OFFICE OF THE MEDICAID INSPECTOR GENERAL

Annual Report
Fiscal Year 2017

Elizabeth Smith, Medicaid Inspector General

Office of the
Medicaid Inspector General

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Dear Governor Hutchinson, General Rutledge, and Legislators,

It is my pleasure to present the Annual Report on behalf of the Office of the Medicaid Inspector General (OMIG). I am proud to report OMIG identified and recovered $3,791,902.58 in Fiscal Year 2017, which is a 28.4% increase over Fiscal Year 2016. This report details our activities and initiatives, as required by Ark. Code Ann. §20-77-2509.

As the Medicaid Inspector General for Arkansas, I strive for expertise in detection and elimination of fraud, abuse and waste throughout the Medicaid system. My strategy utilizes analytical tools to identify issues involving abuse of Medicaid funds. These tools allow us to detect fraudulent behaviors, inappropriate payments, and policies ripe for revision. While detection of fraud is extremely important, insuring compliance of all providers is crucial. In an effort to increase compliance, I feel it is necessary to collaborate directly with providers to assist them in independently assessing their billing practices.

OMIG is charged with recommending changes to Medicaid policy to improve integrity in our program, and identify savings. The most significant changes OMIG championed this year were in the Behavioral Health and Pharmacy programs. Our recommended changes in Behavioral Health resulted in savings of nearly $15 million in Fiscal Year 2017 and serve as a catalyst to the Behavioral Health Transformation which is currently underway. OMIG is working with DHS to actively supervise the developing provider-led managed care model for the Behavioral Health and Developmentally Disabled Medicaid population. Regarding the pharmacy program, OMIG supported implementation of an Early Refill edit along with the 14-day reversal policy change which brought a significant and

immediate increase in provider compliance and delivered a cost savings of over $20 million dollars.

The OMIG Provider Awareness Letter initiative, “PAL”, is an endeavor of which I am truly proud, given its success and impressive return on investment. This particular initiative style reaches more providers than the traditional audit model and forms relationships that lead to the overall improvement of the Medicaid program. Our office intends to continue this productive trend.

Looking ahead to 2018, OMIG will continue to work diligently with Medicaid and other DHS divisions to protect and ensure that all state and federal dollars are being spent appropriately to provide necessary treatment and care to Medicaid recipients. Fostering positive relationships with Medicaid providers remains a central theme in this office. I appreciate your interest in OMIG's efforts to combat fraud, abuse, and waste in the Medicaid program because collectively, we will thrive.

Sincerely,

Elizabeth Thomas Smith
Medicaid Inspector General

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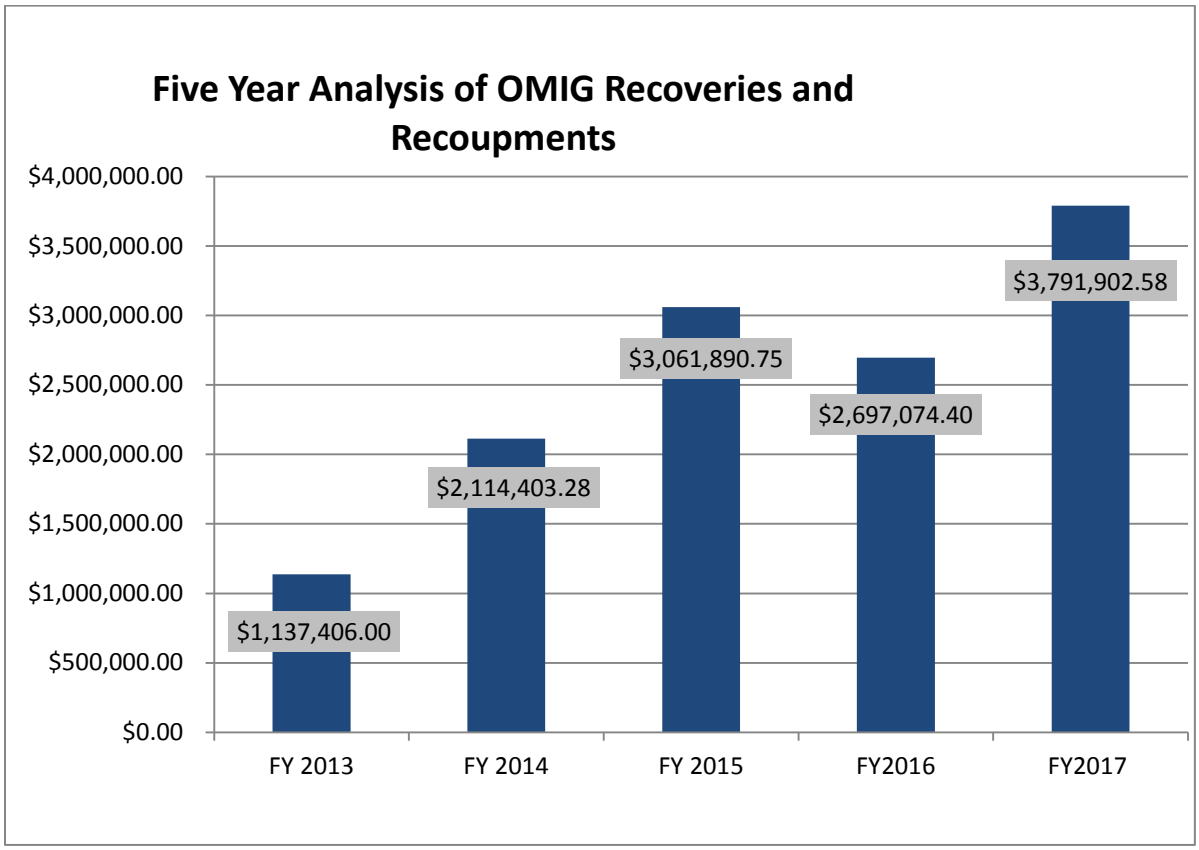
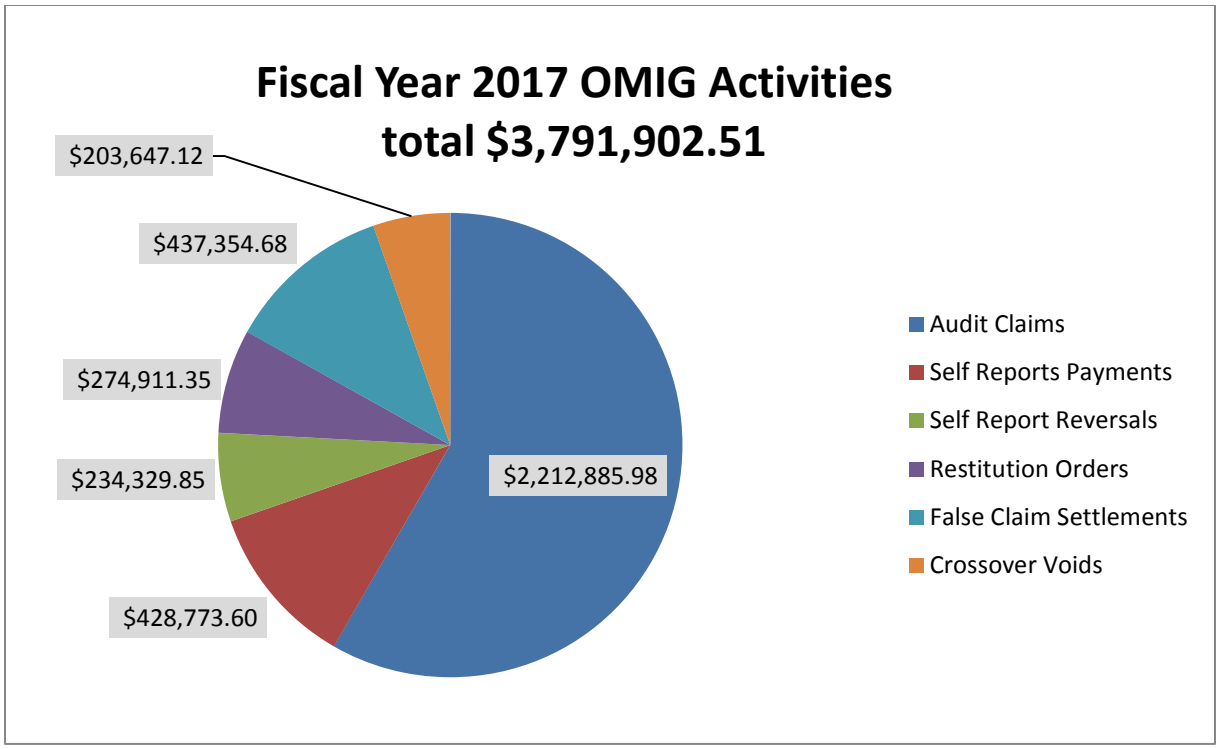
The total amount of Medicaid funds identified for recoupment and recovery in Fiscal Year 2017 by OMIG investigations is $3,791,902.58, which is a 28.4% increase from last fiscal year. The increase this year can be attributed to OMIG's ability to more accurately identify issues through use of analytical tools, an increase in provider reviews and contacts through the Provider Awareness Letter initiative resulting in increased self-reports. The breakdown of OMIG activities is depicted in the charts and report below.

