U.S. Department of Health and Human Services

Office of Inspector General

Arkansas Medicaid Fraud Control Unit: 2019 Onsite Inspection

OEI-12-19-00450
September 2020

oig.hhs.gov

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Report in Brief
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What OIG Found

We found that the Arkansas Medicad Fraud Control Unit (MFCU or Unit) generally operated in accordance with applicable laws, regulations, and policy transmittals during Federal fiscal years (FYs) 2016–2018 but did not always comply with Federal regulations regarding its fiscal controls. We made two additional findings involving the Unit's adherence to the performance standards:

- The Unit did not regularly communicate and worked few joint cases with OIG's Office of Investigations during our review period.
- Although the Unit had procedures for reporting convictions and adverse actions to Federal partners, the Unit did not always report them within the appropriate timeframes.

We also identified a beneficial practice that may be useful as a model to other Units.

- The Unit director designated Unit investigators as subject matter experts of specific provider types for efficient assignment and improved investigation of cases.

What OIG Recommends and How the Unit Responded

To address the three findings, we recommend that the Arkansas Unit: (1) strengthen its fiscal controls in the four areas the report identified; (2) take steps to improve its communication and seek more opportunities to investigate joint cases with OIG's Office of Investigations; and (3) take steps to ensure that its staff reports all convictions and adverse actions to Federal partners within the appropriate timeframes. The Unit concurred with all three recommendations.

Unit Case Outcomes

FYs 2016–2018

- 73 indictments
- 76 convictions
- 86 civil settlements and judgments
- $18.8 million in recoveries with $14.1 million from "global"* civil cases, $2.5 million from nonglobal civil cases, and $2.2 million from criminal cases

Unit Snapshot

The Unit is part of the Arkansas Office of the Attorney General.

The 22-person MFCU staff—10 investigators, 6 attorneys, 2 auditors, and 4 support staff—is located in Little Rock.

*"Global" recoveries derive from civil settlements or judgments involving the U.S. Department of Justice and a group of State MFCUs and are facilitated by the National Association of Medicaid Fraud Control Units.

Full report can be found at oig.hhs.gov/oei/reports/oei-12-19-00450.asp

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Take steps to ensure that the Unit staff reports all convictions and adverse actions to Federal partners within the appropriate timeframes

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BACKGROUND

Objective
To examine the performance and operations of the Arkansas Medicaid Fraud Control Unit

Medicaid Fraud Control Units

Medicaid Fraud Control Units (MFCUs or Units) investigate (1) Medicaid provider fraud and (2) patient abuse or neglect in facility settings, and prosecute those cases under State law or refer them to other prosecuting offices.[1, 2] Under the Social Security Act (SSA), a MFCU must be a "single, identifiable entity" of State government, "separate and distinct" from the State Medicaid agency, and employ one or more investigators, attorneys, and auditors.[3] Each State must operate a MFCU or receive a waiver.[4]

Currently, 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands operate MFCUs.[5] Each Unit receives a Federal grant award equivalent to 90 percent of total expenditures for new Units and 75 percent for all other Units.[6] In Federal fiscal year (FY) 2019, combined Federal and State expenditures for the Units totaled approximately $302 million, with a Federal share of $227 million.[7]

[1] SSA § 1903(q)(3). Regulations at 42 CFR § 1007.11(b)(1) clarify that a Unit's responsibilities include the review of complaints of misappropriation of patients' private funds in health care facilities.

[2] References to "State" in this report refer to the States, the District of Columbia, and the U.S. territories.

[3] SSA § 1903(q).

[4] SSA § 1902(a)(61).

[5] The territories of American Samoa, Guam, and the Northern Mariana Islands have not established Units.

[6] SSA § 1903(a)(6). For a Unit's first 3 years of operation, the Federal Government contributes 90 percent of funding and the State contributes 10 percent. Thereafter, the Federal Government contributes 75 percent and the State contributes 25 percent.

[7] OIG analysis of MFCU annual statistical reporting data for FY 2019. The Federal FY 2019 was from October 1, 2018, through September 30, 2019.

OIG Grant Administration and Oversight of Medicaid Fraud Control Units

The Office of Inspector General (OIG) administers the grant award to each Unit and provides oversight of Units.[8, 9] As part of its oversight, OIG reviews and recertifies each Unit annually and conducts periodic reviews and inspections.

In its annual recertification review, OIG examines the Unit's reapplication, case statistics and the questionnaire responses from Unit stakeholders. Through the recertification review, OIG assesses the Unit's case outcomes; the Unit's compliance with applicable laws, regulations, and OIG policy transmittals;[10] and the Unit's performance as it is measured by the Unit's adherence to published performance standards.[11]

OIG further assesses Unit performance by periodically conducting reviews and inspections that may identify findings and make recommendations for improvement. During a review or inspection, OIG also makes observations regarding Unit operations and practices, including identifying beneficial practices that may be useful to share with other Units. In addition, OIG provides training and technical assistance to Units, as appropriate, both during the review or inspection and on an ongoing basis.

