ARKANSAS LEGISLATIVE AUDIT
REPORT ON:
DEPARTMENT OF HUMAN SERVICES
FOR THE YEAR ENDED JUNE 30, 2021

Finding 1:
During our review of expenditures, we noted two duplicate payments in the amounts of $7,500 and $6,000 issued to United Family Services, Inc., a vendor providing services within the Division of Youth Services (DYS). The original payments were issued during May 2021, and the duplicate payments were issued during June 2021. The Agency was unaware of the duplicate payments, until notified by Arkansas Legislative Audit (ALA) during April 2022. The Agency received and deposited recoupment of the duplicate payments in May 2022.

Recommendation:
We recommend the Agency strengthen controls over disbursements by implementing procedures designed to detect and prevent duplicate payments of the same invoice and/or for same services provided.

Agency Response:
The Department of Human Services (DHS) concurs with this finding. DYS contract and finance teams have implemented a contract and invoice tracking system to prevent future duplicate payments to vendors. Upon receipt of an invoice, DYS enters the vendor name, invoice number, invoice amount, and service dates, plus additional information, into a tracking spreadsheet. This information must be reviewed prior to approving invoices for payment. The duplicate payments have been recouped from the vendor.

Finding 2:
Regulation R4-19-4-501 of the State Financial Management Guide states that strict control needs to be maintained during the processing of cash receipts to ensure that they are properly accounted for. The Agency's Administrative Procedures Manual Ch. 201, Section III, states that receipt books and/or cash logs are to be maintained for purposes of audit and internal control and that funds received must be receipted and deposited timely. Our review of the Agency's receipt and deposit of funds received in the various program areas revealed the following:

- Receipts not traced to deposit:
  - **Arkansas State Hospital (ASH)-Finance Office:** Two checks in the amounts of $794 and $72, out of 25 sampled items totaling $38,015, could not be traced to deposit. The Agency stated the checks were either returned to the payor or forwarded to the client's last known address; however, no documentation of return was maintained.
  - **Division of Aging, Adult, and Behavioral Health Services (DAABHS)**: One check in the amount of $29, out of three checks receipted for the year totaling $35,423, could not be traced to deposit.
  - **Office of Finance – Accounts Payable Returned Checks**: Two checks in the amounts of $2 and $1,076 picked up by Central Office Accounts Receivable for processing and one check in the amount of $677 picked up by the Payroll Division for processing, out of 25 sampled items totaling $31,687, could not be traced to deposit. Subsequent to ALA testing, two of the payors have agreed to re-issue a check to the Agency.
- Untimely deposit:
  - **Division of Youth Services (DYS):** Six checks totaling $69,619, out of 11 checks receipted for the year totaling $140,493, were held from 18 up to 83 days before being deposited.
  - **Division of Aging, Adult, and Behavioral Health Services**: Two checks totaling $35,394, out of three checks receipted for the year totaling $35,423, were held from 77 up to 201 days before being deposited.
- Failure to maintain receipt books and/or check log:
  - **Central Office Receipting** failed to maintain one book of 200 receipts for funds received from September 2020 through November 2020.
  - **Division of Provider Services and Quality Assurance (DPSQA)** failed to maintain a check log for August 2020 through November 2020.

Recommendation:
We recommend the Agency review and follow Regulation R4-19-4-501 of the State Financial Management Guide and the Agency's Administrative Procedures Manual Ch. 201, Section III, regarding the processing of cash receipts.

Agency Response:
DHS concurs with this finding. ASH, DAABHS, and DYS have implemented new procedures for tracking and reconciling cash receipts and deposits. DYS and DAABHS have updated their procedures for tracking and reconciling cash receipts and deposits. Both have updated their documented controls to require documentation of the reason for a delay in depositing checks. Office of Finance staff has been trained in the record retention and safekeeping of receipt books. The DPSQA check log was previously combined with the Division of Medical Services (DMS) check log. DPSQA's check log is now separate from the check log of DMS.