Recoveries and Recoupments

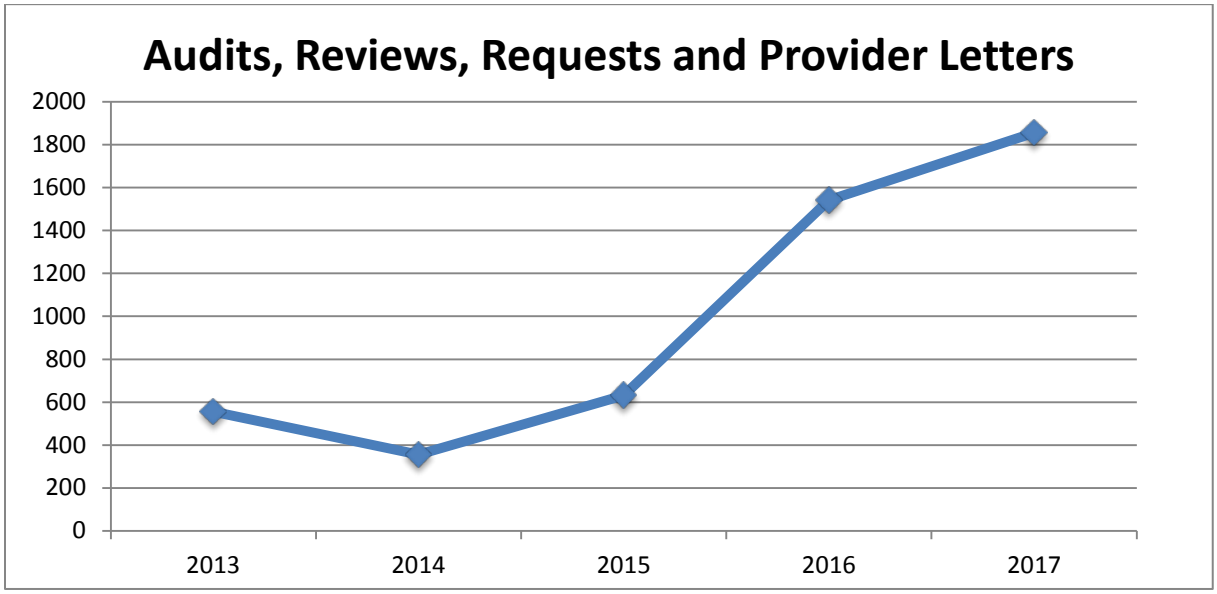
Identified for Recovery and Recoupment in Fiscal Year 2017 **$3,791,902.58**





Audits, Reviews, Requests, and Provider Letters

Onsite Audits/Review	70
Desk Audits	281
Provider Self Audit Requests (PALS)	693
Recoupment Letters	635
Provider Requests for Information	53
False Claims Act Compliance Reviews	121
	1856



Claims, Collections, and Reversals

In Fiscal Year 2017, $2,881,579.15 was collected as a result of audits and initiatives from this and prior fiscal years. OMIG claims, collections, and reversals include settlement checks, recoupments of overpayments, provider self-reported payments and reversals of improper claims, along with claims voided as a result of being paid by both Medicare and Medicaid, titled "crossover claims." Recoupment and reversal of claims occurs through the Medicaid payment system and is often spread over a number of months spanning fiscal years.