Arkansas Medicaid Fraud Control Unit

The Arkansas Unit is in Little Rock and is part of the Arkansas Office of the Attorney General (OAG). The Arkansas OAG Operations Department administers the Unit's accounting and other fiscal functions. At the time of our inspection, the Unit employed 22 staff – 10 investigators/special agents (including 1 senior investigator, 1 nurse investigator, and 1 nurse analyst), 6 attorneys (including the director and the 2 senior attorneys), 1 auditor, 1 financial analyst, and 4 support staff. During our review period of FYs 2016–2018, the Unit spent $7,049,617, with a State share of $1,762,404.

Management Structure. The Unit changed its management structure during our review period. Prior to 2016, the Unit had a "chief investigator" who directed and supervised the Unit's investigative activities. In 2016, the Unit established a team approach for its investigations and prosecutions, in which the chief investigator and senior attorneys worked together to supervise and direct two specialized teams – a "fraud team" and an "elder

[8] As part of its administration of the grant award, OIG receives and examines financial information from Units, such as budgets and quarterly and final Federal financial reports, that detail MFCU expenditures.

[9] The SSA authorizes the Secretary of Health and Human Services to award grants (SSA § 1903(a)(6)) and to certify and annually recertify the Units (SSA § 1903(q)). The Secretary delegated these authorities to OIG in 1979.

[10] OIG occasionally issues policy transmittals to provide guidance and instruction to MFCUs. Policy transmittals are located at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp.

[11] A complete publication of the performance standards, including performance indicators, may be found at 77 Fed. Reg. 32645 (June 1, 2012), and also on OIG's website at https://oig.hhs.gov/authorities/docs/2012/PerformanceStandardsFinal060112.pdf.

protection team." After the chief investigator left the Unit in April 2017, the Unit eliminated the chief investigator position, and the two senior attorneys became the "team leaders" of the respective teams.

With assistance from the director, the two senior attorneys supervise and direct all Unit investigators and attorneys. The senior attorneys direct each case and conduct the Unit's quarterly supervisory reviews of case files for the investigators and prosecutors. The director supervises the two senior attorneys and the auditor.

Referrals. The Unit receives referrals from several sources, including the Arkansas Department of Human Services' Office of Long-Term Care, the State Medicaid program integrity unit, and private citizens. When the Unit receives a referral, the Unit "intake/case coordinator" determines if the referral is viable. The team leaders of the fraud and elder protection teams approve the referrals to open as a case.

Investigations and Prosecutions. When the Unit opens a case, the intake/case coordinator assigns the case to an investigator for a full investigation. Throughout the investigation, the team leader meets with the investigator on a quarterly basis to discuss the progress of the case. Following the investigative phase, one of the team's attorneys prosecutes the case, if warranted, and meets quarterly with the team leader to discuss the case's progress.

Arkansas Medicaid Program

The Arkansas Department of Human Services administers the State Medicaid program and provides care for 768,057 beneficiaries enrolled in the program.[12] The Arkansas Office of the Medicaid Inspector General (OMIG) functions as the State Medicaid program integrity unit. The OMIG's mission is to prevent, detect, and investigate fraud, waste, and abuse in the State Medicaid program.

Prior OIG Report

OIG conducted a previous onsite review of the Arkansas Unit in 2013.[13] In that review, OIG found that the Unit: (1) did not have a policies and procedures manual specific to its operations; (2) lacked an updated memorandum of understanding (MOU) with the State Medicaid agency to reflect current law; (3) accepted only a small number of referrals from the State Medicaid agency; (4) lacked evidence of supervisory case file approvals and reviews; (5) incorrectly reported indirect costs; and (6) did not maintain an annual training plan. During the review, OIG also reported the Unit's outreach with the State's Office of Long-Term Care and other stakeholders as a beneficial practice.

[12] April 2020 Medicaid and CHIP Enrollment Data Highlights, Arkansas. Accessed at https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html on August 10, 2020.

[13] OIG, *Arkansas State Medicaid Fraud Control Unit: 2013 Onsite Review* available at https://oig.hhs.gov/oei/reports/oei-06-12-00720.pdf.

OIG recommended that the Unit: (1) establish policies and procedures specific to its operations; (2) update its MOU with the State Medicaid agency to reflect current law; (3) work with the State Medicaid agency to ensure an adequate number of referrals; (4) ensure that all case files contain evidence of supervisory approvals and reviews; (5) ensure that indirect costs are correctly reported; and (6) establish an annual training plan.

The Unit implemented all six OIG recommendations. The Unit developed a policies and procedures manual specific to its operations, revised its MOU with the State Medicaid agency to reflect current law, and increased its efforts to ensure that the State Medicaid agency refer cases to the Unit. The Unit also developed a new form for the supervisory reviews of case files. Further, the Unit received training for indirect costs and established a formal training plan.

Methodology

OIG conducted the onsite inspection of the Arkansas Unit in September 2019. Our review covered the 3-year period of FYs 2016–2018. We based our inspection on an analysis of data and information from 7 sources: (1) Unit documentation; (2) financial documentation; (3) structured interviews with key stakeholders; (4) structured interviews with the Unit's managers and selected staff; (5) a review of a random sample of 92 case files from the 554 nonglobal case files that were open at some point during our review period; (6) a review of all convictions submitted to OIG for program exclusion and all adverse actions submitted to the National Practitioner Data Bank (NPDB) during our review period; and (7) observation of Unit operations. (See Appendix A for a detailed methodology.) We assessed the Unit's operations and performance in accordance with the published performance standards, but we did not assess adherence to every performance indicator for every standard.

