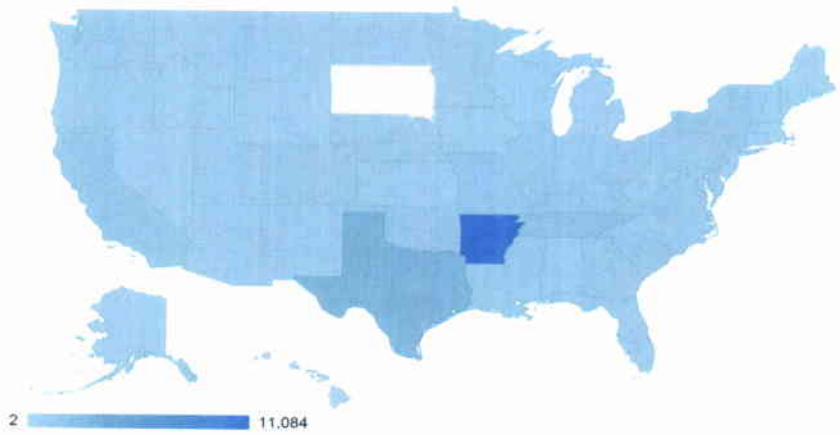
Jul 1, 2015 - Jun 30, 2016

ALL » COUNTRY: United States

All Users
89.16% Sessions

Map Overlay

Summary



Region	Acquisition			Behavior			Conversions		
	Sessions	% New Sessions	New Users	Bounce Rate	Pages / Session	Avg. Session Duration	Goal Conversion Rate	Goal Completions	Goal Value
	19,199 % of Total: 89.16% (21,532)	51.58% Avg for View: 55.85% (-7.65%)	9,902 % of Total: 82.36% (12,025)	42.57% Avg for View: 47.40% (-10.20%)	3.52 Avg for View: 3.29 (7.18%)	00:03:48 Avg for View: 00:03:28 (9.94%)	0.00% Avg for View: 0.00% (0.00%)	0 % of Total: 0.00% (0)	$0.00 % of Total: 0.00% ($0.00)
1. Arkansas	11,084 (57.73%)	40.45%	4,483 (45.27%)	36.47%	3.95	00:04:52	0.00%	0 (0.00%)	$0.00 (0.00%)
2. Texas	2,072 (10.79%)	56.03%	1,161 (11.72%)	46.77%	3.04	00:03:02	0.00%	0 (0.00%)	$0.00 (0.00%)
3. Tennessee	904 (4.71%)	62.50%	565 (5.71%)	41.37%	3.46	00:02:42	0.00%	0 (0.00%)	$0.00 (0.00%)
4. Missouri	506 (2.64%)	65.22%	330 (3.33%)	40.12%	3.42	00:02:22	0.00%	0 (0.00%)	$0.00 (0.00%)
5. California	475 (2.47%)	74.53%	354 (3.58%)	60.63%	2.70	00:02:02	0.00%	0 (0.00%)	$0.00 (0.00%)
6. New York	363 (1.89%)	92.84%	337 (3.40%)	73.55%	1.92	00:00:57	0.00%	0 (0.00%)	$0.00 (0.00%)
7. Illinois	361 (1.88%)	62.05%	224 (2.26%)	56.79%	2.80	00:02:03	0.00%	0 (0.00%)	$0.00 (0.00%)
8. Oklahoma	345 (1.80%)	62.03%	214 (2.16%)	39.42%	3.42	00:02:20	0.00%	0 (0.00%)	$0.00 (0.00%)
9. Kentucky	272 (1.42%)	49.63%	135 (1.36%)	67.28%	1.99	00:01:22	0.00%	0 (0.00%)	$0.00 (0.00%)
10. Florida	212 (1.10%)	85.85%	182 (1.84%)	57.55%	2.69	00:01:54	0.00%	0 (0.00%)	$0.00 (0.00%)

Rows 1 - 10 of 51

Respectfully Submitted,

Elizabeth Smith, Medicaid Inspector General
Office of the Medicaid Inspector General
323 Center Street, Ste. 1200
Little Rock, AR 72201
501-683-8349
FAX: 501-682-8350
Website: http://omig.arkansas.gov
Hotline: 1-855-5AR-OMIG (1-855-527-6644)