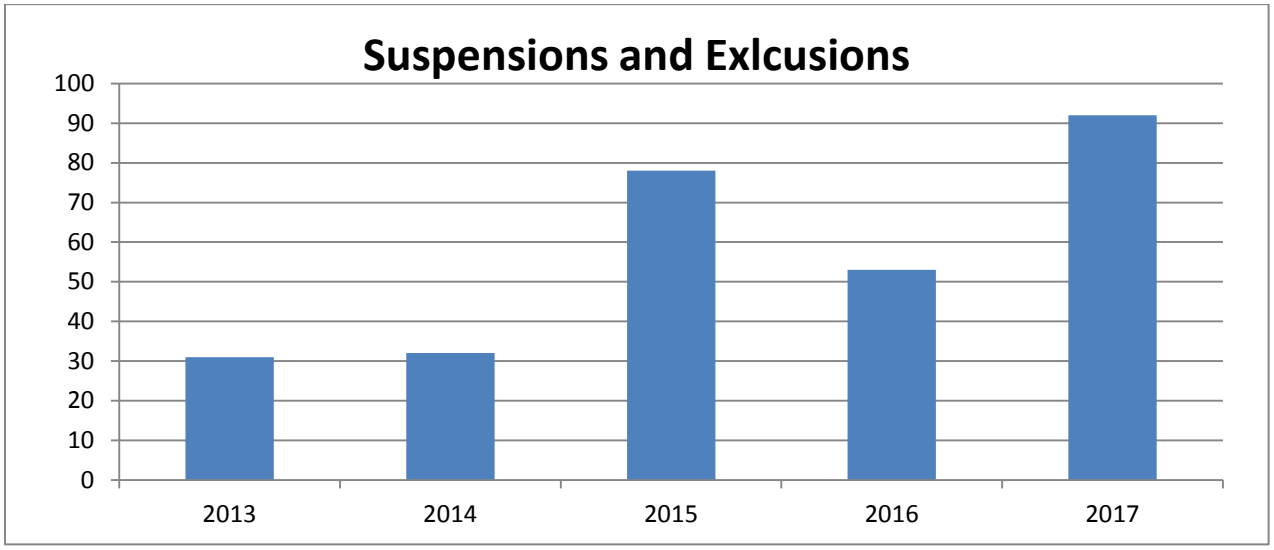
Collections through DHS Claim Adjustments	**$1,736,965.01**
Self-Report Collections	**$ 411,988.00**
Self-Report Reversals	**$ 241,663.95**
Crossover Claim Reversals	**$ 415,643.08**
Restitution and False Claims Collections	**$ 75,319.11**
	$2,881,579.15

Administrative Actions

OMIG pursues civil and administrative actions against individuals or entities engaging in fraud, abuse, and improper billing practices. Administrative actions include suspension or exclusion from the Medicaid program.

Total Administrative Actions in Fiscal Year 2017 **92**

- Provider suspensions from the Medicaid Program 8
- Provider exclusions from the Medicaid Program 84



Administrative Appeals and Hearings

Providers have the right to appeal audit findings and administrative actions. In Fiscal Year 2017, OMIG saw a decrease in provider appeals. Fifty appeals were closed by negotiated settlement in Fiscal Year 2017; some of these appeals had been initiated in prior fiscal years. Settlement proceeds will continue to be recouped from future Medicaid payments.

- Fiscal Year 2017 Provider Audit Appeal Requests 27
- Appeal Requests Closed in Fiscal Year 2017 50
- Total Negotiated Settlement Amount for Appeals $979,255.76

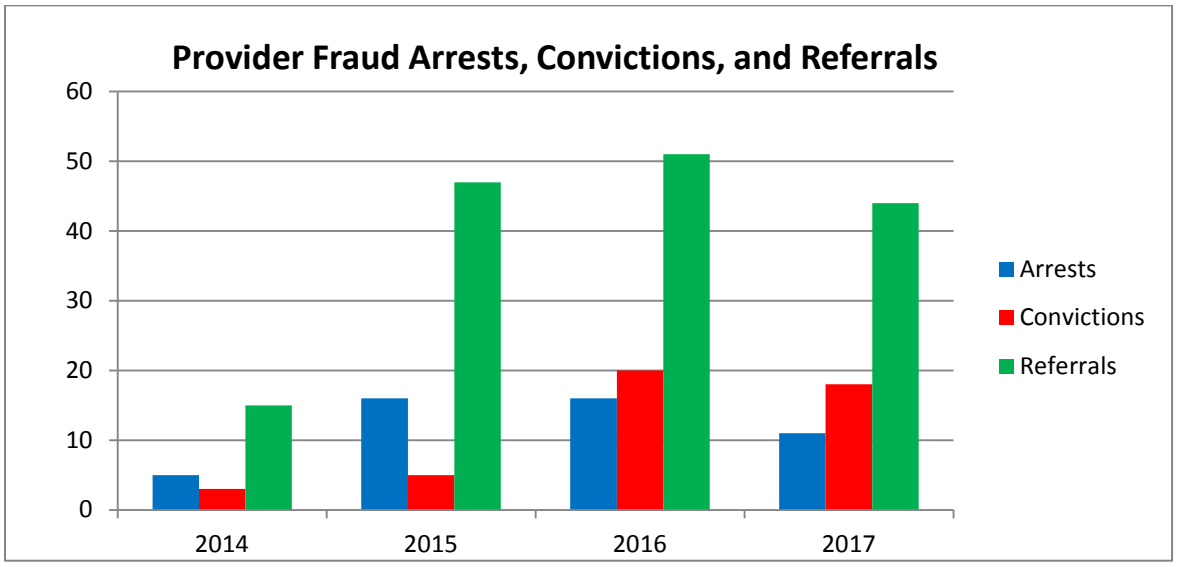
Provider Fraud Referrals

When OMIG suspects fraud, a preliminary investigation is conducted by OMIG. Once a credible allegation of fraud by a provider is determined, OMIG refers the case to the Attorney General's Medicaid Fraud Control Unit (MFCU), and suspends the provider unless MFCU requests a law enforcement hold of the suspension. During the last three years, a total of 142 cases were referred to MFCU. As a result of OMIG referrals, MFCU made 43 arrests and obtained 43 convictions. In Fiscal Year 2017, 44 providers were referred for fraud to MFCU, and 11 arrests and 18 convictions resulted from these referrals. Fraudulent payments are recovered through restitution orders by the criminal courts upon conviction. The total amount of restitution ordered to be paid based on Fiscal Year 2017 convictions was $274,911.35.