Standards

We conducted this inspection in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency. These inspections differ from other OIG evaluations in that they support OIG's direct administration of the MFCU grant program, but they are subject to the same internal quality controls as other OIG evaluations, including internal and external peer review.

PERFORMANCE ASSESSMENT

Below are the results of OIG's assessment of the performance and operations of the Arkansas Unit. OIG found that the Unit generally complied with legal and policy requirements but did not always comply with Federal regulations regarding its fiscal controls. For each of the performance standards, we offer either a finding or observation, including highlighting a beneficial practice.

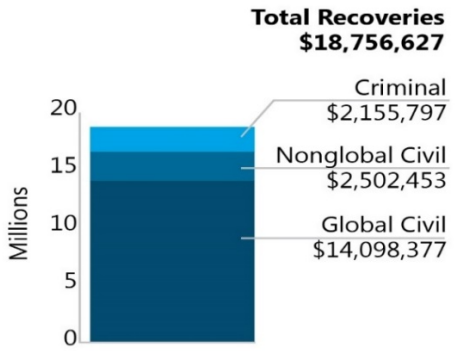
CASE OUTCOMES

Observations

The Unit reported 73 indictments, 76 convictions, and 86 civil settlements and judgments for FYs 2016–2018. From the 76 convictions, 55 involved provider fraud and 21 involved patient abuse or neglect.

The Unit reported total recoveries of $18.8 million for FYs 2016–2018. (See Exhibit 1 for the sources of those recoveries.)

Exhibit 1: The Unit reported combined civil and criminal recoveries of $18.8 million (FYs 2016–18).



Source: OIG analysis of Unit statistical data FYs 2016-18.

Note: "Global" civil recoveries derive from civil settlements or judgments in global cases, which are cases that involve the U.S. Department of Justice and a group of State MFCUs and are facilitated by the National Association of Medicaid Fraud Control Units.

STANDARD 1	A Unit conforms with all applicable statutes, regulations, and policy directives.

Observation

Based on the information we reviewed, the Unit generally complied with applicable laws, regulations, and policy transmittals but did not always comply with Federal regulations regarding its fiscal controls. We address this finding under Performance Standard 11 (see pages 10-12).

STANDARD 2	A Unit maintains reasonable staff levels and office locations in relation to the State's Medicaid program expenditures and in accordance with staffing allocations approved in its budget.

Observation

The Unit's staffing levels were reasonable in relation to the State's Medicaid expenditures; the Unit was fully staffed at the time of our review in accordance with the Unit's approved budget.

STANDARD 3	A Unit establishes written policies and procedures for its operations and ensures staff are familiar with, and adhere to, policies and procedures.

Observation

The Unit maintained a policies and procedures manual specific to its operations; this manual was available to all staff on a shared network drive. The Unit finalized its current policies and procedures manual in June 2019.

STANDARD 4	A Unit takes steps to maintain an adequate volume and quality of referrals from the State Medicaid agency and other sources.

Observation

The Unit took steps to maintain an adequate volume and quality of fraud and patient abuse and neglect referrals. The Unit met quarterly with OMIG to discuss potential fraud referrals, data requests, and fraud trends. For patient abuse or neglect cases, the Unit received and reviewed incident reports submitted to the Arkansas Office of Long-Term Care by the State's long-term care facilities. The Unit also maintained a hotline for private citizens to report Medicaid fraud and patient abuse and neglect.

STANDARD 5	A Unit takes steps to maintain a continuous case flow and to complete cases in an appropriate timeframe based on the complexity of the cases.

Observation

Beneficial Practice

The Unit director designated Unit investigators as subject matter experts of specific provider types for efficient assignment and improved investigation of cases. In 2016, the Unit director implemented a practice of designating Unit investigators as subject matter experts for investigating the most common provider types, such as mental health services, personal care services, and dental services. According to the Unit director, all investigators at the time of our review specialized in at least one provider area; most specialized in two. The Unit director reported that this practice allowed the intake/case coordinator to more efficiently assign cases by matching them with the appropriate subject matter experts. Unit investigators expressed that the Unit director placed them in subject matter areas where they could excel, thus improving the quality of investigations.

STANDARD 6	A Unit's case mix, as practicable, covers all significant provider types and includes a balance of fraud and, where appropriate, patient abuse and neglect cases.

Observation

During our review period, the Unit opened 591 cases of which 311 involved fraud and 280 involved patient abuse or neglect; the cases covered 35 different provider types. The Unit's cases involved facility-based providers such as nursing facilities, mental health facilities, and adult day care centers as well as individual providers such as personal care services attendants, nurses, and nurse's aides.

STANDARD 7	A Unit maintains case files in an effective manner and develops a case management system that allows efficient access to case information and other performance data.

Observation

The Unit maintained case files in an effective manner and retained a case management system that allows access to case information. The Unit used a proprietary electronic case management system, which was available for all Unit staff to record and track case information. The Unit also maintained paper case files. OIG examined the Unit's electronic case management system and paper case files in reviewing the random sample of 92 case files open during our review period. We determined whether the case files contained the appropriate documentation, such as opening and

closing documents, interview summaries, investigative activity summaries, and quarterly supervisory reviews. We also consulted Unit staff to allow them to explain any occasional missing supervisory reviews and activity summaries. In OIG's professional judgment, the Unit's case files were maintained in an effective manner and the case management system allowed efficient access to case information.

