2024 Annual Report

Office of Medicaid Inspector General

Department of Inspector General

Secretary Allison Bragg

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Overview

This annual report, required by Ark. Code Ann. § 20-77-2509(a), summarizes the activities of the Office of Medicaid Inspector General (OMIG) for the preceding year, Fiscal Year 2024 (FY24). OMIG opened **38** fraud investigations, conducted **1,496** audits and related actions, initiated **13** administrative actions, referred **13** cases to prosecutors or licensing authorities, and identified **$9,013,711.09** of Medicaid funds for recovery.

Investigations

In FY24, OMIG opened **38** fraud investigations. OMIG receives leads for investigation from audits, public complaints received through the OMIG fraud hotline, self-reports by Medicaid agencies, referrals from outside agencies, and referrals from law enforcement including the Attorney General's Medicaid Fraud Control Unit (MFCU). OMIG continues to use data analytics to identify fraud consistent with national and federal program integrity trends.

During FY24, the OMIG investigation team continued to work closely with the Special Investigative Units of the Medicaid Management Care Organizations (MCOs), including the Dental Managed Care Organizations (DMOs) and the Provider-Led Arkansas Share Savings Entities (PASSE). These organizations refer providers and beneficiaries to OMIG for potential or suspected fraud to better identify, target, and eliminate fraud, waste, and abuse within the Medicaid program.

Audits

During FY24, OMIG conducted **1,496** audits and audit activities (these include on-site audits, desk audits, False Claims Act compliance reviews, investigations, contractor audits, and recoupment letters). A list of audit activities and details for each is attached (*FY24 Case List*).

Summary of Audit Activities

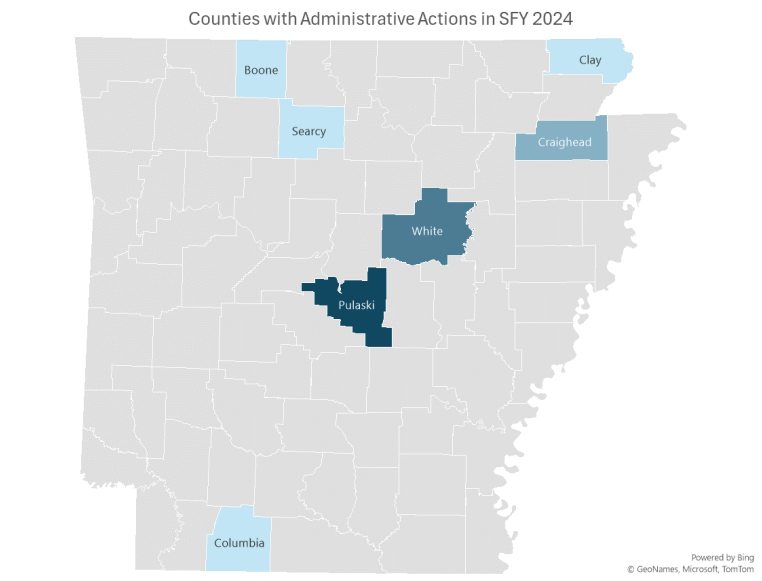
Onsite Audits	4
Desk Audits	28
False Claims Act Reviews	205
Contractor Audits	283
Recoupment Letters	963
TOTAL	**1,496**

Administrative Actions

OMIG initiated administrative action against **13** providers in FY24. Administrative actions are the primary sanctions against Medicaid providers engaging in fraud, abuse, and improper billing practices. Administrative actions include suspension from payment of Medicaid claims, exclusion from participation in the Medicaid program, and termination from the Medicaid program. When OMIG refers criminal actions to MFCU, federal law 42 C.F.R. § 455.23 requires the provider to be suspended under most circumstances. Depending on the outcome of the criminal matter, OMIG will either exclude or reinstate the provider.