The Arkansas Medicaid Fraud False Claims Act, Ark. Code Ann. §20-77-901, et seq., requires a person 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 Medicaid program. In Fiscal Year 2017, MFCU settled six false claims act cases referred by OMIG. As a result of OMIG's referrals, a total of $437,354.68 was ordered to be recovered.

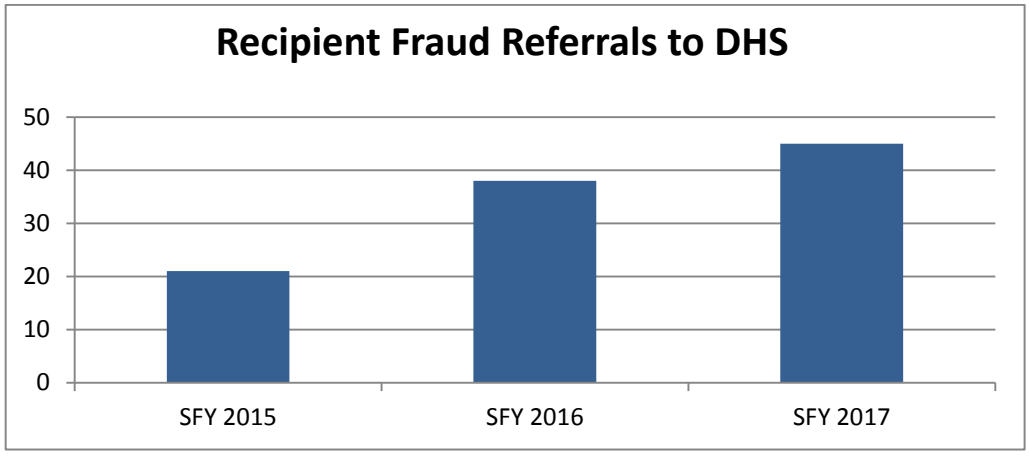
Fraud investigations and referrals are handled by OMIG's investigator who serves as the agency liaison to MFCU. In Fiscal Year 2017, 91 cases were opened for investigation, 20 of which were referred to MFCU for suspected or credible allegation of fraud. Thirty-eight cases were closed with no action taken and 33 are currently under review. OMIG's fraud investigations originate from public complaints received through OMIG's fraud hotline or website, provider self-reports, data analytics, audit investigations, agency referrals and law enforcement referrals. In Fiscal Year 2017, OMIG increased use of data analytics to identify audit and investigation

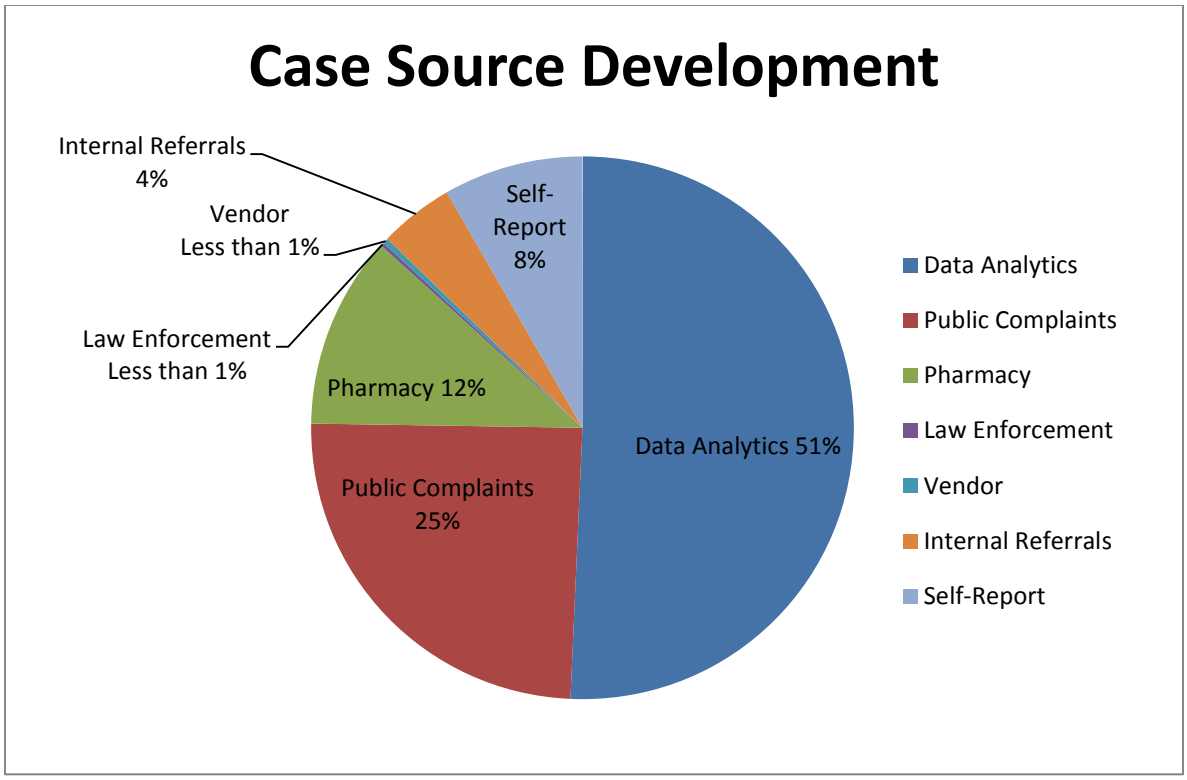
targets. The increased reliance on data analytics has contributed to more efficient and effective audits and investigations, as well as increased recoupments and cost avoidance.