STANDARD 8	A Unit cooperates with OIG and other Federal agencies in the investigation and prosecution of Medicaid and other health care fraud.

Findings

The Unit did not regularly communicate and worked few joint cases with OIG's Office of Investigations (OI) during our review period. We found that the Unit director did not regularly communicate with OI management during our review period. Performance Standards 8(a) and 8(b) state that the Unit should regularly communicate and cooperate with OI.[14] Other than attending joint biannual health care task force meetings, the Unit director and OI management did not meet or communicate on a regular basis. However, the Unit director reported that one of the Unit investigators communicated regularly with an OI agent about the Unit investigator's cases. The Unit reported that it only communicated, or "deconflicted," with OI if a case involved both Medicare and Medicaid.

Additionally, we found that the Unit and OI worked few joint cases. Specifically, OI officials reported working only seven joint cases with the Unit during FYs 2016–2018. To improve communication and increase the number of joint cases, OI officials suggested that it would be beneficial for the Unit and OI to conduct joint trainings. After our onsite visit, both the Unit director and OI management reported that their working relationship was improving through better communication.

Although the Unit had procedures for reporting convictions and adverse actions to Federal partners, the Unit did not always report them within the appropriate timeframes. Performance Standard 8(f) states that the Unit should report to OIG all convictions for the purpose of exclusion from Federal health care programs within 30 days of sentencing.[15] We

[14] Current Federal regulations, which were effective after our review period, also state that the Unit should establish a practice of regular meetings or communication with OI (42 CFR § 1007.11(e)(3) (effective May 21, 2019)).

[15] Effective May 21, 2019, 42 CFR § 1007.11(g) requires the Unit to transmit information on convictions within 30 days of sentencing, or as soon as practicable if the Unit encounters delays in receiving the necessary information from the court.

found that the Unit did not report 39 of its 76 convictions to OIG within the appropriate timeframes.[16]

According to the Unit, it reported 25 convictions late because the conviction information was not forwarded within the Unit in a timely manner. It reported eight convictions late because of delays in receiving the necessary information from the sentencing court. At the time of our onsite visit, Unit officials believed that if the Unit investigated but did not prosecute cases, the Unit did not need to report any resulting convictions to OIG. Consequently, the Unit had not reported six convictions to OIG.[17] However, the Unit should be reporting all convictions to OIG, regardless of who prosecutes the cases.[18]

Federal regulations require that the Unit report all adverse actions resulting from investigations or prosecution of health care providers to the NPDB within 30 days of the final adverse action's date.[19] Performance Standard 8(g) also states that the Unit should report qualifying cases to the NPDB.[20] We found that the Unit did not report 30 of its 76 adverse actions to the NPDB within the appropriate timeframes.[21]

According to the Unit, it reported 19 adverse actions late because the adverse action information was not forwarded within the Unit in a timely manner. At the time of our onsite visit, Unit officials believed that if the Unit investigated but did not prosecute cases, the Unit did not need to report any resulting adverse actions to the NPDB. Consequently, the Unit did not report four adverse actions to the NPDB.[22] The Unit reported most of the remaining adverse actions late because of court delays in receiving the necessary information from the sentencing court.

[16] The Unit reported 9 of the 39 convictions to OIG within 35 days of sentencing.

[17] Since our onsite visit, the Unit has reported these six convictions to OIG.

[18] Policy Transmittal 2014-2 provides guidance for Units to report all convictions to OIG.

[19] 45 CFR § 60.5. Examples of final adverse actions include, but are not limited to, convictions, civil judgments (but not civil settlements), and program exclusions (SSA § 1128E(g)(1)).

[20] The NPDB is intended to restrict the ability of physicians, dentists, and other health care practitioners to move from State to State without disclosure or discovery of previous medical malpractice and adverse actions.

[21] The Unit reported 9 of the 30 adverse actions to the NPDB within 35 days of the adverse action.

[22] Since our onsite visit, the Unit has reported these four adverse actions to the NPDB.

STANDARD 9	A Unit makes statutory or programmatic recommendations, when warranted, to the State government.

Observation

The Unit made 17 recommendations to the State Medicaid agency during our review period. The Medicaid agency implemented 10 of the Unit's recommendations, which covered a range of service areas including mental health and home health care. For example, the Medicaid agency implemented the Unit's recommendations to require (1) specific dates on mental health services claims to denote when the services were rendered and (2) each home health care provider to have a provider number and include the provider number on Medicaid claims. This additional information could allow the State Medicaid agency to more easily identify questionable services and identify providers for further review or investigation.

STANDARD 10	A Unit periodically reviews its Memorandum of Understanding (MOU) with the State Medicaid agency to ensure that it reflects current practice, policy, and legal requirements.

Observation

The Unit's MOU with the State Medicaid agency and the State Medicaid program integrity unit reflected current practice, policy, and legal requirements. The Unit finalized its MOU with the Medicaid agency and OMIG (the program integrity unit) in September 2017.

STANDARD 11	A Unit exercises proper fiscal control over its resources.