In non-criminal matters, OMIG also pursues suspension, exclusion, or termination when a provider continually abuses the program by failing to adhere to requirements set out in the Medicaid Provider Manuals. After OMIG imposes sanctions, each provider is afforded legal due process to appeal OMIG's decision in a hearing before an Administrative Law Judge who will confirm or deny whether a credible allegation of Medicaid fraud exists to support the sanction. During FY24, OMIG suspended 4 providers and excluded 9 providers. The map below depicts the provider suspensions, exclusions, and terminations by county.

OMIG sanctioned Medicaid providers in 7 Arkansas counties for FY24



Provider Suspensions	4
Provider Exclusions	9
FY24 Total	13

Referrals

In FY24, OMIG made **13** referrals for prosecution or to licensing authorities to the Attorney General's Medicaid Fraud Control Unit (MFCU), which resulted in four arrests due to a credible allegation of fraud. One provider was referred to the MFCU civil division. These referrals are detailed in the attached spreadsheet (*FY24 Case List*).

OMIG sometimes receives complaints regarding potential beneficiary fraud. If a complaint involves collusion between a beneficiary and a Medicaid provider, OMIG will continue the investigation and referral to MFCU. Beneficiary-related matters will be referred to the Department of Human Services or the Social Security Administration Office of Inspector General for investigation, depending on the benefits involved. In FY24, no suspected Medicaid beneficiary fraud cases were reported to DHS.

Administrative and Educational Activities

In FY24, OMIG personnel attended the National Association for Medicaid Program Integrity (NAMPI), the National Healthcare Anti-Fraud Association State Information Sharing Session, the Central Arkansas chapter of the American Academy of Professional Coders, Arkansas Foundation for Medical Care Workshops, and the Healthcare Fraud Prevention Partnership.

Office Performance: OMIG Recoveries

The total amount of Medicaid funds OMIG identified for recovery in FY24 is **$9,013,711.09.** OMIG's internal identified recoveries include:

Onsite Audits	$7,277.20
Desk Audits	$529,305.65
MFCU Referrals	$71,211.92
Recoupment Letters	$507,740.79
TOTAL (OMIG internal)	**$1,115,535.56**

Additional Recoveries

Contractor Identified Recoveries

Delta Dental of Arkansas and Managed Care of North America Dental (collectively, DMOs) served in FY24 as the dental benefits managers by providing dental services to Medicaid recipients. Each DMO is contractually obligated to investigate fraud, waste,

and abuse internally and report to OMIG every quarter. OMIG has monitored the quarterly reports and acted as a liaison between the organizations and MFCU. Soon, the Medicaid program (Fee-For-Service, or FFS) will manage and pay for dental services and the DMOs will no longer serve as dental benefit managers for Medicaid recipients. This transition is expected to occur by November 1, 2024.

Arkansas Total Care, CareSource, Empower Healthcare Solutions, and Summit Community Care are the full-risk benefits managers serving as Provider-led Arkansas Shared Savings Entities (PASSEs) for Tier 2 and Tier 3 behavioral health and developmentally disabled recipients. The PASSE contract requires quarterly reporting on fraud, waste, and abuse. OMIG is responsible for ensuring that each PASSE follows the program integrity rules. In June 2024, OMIG conducted its third annual training on implementing and reporting these efforts. Collectively, DMOs, PASSEs, and other contractor-identified recoveries for FY24 total **$7,159,048.87.**

Optum Pharmacy

In FY24, OMIG continued its partnership with Optum to conduct pharmacy audits by reviewing 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 by Optum. A total of **$739,126.66** has been identified for recoupment.

Conclusion

OMIG is expanding its focus on provider outreach by developing strategies that create the greatest return on investment and increase program integrity. We rely on our staff of auditors, registered nurses, professional coders, licensed clinical social workers, and investigators to fully execute our role in detecting and preventing fraud, waste, and abuse within the Medicaid program. Please feel free to contact our office any time if we can help or provide more information.

Thank you,

Allison Bragg
Secretary
Department of Inspector General