Recipient Fraud Referrals

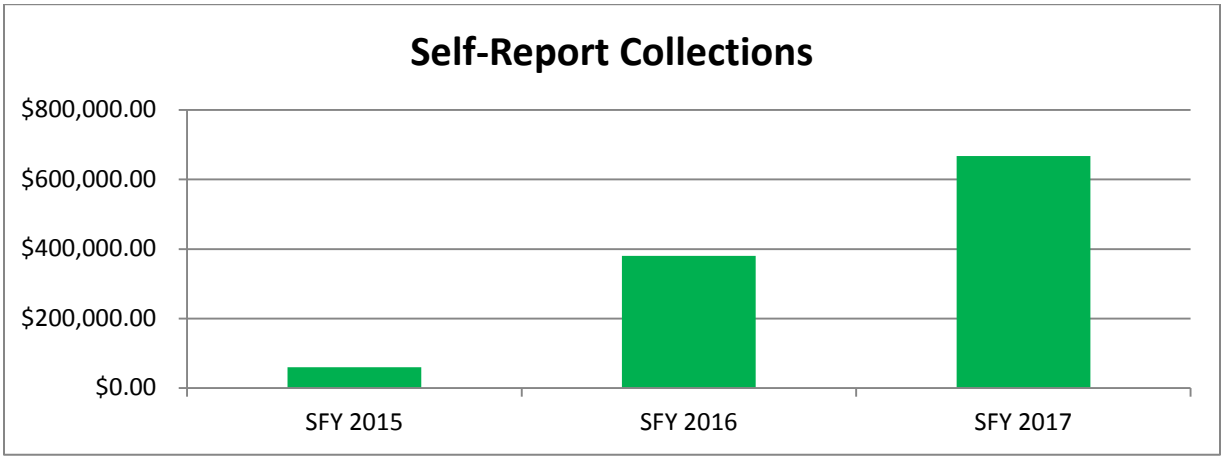
Recipient fraud is referred to the Department of Human Services. In Fiscal Year 2017, OMIG referred 45 cases of suspected recipient fraud to the DHS Fraud Unit. The DHS Fraud Unit reviews these cases to determine recipient eligibility and refers cases to local prosecutors. OMIG has had a steady increase in recipient fraud referrals over the last three years. The increase can be attributed to public awareness of OMIG and the multiple avenues available for the public to report suspected Medicaid fraud.





Medicaid Provider Self-Reports

OMIG's self-report procedure continues to enhance OMIG's efforts to eliminate fraud, waste, and abuse, while offering Medicaid providers a mechanism to reduce their legal and financial exposure. For Fiscal Year 2017, OMIG received $667,729.15 from 70 Medicaid providers self-reporting. Of that amount, $469,605.58 was reported in response to letters sent to providers pursuant to the Provider Awareness Letters (PALS) initiative, while the remaining $198,123.57 is comprised of independent reports from providers. Providers self-reporting must create and submit a Corrective Action Plan (CAP) to OMIG addressing the issues self-reported and including appropriate measures to prevent those issues from reoccurring.



Special Projects and Initiatives for 2017

OMIG is continually expanding its focus beyond the traditional Program Integrity audit processes by developing strategies to bring savings and reform to the Medicaid program. OMIG special projects and initiatives have served as a manner to effectively correct behaviors across a wide range of provider groups and have served as a manner to identify areas ripe for change and edits in the Medicaid program. Cost avoidance opportunities have developed while identifying cost effective ways to maximize the use of agency resources to identify fraud, waste, abuse.

Behavioral Health - Group Psychotherapy

The 90853 Group Psychotherapy Initiative is one of the most successful initiatives since the creation of OMIG. The previous policy for 90853 Group Psychotherapy billing created vulnerability in the Medicaid program for fraud, waste, and abuse. OMIG's recommendation to reform the 90853 code has resulted in savings of nearly **$15 million** in Fiscal Year 2017. OMIG continues to audit and investigate behavioral health issues while implementing necessary interventions. The efforts of OMIG have been recognized nationally and Inspector General Smith has been asked to make national presentations on OMIG's review and recommendations, and the ultimate reform of Behavioral Health in the Arkansas Medicaid Program.

	Group Psychotherapy (90853) Dollars Paid by State Fiscal Year						
	FY2014	FY2015	FY2016	3 Year Average (2013 - 2015)	FY2017	Difference	% Change
July	$6,525,915.93	$6,817,285.23	$6,632,051.43	$6,658,417.53	$4,954,375.81	$1,704,041.72	-26%
August	$3,614,736.69	$3,661,713.59	$3,615,950.09	$3,630,800.12	$3,573,819.42	$56,980.70	-2%
September	$3,322,193.61	$3,887,577.95	$3,695,269.97	$3,635,013.84	$3,413,178.52	$221,835.32	-6%
October	$4,030,174.49	$4,153,433.71	$3,954,003.51	$4,045,870.57	$2,874,624.23	$1,171,246.34	-29%
November	$3,369,062.37	$3,408,955.29	$3,660,764.94	$3,479,594.20	$2,539,534.01	$940,060.19	-27%
December	$3,019,089.82	$3,734,161.42	$3,996,450.57	$3,583,233.94	$2,349,014.20	$1,234,219.74	-34%
January	$3,759,935.35	$3,704,827.81	$3,640,594.15	$3,701,785.77	$2,458,827.95	$1,242,957.82	-34%
February	$3,425,032.57	$3,096,289.56	$4,159,368.92	$3,560,230.35	$2,361,349.99	$1,198,880.36	-34%
March	$3,718,629.71	$4,003,833.18	$4,320,609.22	$4,014,357.37	$2,612,637.39	$1,401,719.98	-35%
April	$4,223,327.90	$4,220,277.45	$3,882,045.56	$4,108,550.30	$2,312,451.29	$1,796,099.01	-44%
May	$3,889,944.62	$3,731,905.66	$3,635,505.70	$3,752,451.99	$2,329,971.17	$1,422,480.82	-38%
June	$5,530,663.67	$5,849,822.74	$5,449,323.75	$5,609,936.72	$3,096,618.01	$2,513,318.71	-45%
TOTALS:	$48,428,706.73	$50,270,083.59	$50,641,937.81	$49,780,242.71	$34,876,401.99	**$14,903,840.72**	**-30%**

OMIG Provider Awareness Letters

OMIG expanded its provider awareness initiative of requesting providers to review specific questionable claims in Fiscal Year 2017. Rather than OMIG conducting a full scale audit of these providers, the letters allowed OMIG to reach more providers in a less intrusive manner. OMIG analyzed claims data to identify providers who deviated significantly from their peer group. Letters were sent to outlying providers requesting review of the claims, self- report and return of any improper payments as well as submission of a corrective action plan. The Provider Awareness Letters Initiative focused on the following issues:

School District Matching Funds Awareness Letters

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 cover the state match portion for Medicaid services provided as part of a student's Individualized Education Program (IEP). For Fiscal Year 2017, OMIG continued the School District Matching Funds Initiative by submitting 556 Provider Awareness Letters (PALS) to the Arkansas school districts. OMIG also conducted awareness and education regarding appropriate billing for Medicaid services and match payments. OMIG's analysis revealed an increase of $682,622.75 in match payments for Fiscal Year 2017. OMIG will continue monitoring state match payments by school districts to measure any increased reporting of school-based therapy services as a result of OMIG's awareness and education efforts.