Finding

The Unit did not always comply with Federal regulations regarding its fiscal controls. We identified four areas in which the Unit lacked proper fiscal controls during our review period. Specifically, we found that the Unit (1) claimed both unallowable and unsupported costs on its Federal grant; (2) submitted required financial reports late; (3) did not encrypt employee laptops; and (4) incorrectly calculated its indirect costs.

The Unit claimed both unallowable and unsupported costs on its Federal grant. We found that the Unit claimed $5,274 in unallowable costs and $1,500 in unsupported costs on its Federal grant.[23] The unallowable costs

[23] 45 CFR § 75.405(a) states that a cost is allocable to a Federal award or other cost objective if the goods or services involved are chargeable or assignable to that Federal award or cost objective in accordance with relative benefits received. This standard is met if the cost is incurred specifically for the Federal award. 45 CFR § 75.403(g) states that costs must be adequately documented to be allowable under Federal awards.

related to $2,499 for vehicle repairs to a non-Unit vehicle and $2,775 in travel charges for non-Unit staff. For the unsupported costs, the Unit could not locate supporting documentation for $1,500 in FY 2018 costs. According to the Unit, the unallowable costs occurred because of coding errors in the processing of invoices and the unsupported costs occurred because the Arkansas OAG financial manager at the time did not maintain sufficient records. To avoid future issues, Unit officials stated that they have discussed with the Arkansas OAG financial staff the importance of ensuring that the Unit's costs are coded correctly, and the Unit has created a new financial analyst position to review the Unit's costs on a monthly basis.

The Unit submitted 8 of its 15 required financial reports late. Of the eight late reports, the Unit submitted one report more than 6 months late, one report more than 3 months late, and two reports more than a month late. The Unit submitted the remaining four reports less than a month late. Unit officials attributed the late reports to the Arkansas OAG financial manager's failure to comply with Federal grants reporting requirements.[24] The Arkansas OAG terminated the financial manager's employment shortly before the OIG onsite inspection, and the Unit hired a financial analyst to complete all of the Unit's Federal reporting requirements.

The Unit did not encrypt employee laptops storing sensitive data. Federal regulations require Units to safeguard protective personally identifiable information and other sensitive data to prevent misuse.[25] According to Unit officials, the Unit had encrypted laptops until 2018, at which point the encryption was turned off because of technical issues. In January 2020, the Unit director reported to OIG that all of the Unit's computers had been encrypted.

The Unit incorrectly calculated its indirect costs. The Unit should apply its approved indirect cost rate to its base, which is salaries and fringe benefits.[26, 27] This calculation produces the dollar amount of indirect costs to which the Unit is entitled. However, the Unit did not use the

[24] 45 CFR § 75.342(b)(1) states that annual reports must be due 90 calendar days after the reporting period, while quarterly or semiannual reports must be due 30 calendar days after the reporting period.

[25] 45 CFR § 75.303(e) and 42 CFR § 1007.11(f).

[26] 45 CFR § 75, Appendix VII(B)(7) defines an "indirect cost rate" as a device for determining in a reasonable manner the proportion of indirect costs each program should bear. The indirect cost rate is the ratio (expressed as a percentage) of the indirect costs to a direct cost base.

[27] The U.S. Department of Health and Human Services (HHS) Cost Allocation Services approves the Unit's indirect cost rate agreements. In the Unit's indirect cost rate agreement, its base is defined as "direct salaries and wages including all fringe benefits."

HHS-approved indirect cost rate or base to determine its indirect costs. Instead, the Unit calculated its indirect costs by adding together monthly direct costs, including rent and lease expenses, and allocating them as indirect costs. As a result, the Unit underclaimed its indirect costs by $362,889 ($272,167 Federal share) for FYs 2016–2018. The Unit's financial analyst attributed the incorrect calculation of indirect costs to the Arkansas OAG's inability to apply the HHS-approved indirect cost rate in its accounting system.

STANDARD 12	A Unit conducts training that aids in the mission of the Unit.

Observation

The Unit maintained a training plan for each professional discipline. The training plan included the minimum number of training hours required for professional certification.

CONCLUSION AND RECOMMENDATIONS

From the information we reviewed, we found that the Arkansas Unit generally complied with applicable legal requirements, except that the Unit did not always comply with Federal regulations regarding its fiscal controls.

We also identified other opportunities for improvement. Specifically, during our review period, we found that the Unit did not regularly communicate and worked few joint cases with OIG's Office of Investigations (OI). Additionally, we found that the Unit staff did not report all convictions and adverse actions to Federal partners within the appropriate timeframes.

To address these findings, we recommend that the Arkansas Unit:

Strengthen the Unit's fiscal controls in the four areas the report identified.

The Unit should strengthen its fiscal controls in the report's four identified areas and take the following actions:

(1) Refund the Federal grant $6,774 in the unallowable and unsupported costs, ensure that future costs are coded accurately, and maintain supporting documentation for future costs on the Federal grant;
(2) Take steps to ensure that the Unit submits all required financial reports on time;
(3) Ensure that all Unit laptops continue to be encrypted to protect the electronic information under the Unit's control; and
(4) Establish policies and procedures to properly apply its approved indirect cost rate in calculating its indirect costs for Federal reimbursement.

Take steps to improve the Unit's communication and seek more opportunities to investigate joint cases with OI.