Hospital Inpatient One-Day Stays Awareness Letters

In Fiscal Year 2017, OMIG submitted 28 Provider Awareness Letters to hospital providers requesting self-audit of certain inpatient claims. Self-audits performed by the providers resulted in $309,390.00 being returned to the Medicaid program. As a result of OMIG's efforts, cost avoidance for Fiscal Year 2017 for hospital inpatient one-day stays is $586,013.76.

Evaluation and Management Code Billing Awareness Letters

Through data analytics, OMIG identified potentially abusive billing of high-level established evaluation and management codes. In Fiscal Year 2017, OMIG sent 77 Provider Awareness Letters to providers showing high-risk behavior for billing high-level established evaluation and management codes. A cost avoidance review by Optum of the providers' billing

practice after OMIG's letter revealed that the providers' compliance has improved resulting in a cost avoidance of $312,703.39 and a 27.76% reduction in billing.

Dental Stainless Steel Crown Awareness Letters

Through data analytics, OMIG identified questionable billing of stainless steel crowns for children. In Fiscal Year 2016, OMIG sent 16 Provider Awareness Letters to pediatric dentists concerning claims for application of stainless steel crowns on children under the age of six. OMIG also met with representatives of the Arkansas Dental Association, Arkansas Pediatric Dental Association, and the Arkansas DMS Dental review board. A cost avoidance review by Optum of claims billed in Fiscal Year 2016 and 2017 showed providers' compliance with Medicaid regulations improved after being contacted by OMIG, resulting in cost avoidance of $210,328.24 and an 11.66% reduction in total stainless steel crown claims.

Tobacco Cessation Counseling Billing Awareness Letters

Through data analytics, OMIG identified potentially abusive billing of tobacco cessation counseling services for children by dentists and physicians. In Fiscal Year 2017, OMIG sent 17 Provider Awareness Letters to providers who showed high-risk behavior for billing of tobacco cessation counseling services for children. A cost avoidance review by Optum of the providers' billing practice after being contacted by OMIG revealed the providers' compliance with Medicaid regulations has improved resulting in a cost avoidance of $48,110.50 and a 74.05% reduction in total tobacco cessation counseling claims billed.

Emergency Transportation Billing Awareness Letters

Through data analytics and outside referrals, OMIG identified potentially abusive billing of Advanced Life Support (ALS) codes for ambulance transportation claims. In Fiscal Year 2016, OMIG sent Awareness Letters to providers who showed high-risk behavior for billing of ALS codes and also provided education regarding proper billing of ALS codes to a large group of ambulance providers at the Arkansas Ambulance Association EMS Expo. OMIG's education efforts in the provider community resulted in a $1.79 million dollar program-wide reduction in total dollars paid for ALS codes and 16.4% reduction in total ALS claims billed in Fiscal Year 2017. This education effort and program impact was highlighted by Elizabeth Smith in her presentation regarding Provider Awareness Letters at the annual National Association for Medicaid Program Integrity conference.

OMIG Recoupment Letters

Provider Recoupment Letters are submitted when OMIG is confident that an improper claim has been submitted and resulted in an overpayment. Advanced data analysis allows OMIG to identify these improperly submitted claims. In these instances, fraud was not suspected and there are no system edits to avoid the improper claims. During Fiscal Year 2017, OMIG sent 635 Provider Recoupment Letters.

Medicare/Medicaid Crossover Claims Recoupment Letters

Medicaid 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 assistance of the Medi-Medi, the Arkansas Zone Program Integrity Contractor, AdvanceMed, OMIG recovered $367,791.29 in Medicaid crossover claims in which the Medicare claim had been voided or reversed. OMIG will continue its review and recoupment of paid Arkansas Medicaid claims affected by the void or reversal of an associated Medicare claim in order to recoup those funds.

Vision Reviews and Reform

Through data analytics, OMIG identified multiple instances in which vision providers submitted duplicate refraction exam claims. OMIG investigations revealed that the duplicate claims resulted from incorrect interpretation of Medicaid regulations or problems with electronic billing software. OMIG sent a total of 65 recoupment letters to providers and recouped a total of $162,517.00 in improperly billed refraction claims. OMIG is developing recommendations to clarify Medicaid policy and implement MMIS system edits to prevent future duplicate payments. Over the last two years, OMIG has conducted several audits of Optometry providers for services billed with procedure code 92065 (Pleoptic Therapy). OMIG audits, education, and reform recommendations prompted much needed manual changes and limitations. A data analysis based on the reform has determined cost avoidance for OMIG's recommended revision to procedure code 92065 to be $569,348.49.

Add-On Code Recoupment Letters

Through data analytics, OMIG identified multiple instances in which add-on codes were not billed with the appropriate primary procedure performed by the same practitioner. Add-on codes describe services that are only performed in conjunction with a primary service. OMIG sent a total of 166 recoupment letters to providers and recouped a total of $22,408.35 in improperly billed add-on codes, and is currently developing recommendations to implement edits in the MMIS system that will prevent future improper payments.

Pharmacy Audits, Reviews, and Edits

OMIG has continued its partnership with Optum to conduct pharmacy audits by reviewing documentation on selected pharmacy claims. Optum's analytics team, along with the expertise of a licensed Arkansas pharmacist and pharmacy technician, select pharmacies to perform both desk and onsite reviews. The audit selections are approved by OMIG, and the pharmacies are notified appropriately. In Fiscal Year 2017, 110 pharmacies were audited. Twenty were selected for an onsite review, and the remaining 90 were selected for a desk review. Twenty-eight audits were completed and a total of $113,223.67 was refunded. Since this partnership began in Fiscal Year 2015, $317,529.41 has been refunded to Arkansas Medicaid.

Some of the most significant work from the OPTUM pharmacy initiative has been the implementation of two reforms, both of which became effective in February 2016. On February 1, 2016, the 14-day reversal policy change became effective. Prior to this, zero pharmacies were compliant in reversing claims when the prescription was not provided to the beneficiary within 14 days. After the implementation, the average number of days it took for a pharmacy to reverse claims went down by 11 days, resulting in cost avoidance of $1.8 million for Fiscal Year 2017.

The Prospective Drug Utilization (ProDUR) Early Refill (ER) edit became effective on February 16, 2016. Early refills (those filled seven or more days early) accounted for almost five percent of the monthly paid amount for pharmacy claims. This overpayment is estimated to have been over $1 million per month until the implementation of the ER edit on February 16, 2016.

As indicated in the chart below, prior to the implementation of this edit, over 20,000 claims were overridden every month. In February 2016, that number plummeted to 74 claims that were overridden, and continues to remain under 200 claims every month. This equated to an average of 4.98% of the total monthly cost to the Arkansas Medicaid program. The edit resulted in immediate savings between February and June 2016 of approximately $8.6million.

	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
1	415,446	427,044	433,630	460,201	440,289	457,589	452,155	449,876	480,905	440,567	414,571	392,537
2	$34M	$34.6M	$35.4M	$35.3M	$35M	$37M	$35.9M	$36.2M	$38.8M	$34.9M	$31.7M	$31.6M
3	21,646	21,646	21,646	22,491	22,491	22,491	21,211	74	170	155	126	143
4	5.21%	5.07%	4.99%	4.89%	5.11%	4.92%	4.69%	0.0164%	0.0354%	0.0352%	0.0304%	0.0364%

The cost avoidance continued into Fiscal Year 2017, as illustrated below:

	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
1	380,688	447,683	447,550	443,922	451,426	452,859	473,532	478,533	476,301	439,576	447,787	411,272
2	$30.2M	$36.9M	$34.9M	$34.5M	$34.9M	$34.8M	$37.2M	$37.9M	$39.1M	$33.9M	$34.4M	$32.3M
3	165	165	165	195	195	195	195	169	188	169	169	188
4	0.0433%	0.0369%	0.0369%	0.0439%	0.0432%	0.0431%	0.0412%	0.0353%	0.0395%	0.0384%	0.0377%	0.0457%

Key	
1	Total # of pharmacy claims in that month
2	Paid amount
3	# of paid claim overrides
4	% of Claims Overpaid Compared to Total

Because provider billing behavior regarding ProDUR alerts has not changed since the ER hard edit has been put in place, the cost avoidance for Fiscal Year 2017 was determined based on the pre-edit information listed above. The early refills for Fiscal Year 2017 claims were associated with an average of less than 0.04% of total annual claims of approximately $421 million. This resulted in an estimated cost avoidance of $21 million for Fiscal Year 2017.

Personal Care and Home-Based Waiver Services

In August 2017, OMIG implemented an initiative to review and investigate programs in Medicaid Personal Care and home-based waiver services. Concerns for ongoing fraud and abuse in these programs stem from OMIG audits, complaints and investigations. In the last two years, OMIG conducted over 200 audits or reviews of Personal Care or home-based waiver services. The audits and reviews resulted in nearly $800,000.00 in recoupments and 73 suspensions and fraud referrals for criminal investigation.

Based on the growing concerns for fraud and abuse in these program areas, OMIG invited DHS leadership to discuss concerns of fraud, waste, and abuse in Personal Care and home-based waiver services. The primary recommendation by OMIG was for Arkansas Medicaid to reform Personal Care and home-based waiver services, and require additional claims data to identify rendering or performing providers who provide hands-on services to recipients.

From August through June, OMIG audited and investigated Personal Care and home-based waiver service providers with emphasis towards identifying performing providers and reviewing service plans. The investigations and reviews resulted in recoupments, suspensions for fraud, referrals for prosecution, and additional requests for information. The initiative confirmed that changes and reforms to Personal Care and home-based waiver services would provide additional protection and safety to a vulnerable Medicaid population, as well as reduce fraud, and potentially save the Arkansas Medicaid program millions of dollars.

Recently, OMIG met with DHS leadership and was advised that reform and implementation of new processes are being developed to identify rendering and performing providers and that DHS is moving forward with implementation of the Electronic Visit Verification Program (EVV). OMIG will continue to monitor, review, and investigate fraud and abuse in the Personal Care and home-based waiver services, and will provide assistance in the implementation and development of reform in these areas.

Opioids Review and Reform

In September 2016, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) awarded the Division of Behavioral Health Services (DBHS) a $3.98 million grant for the Arkansas Prescription Drug/Opioid Overdose (PDO) Prevention Program. With this grant, a comprehensive prescription-drug misuse prevention program is being developed to effectuate three goals: 1) reduce the number of prescription drug and opioid overdose-related deaths among Arkansans 18 years of age and older; 2) address behavioral health disparities among racial and ethnic minorities; and 3) replicate a successful local police department naloxone program. OMIG currently serves on the PDO Advisory Workgroup of the Arkansas Alcohol and Drug Abuse Coordinating Council, which, among other responsibilities, was the deciding body for selecting the High Needs Communities (HNC) to receive funding from the SAMHSA grant. Additionally, OMIG is analyzing claims from Medicaid providers who prescribe high amounts of opioids or prescribe high numbers of prescriptions of opioids. OMIG is consulting with other agencies, planning audits for high prescribers, as well as assisting in forming a task force with federal and state agencies to address the growing concern.

Managed Care Organizations and Oversight

In 2017, Delta Dental of Arkansas (DDAR) and Managed Care of North America Dental (MCNA) entered into statewide contracts with the Arkansas Department of Human Services as

dental benefits managers for the Arkansas Medicaid /CHIP program. OMIG bolsters the transparency, accountability, and integrity of these Medicaid Managed Care Organizations (MCOs) by clarifying and imposing requirements meant to reduce fraud, waste and abuse. The OMIG Oversight Division will meet with and analyze reports from the MCOs which include financial statements, claims data, trends in provider complaints, staff and training requirements and reviews of disputed claims to ensure the MCOs are financially solvent and operating in compliance with statutory and contractual requirements.