The Unit should establish a practice of regular meetings or communication with OI, which should include deconfliction of cases. Additionally, the Unit should seek more opportunities to conduct joint cases. To improve communication and increase joint cases, the Unit could conduct joint training with OI to help both groups understand each other's roles and responsibilities.

Take steps to ensure that the Unit staff reports all convictions and adverse actions to Federal partners within the appropriate timeframes.

The Unit should take steps to ensure that it reports all convictions to OIG within 30 days of sentencing and adverse actions to the NPDB within 30 days of the action. The Unit could provide conviction and adverse action

training to necessary staff or implement automated reminders to alert Unit staff when to report the convictions or adverse actions.

UNIT COMMENTS AND OIG RESPONSE

The Arkansas Unit concurred with all three of our recommendations.

The Unit concurred with our first recommendation to strengthen its fiscal controls and stated that it has either implemented or will implement the four actions that we recommended in the report. First, the Unit stated that it will refund the Federal grant $6,774 in unallowable and unsupported costs, will monitor and review Unit costs to ensure that they are coded accurately, and will maintain supporting documentation for Unit costs. Second, the Unit reported that its newly hired internal financial analyst has been submitting required financial reports timely and will continue to do so. Third, the Unit stated that it has encrypted all Unit laptops and is amending its policies and procedures manual to require encryption for any new Unit laptops. Fourth, the Unit stated that its financial analyst is reviewing expenses on a monthly basis and that the Unit will develop policies and procedures to apply the correct indirect cost rate in the future.

The Unit also concurred with our second recommendation to take steps to improve its communication and seek more opportunities to investigate joint cases with OI. The Unit reported that it has created an action plan with OI to establish regular meetings and communication about cases. The Unit stated that since our onsite visit, it has opened five joint cases with OI. The Unit stated that it also plans to conduct joint training with OI as well.

Finally, the Unit concurred with our third recommendation to take steps to ensure that its staff reports all convictions and adverse actions to Federal partners within the appropriate timeframes. The Unit stated that it has provided training to all employees and improved its automated reminders to alert its staff as to when to report convictions and adverse actions.

For the full text of the Unit's comments, see Appendix B.

APPENDIX A: Detailed Methodology

Data Collection and Analysis

We collected and analyzed data from the seven sources below to identify any opportunities for improvement and instances when the Unit did not adhere to the performance standards or was not operating in accordance with laws, regulations, or policy transmittals.[28] We also used the data sources to make observations about the Unit's case outcomes as well as the Unit's operations and practices concerning the performance standards.

Review of Unit Documentation. Prior to the onsite inspection, we reviewed the recertification analysis for FYs 2016–2018. The review involved examining the Unit's recertification materials, including (1) the annual reports, (2) the Unit Director's recertification questionnaires, (3) the Unit's memorandum of understanding with the State Medicaid agency and OMIG (the Medicaid program integrity unit), (4) the OMIG program integrity director's questionnaires, and (5) the OIG Special Agent in Charge's questionnaires. We also reviewed the Unit's policies and procedures manual and the Unit's self-reported case outcomes and referrals included in its annual statistical reports for FYs 2016–2018. We examined the recommendations from the 2013 OIG onsite review report and the Unit's implementation of those recommendations.

Review of Unit Financial Documentation. OIG auditors reviewed the Unit's internal fiscal controls and use of fiscal resources to identify any internal control issues or other issues involving the use of resources. We reviewed and discussed with Unit staff their responses to an internal controls questionnaire over accounting, budgeting, personnel, procurement, property, equipment, and the Unit's financial policies and procedures.

Additionally, we examined the Unit's claimed grant expenditures for FYs 2016–2018. For these expenditures, we (1) reviewed the Unit's payment records to identify unusual patterns of withdrawal amounts; (2) reconciled the Unit's Federal financial status reports (SF-425 forms) that the Unit submitted to OIG with the Unit's transaction detail reports for our review period; (3) compared the Unit's transactions detail reports to its approved budgets; and (4) reviewed the Unit's indirect costs to determine if the costs were adequately allocated to the Unit in accordance with the HHS-approved indirect cost rates.

[28] All relevant regulations, statutes, and policy transmittals are available online at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp.

While onsite, we reviewed three purposive samples to assess the Unit's internal control of fiscal resources:

1. We selected and reviewed 71 transactions, totaling $204,337. We included transactions from different Federal cost categories. We then requested and reviewed documentation supporting the selected transactions.
2. We reconciled the Unit's payroll registers with payroll costs. We selected 29 Unit employees' salaries and reviewed their supporting documentation.
3. We reviewed the Unit's fixed asset inventory by selecting 19 of the Unit's 562 fixed assets and verifying the sample's existence.

Interviews with Key Stakeholders. In August 2019, we interviewed key stakeholders, including officials in the OMIG, the State's Office of Long-Term Care, and the U.S. Attorney's Office. We also interviewed the managers from OIG's Office of Investigations who work with the Unit. We focused these interviews on the Unit's relationship and interaction with the stakeholders as well as opportunities for improvement. We used the information collected from these interviews to develop subsequent interview questions for Unit management and staff.

Onsite Interviews with Unit Management and Selected Staff. We conducted structured onsite interviews with the Unit's management and selected staff in September 2019. We interviewed the Unit director, the two senior attorneys, one auditor, and five investigators, including the senior investigator. We also interviewed the Chief Deputy Attorney General, who is the supervisor of the Unit director. We asked these individuals questions related to (1) Unit operations; (2) Unit practices that contributed to the effectiveness and efficiency of Unit operations and/or performance; (3) opportunities for the Unit to improve its operations and/or performance; (4) clarification regarding information obtained from other data sources; and (5) the Unit's training and technical assistance needs.

Onsite Review of Case Files. To craft a sampling frame, we requested that the Unit provide us with a list of cases that were open at any time during FYs 2016–2018 and include the status of the case; whether the case was criminal, civil, or global; and the dates on which the case was opened and closed, if applicable. The total number of cases was 591.

We excluded all global cases from our review of the Unit's case files because global cases are civil false claims actions that typically involve multiple agencies, such as the U.S. Department of Justice and a group of Units. We excluded 37 global cases, leaving 554 case files.

We then selected a simple random sample of 92 cases from the population of 554. This sample allowed us to make estimates of the overall percentage of case files with various characteristics with an absolute precision of

+/- 10 percent at the 95-percent confidence level. We reviewed the 92 case files for adherence to the relevant performance standards and compliance with statute, regulation, and policy transmittals. During the onsite review of the sampled cases, we consulted Unit staff to address any apparent issues with individual case files, such as missing documentation.

Review of Unit Submissions to OIG and NPDB. We also reviewed all 76 convictions submitted to OIG for program exclusion during our review period, and all 76 adverse actions submitted to the NPDB during our review period. We reviewed whether the Unit submitted information on all sentenced individuals and entities to OIG for program exclusion and all adverse actions to the NPDB for FYs 2016–2018. We also assessed the timeliness of the submissions to OIG and the NPDB.

Onsite Review of Unit Operations. During the onsite inspection, we observed the Unit's workspace and operations of the Unit's office in Little Rock. We observed the Unit's offices and meeting spaces; security of data and case files; location of select equipment; and the general functioning of the Unit.

APPENDIX B: Unit Comments

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September 11, 2020

Suzanne Murrin
Deputy Inspector General for Evaluation and Inspections
Cohen Building, Room 5660
330 Independence Avenue, SW
Washington, D.C. 20201

RE: Arkansas Medicaid Fraud Control Unit Official Draft Onsite Inspection Report (OEI-12-19-00450)

Dear Ms. Murrin:

The Arkansas Attorney General's Office is in receipt of the Arkansas Medicaid Fraud Control Unit ("MFCU") Official Draft Onsite Inspection Report for Federal Fiscal Years ("FFYs") 2016-2018. The MFCU would like to thank you and your team for your time and effort in assisting the Arkansas Unit to become a more efficient protector of Arkansans in the fight against Medicaid provider fraud and patient abuse and neglect in facility settings. Your thorough review of the MFCU was enlightening and informative. As a result of the HHS OIG 2019 onsite audit, the auditors made three findings with recommendations for corrective action. The Arkansas MFCU concurs with all three findings and has already aggressively implemented most of the recommendations and continues to address others.

The Unit concurs with the findings and recommendations and will address each action individually below.

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1. **Strengthen the Unit's fiscal controls in the report's four identified areas:**

   a. **The Unit should refund the Federal grant $6,774 for unallowable and unsupported costs, ensure that future costs are coded accurately, and maintain supporting documentation for future costs of the Federal grant.**

   The three inappropriate expenditures charged to the MFCU grant were inadvertently charged to the grant by the Office of Attorney General ("OAG") financial staff who were not sufficiently familiar with the grant's restrictions. To prevent any recurrence, the MFCU hired an internal financial analyst in July 2019 and has subsequently worked with the OAG to develop policies and procedures to prevent this from happening again. The MFCU financial analyst now has direct access to all MFCU accounts and reviews all MFCU financial records before they are submitted for payment. The OAG financial staff can no longer pay any expenses without the expenses being reviewed by the MFCU financial analyst to ensure the expenditures are covered by the grant and that the expenditure records appropriately identify the costs with the correct coding notation attached pursuant to 45 CFR §§75.405(a) & 75.403(g). The MFCU financial analyst has initiated the reimbursement process with HHS. According to the Grants Management Officer, Alexis Crowley, the refund may be offset by the underclaimed FFP of indirect expenses that occurred in the 4th quarter of FFY 2018. The claim request must be sent to Ms. Crowley by September 30, 2020, and be verified before the offset can take place and before the Unit can act on any remaining balance. The MFCU will take all necessary actions to the satisfaction of HHS to reconcile the grant.

   b. **The Unit should take steps to ensure that it submits all required financial reports on time.**

   The MFCU hired an internal financial analyst in July 2019 to complete all the Unit's Federal reports. Since the MFCU hired an internal financial analyst, all eleven required financial reports to OIG or Payment Management System for FFYs 19 and 20 have been timely filed.

   c. **The Unit should ensure that all Unit laptops continue to be encrypted to protect the electronic information under the Unit's control.**

   All MFCU laptops are now encrypted and will remain encrypted. The MFCU Standard Operating Procedures is being amended to require encryption of any laptop purchased by the MFCU or assigned to the MFCU by OAG.