OPTUM DSS Partnership

Optum hosts the Arkansas Medicaid Enterprise Decision Support System (DSS), which contains the Fraud and Abuse Detection System (FADS) and data extraction tools utilized by OMIG to prevent and detect fraud, waste and abuse. OMIG utilizes the Optum FADS Case Tracking system to maintain an audit case from initiation to completion. The case tracking system allows OMIG to effectively organize and manage audits while maintaining all historic information pertaining to any work completed. Peer Group Profiling provides a statistical comparison of providers or beneficiaries in a defined peer group of user-defined common characteristics to analyze behaviors. The tool serves as a symptomatic analysis identifying high-risk areas prone to fraud, waste, or abuse. Optum and OMIG meet routinely to collaborate on analytics, studies, and potential leads focused on OMIG's mission to prevent, detect and investigate fraud, waste and abuse within the medical assistance program. This consistent and frequent interaction cultivates our relationship allowing us to align our goals.

OMIG Medi-Medi Partnership

OMIG participates in the Centers for Medicare and Medicaid Services funded Medicare-Medicaid Data Matching Program referred to as "The Medi-Medi program". Currently the contractor for our zone is AdvanceMed. As a participant in the Medi-Medi Program, OMIG has access to Medicare data for Arkansas recipients in both Medicare and Medicaid allowing OMIG to monitor Arkansas providers who are enrolled in both programs. The Medi-Medi provides insight into the complete impact of providers on the federal and state programs and offers analytic and investigative resources to supplement those already available to OMIG. It was AdvanceMed who reported the Behavioral Health Program Vulnerability regarding 90853 Group Psychotherapy to OMIG in 2016 and assisted OMIG with the reformation efforts which resulted

in nearly $15 million reduction in billing and serves as a catalyst for the ongoing transformation of Behavioral Health in Arkansas.

Additionally, AdvanceMed identified the crossover claim issues and recently identified multi-state beneficiary eligibility issues which are currently under review by OMIG and AdvanceMed. OMIG and AdvanceMed share proactive data studies, program updates, policy changes, updates on ongoing projects, and current investigation activities. OMIG also participates in biannual meetings with the Medi-Medi Health Care Task Force which includes AdvanceMed, local and federal law enforcement, FBI, Arkansas Attorney General's Medicaid Fraud Control Unit, the United States Attorney's Office, and Arkansas Works insurance carriers.

OMIG Provider Education

OMIG makes a concerted effort to build relationships with Arkansas provider organizations and associations. OMIG is available to any provider organization or association to attend meetings and deliver presentations. This face-to-face interaction allows the provider to come forward with questions or concerns. OMIG's agency website continues to see a high volume of traffic and views. The agency website maintains links to report Medicaid fraud as well as provider resources such as: audit protocols, self-disclosure protocols, reconsideration protocols, appeals, CAPs, and False Claims Act Education compliance. The web link for provider-specific resources is: http://omig.arkansas.gov/providers

Through the audit and review process, OMIG educates Medicaid providers and requires submission of Corrective Action Plans (CAPs) when deficiencies are substantiated. OMIG performs follow-up audits to ensure compliance with a provider's CAP response. OMIG will continue to develop other methods of encouraging providers to attend training and review courses as part of negotiated settlements to ensure compliance. The Provider Awareness Letter Initiative also serves as a valuable education tool.

OMIG Staff 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 the Department of Justice, Center for Medical Services, Medicaid Integrity Institute, on the University of South Carolina campus. These courses are provided to qualified state employees, and are 100% funded by the federal government. In Fiscal Year 2017, ten OMIG personnel attended and completed 16 courses at the MII.

In August 2017, Elizabeth Smith, Inspector General was a returning presenter regarding Arkansas Medicaid's Group Psychotherapy Vulnerability. General Smith also presented on OMIG's Provider Awareness Letter Initiative at The National Association for Medicaid Program Integrity (NAMPI) 33rd Annual Conference in Miami, Florida. 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 the nation. OMIG personnel made several presentations at the Medicaid Integrity Institute (MII) throughout the year.

The Inspector General and other OMIG personnel have conducted presentations and provided training at multiple conferences and seminars throughout the year including the Arkansas Hospital Association, Community Health Centers of Arkansas, Arkansas Government Accountants, 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 Medicaid.

False Claims Act Compliance Initiative

OMIG completes False Claims Act Compliance Reviews after the close of the federal fiscal year per the requirements of the Arkansas Medicaid State Plan. This annual campaign ensures compliance with the Section 6032 of the Deficit Reduction Act, and the Social Security Act, Section 1902(a)(68) regarding education of false claims recovery to employees. OMIG conducted 121 total False Claims Act Compliance Reviews during Fiscal Year 2017.

OMIG Contract Review

The Contract Administration Division was created within the Office of Medicaid Inspector General in September 2015; since creation 40 contracts have been reviewed. The purpose of the Medicaid contract reviews is to determine whether there are any deficiencies in the contract including meeting performance-based contracting standards, whether DHS is properly monitoring contract performance, whether the contractor is fulfilling its responsibilities under the contract, and finally, whether there are duplications with other contracts and/or programs. In Fiscal Year 2017, the following six contracts were reviewed: Beacon Health Options, Inc. (formerly Value Options, Inc.), Arkansas Department of Health – ConnectCare, UAMS – Arkansas Center for Health Improvement, Prometric, Inc. – Nursing Assistants for Long Term Care Facilities, Emeritus Corporation dba Bock Associates, Inc., Navigant – Chip –

Children's Health Insurance Program. A thorough analysis and report has been submitted to the Payment Integrity Division of the Department of Human Services.

OMIG Cost Avoidance and Deterrence

Although difficult to quantify or measure, cost avoidance and deterrence are important factors for OMIG to consider and review to fully determine OMIG's impact on the Medicaid program. OMIG strives to increase provider and stakeholder awareness through provider awareness letter contacts, communication, audits and reviews, program education, and monitoring of the Medicaid program and Medicaid providers. OMIG has conducted preliminary studies and reviews to evaluate cost avoidance and determine how agency's initiatives impact the Medicaid program. Although preliminary and subject to other factors, the studies and reviews validate reductions in spending by Medicaid providers where OMIG intervention has resulted in administrative actions, MFCU referrals, suspensions, provider education, provider settlements, Provider Awareness Letters, and self-disclosures. OMIG's requirement for Corrective Action Plans by Medicaid providers to remedy deficiencies and prevent further improper billing play a significant role in deterrence and 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. Key factors in deterrence and improving program integrity are OMIG's increased visibility and transparency with providers, education initiatives, encouragement of self-disclosures, and increasing awareness along with collaboration with law enforcement groups and medical and health care service associations.

Respectfully Submitted,

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