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d. **The Unit should establish policies and procedures to properly apply its approved indirect cost rate in calculating its indirect costs for Federal reimbursement.**

The audit revealed that the Unit had underclaimed its indirect costs. The Unit wants to take full advantage of these important funds. To remedy this situation, the Unit's financial analyst is reviewing actual expenses on a monthly basis and indirect costs are recorded for the Unit utilizing the approved indirect cost rate which was determined by applying the HHS-approved indirect cost rate standards. Policies and procedures to explain the process of determining and applying the correct indirect cost rate for the future will be developed in coordination with the OAG Financial Manager. The Arkansas MFCU is now utilizing 100% of available indirect costs.

2. **The Unit should take steps to improve the Unit's communication and seek more opportunities to investigate joint cases with OI.**

a. **The Unit should establish a practice of regular meetings or communication with OI, which should include deconfliction of cases.**

The following Unit action plan has been agreed to by HHS/OIG/OI Mike Stapleton, Assistant Special Agent in Charge ("ASAC"), to increase the number of communications with our federal counterparts:

- The MFCU Director and the OI Assistant Special Agent in Charge will meet at least twice a year in January and July. Other meetings will be scheduled when needed and when the ASAC visits federal agents in Arkansas.
- The MFCU Sr. Investigator and Sr. Auditor will host quarterly law enforcement only meetings with local HHS OI agents. Due to COVID-19, the start of the law enforcement meetings have been delayed until January 2021. An earlier start date will occur if it becomes prudent to do so.
- Because of COVID-19, the MFCU has provided the HHS/OIG/OI Assistant Special Agent in Charge an Excel spreadsheet that details all open MFCU cases. These reports will now be provided to the HHS/OIG/OI Assistant Special Agent in Charge at the beginning of each quarterly meeting, at least until deconfliction meetings are being held on a regular basis.

b. **The Unit should seek more opportunities to conduct joint cases.**

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While the Unit acknowledges deconfliction meetings halted for a time, it needs to be clear that agents from the units never stopped working cases together. In fact, MFCU agents cooperated with HHS OI agents on several cases during the audit period. Those cases included a combined Medicaid and Medicare fraud case that resulted in prison time for the director of a MEMS company. The MFCU agrees, though, that the deconfliction meetings are important and that the Unit can do better in this area. The MFCU is committed to working more cases with our federal counterparts in Arkansas and is looking forward to working with new leadership at OI in our HHS Region. They have demonstrated that they are equally committed.

Since the August 2019 onsite audit, the MFCU has opened five criminal cases that are being worked in conjunction with federal agents, and quite possibly an additional dental case will be added to that number any day now. One of the criminal cases has already resulted in an arrest and charges are pending. Notably, the Unit has also been asked to assist with a federal qui tam case which, to my knowledge, is the first time that the AR MFCU has been asked to assist on a federal civil case that the MFCU did not initiate.

c. **The Unit could conduct joint training with OI to help both groups understand each other's roles and responsibilities.**

The MFCU is already conducting some joint training at our health care taskforce meetings, but the MFCU Director and ASAC intend to meet to consider additional training opportunities as soon as COVID-19 restrictions are lifted.

3. **The Unit should take steps to ensure that the MFCU staff reports all convictions and adverse actions to Federal partners within the appropriate timeframes.**

During the audit period of FYs 2016-2018, the Unit did not report 39 of its 76 convictions to OIG within 30 days of sentencing and 30 of 76 adverse actions to NPDB within the allotted 30 day window. A few of the delinquent reports occurred because the Unit had an incorrect understanding as to whether the Unit was required to report federal cases it did not actively prosecute. Most of the remaining cases not reported in a timely manner were cases assigned to an individual employee who is no longer with the MFCU.

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The Unit has provided conviction and adverse action training to all employees and has improved our automated reminders to alert Unit staff when to report the convictions or adverse actions. Both suggestions have been implemented within the MFCU. Furthermore, not only has timely reporting been discussed at staff meetings, but references to the timely reporting of convictions have been detailed in the MFCU Standard Operating Procedures Manual (updated June 20, 2019) under the "Closing" section and as part of a checklist for staff to follow in Appendix B. All staff members have tickler systems available within Legal Files (office case management system) and Microsoft software to generate automatic notifications for reminders for all areas of case management. Since January 2019, the MFCU has timely reported 35 out of 38 convictions per Performance Standard 8(f). We will continue to work toward 100% compliance.

The MFCU would again like to thank you and your team for your patience and professionalism throughout this audit process. If you have any future comments or questions, please do not hesitate to contact me.

Regards,

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ACKNOWLEDGMENTS

Keith Peters of the Medicaid Fraud Policy and Oversight Division served as the team leader for this inspection. Susan Burbach of the Medicaid Fraud Policy and Oversight Division also participated in the inspection. Two agents from the Office of Investigations also participated in the inspection. Office of Evaluation and Inspections staff who provided support include Kevin Farber, Christine Moritz, and Colleen White.

We would also like to acknowledge the contributions of the Office of Audit Services staff, including Matthew Odom, Laura Cummings, Meagan Summers, and Kelsey Minchew.

This report was prepared under the direction of Richard Stern, Director of the Medicaid Fraud Policy and Oversight Division.

To obtain additional information concerning this report or to obtain copies, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov

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