Finding 3:
Regulation R1-19-4-501 of the State Financial Management Guide states that agencies must have an established system of internal control and that strict control should be maintained during the processing of cash receipts. Our review of the Arkadelphia Human Development Center (HDC) Individual Personal Fund bank account and corresponding receipt and expenditure transactions revealed the following issues:

- Review of Receipt Books:
  - The receipt book was not maintained for July's manual deposits totaling $13,648.
  - Manual receipts were not issued for two bank deposits, totaling $300 and $1,600, respectively, during October and March.
  - Four receipts issued during May, totaling $223, were not deposited intact.
  - One June receipt was not used; however, it was not voided to prevent the practice of issuing receipts out of sequence.
  - One June receipt was missing due to being torn out of the receipt book; the Agency was unable to explain why it had been removed.
  - Five instances occurred throughout the year in which the applicable receipts did not match a bank deposit, resulting in a net total of $3 in funds receipted that could not be traced to an actual bank deposit.
- Testing of Receipts:
  - Two receipt items totaling $168, out of 30 items tested totaling $7,405, were applied to incorrect client accounts, resulting in two client ledger accounts being overstated and two client ledger accounts being understated.
- Testing of Expenditures:
  Review of 20 expenditure items totaling $10,500 revealed the following issues:
  - One instance, totaling $324, was noted in which client funds were drawn to purchase an in-store Walmart gift card used to place an online order. The online invoice maintained by the Agency documented that the order had been placed but did not provide detail as to whether the actual gift card was used as payment for the order.
  - In two instances, totaling $68, where multiple draws of petty cash funds for use by clients were replenished, the Agency failed to document management authorization and approval of the withdrawals. The Agency also did not maintain store receipts for $29 of the replenishments and, therefore, failed to document how the petty cash was spent. Additionally, upon the Agency's posting of the replenishment transactions in the general ledger, one client account was overcharged by $14, while another client account was under-charged by $10. Because of such errors in replenishment, the Agency has maintained a current overage in the petty cash drawer of $4.
  - In four instances totaling $2,450, client funds were drawn for personal expenditures, and store receipts documented a total of $2,505 spent, resulting in an excess of $55 in funds spent compared to funds withdrawn. No documentation was available as to who paid the extra $55, and no entries were posted in the general ledger documenting if the client account was ever charged for reimbursing the applicable party.

Inadequate documentation inhibits maintenance of an audit trail for review. Additionally, lack of due diligence in posting client account activity could lead to misappropriation of client funds entrusted to the Agency.

Recommendation:
We recommend the Agency implement policies and procedures regarding the receipt and use of client funds and for the adequate recording and monitoring of financial activity for the Arkadelphia Human Development Center Individual Personal Funds.

Agency Response:
DHS concurs with this finding. Division of Developmental Disabilities Services (DDS) conducted a comprehensive training for all HDC Business Office staff on the cash receipt, deposit, and withdrawal process in accordance with State Financial Management guidelines. All HDC Business Office staff will be required to complete this training course on an annual basis. New hires will be required to complete this training course as part of their orientation.

Finding 4:
Regulation R1-19-4-505 of the State Financial Management Guide states that government agencies must have an established system of internal control in relation to the safeguarding of assets. During our review of the Agency's Arkansas ABLE investments of Foster Care Trust funds, we noted a total of $906,437 in contributions, as of the 2021 fiscal year-end, were sent to a third-party administrator for investment against multiple foster care client investment accounts. The contributions were made over a three-year period in the amounts of $559,450, $212,065, and $134,922 for fiscal years 2021, 2020, and 2019, respectively.

We reviewed 25 of 269 client investment accounts, along with corresponding third-party administrator system reports, and noted the following discrepancies:

- One check contribution of $1,150, issued during November 2020, was applied against the wrong client investment account. The Agency was unaware of the error until notified by ALA during April 2022.
- One check contribution in the amount of $1,500, issued during December 2019, was sent back by the third-party administrator in January 2020 due to lack of identifying information. The Agency has allowed this check to remain outstanding, rather than re-issuing the funds for the intended client's account.
- One client investment account's prior-year activity of both funding and closure transactions was not listed on any of the system reports received by the auditor from the third-party administrator. Such omissions require the Agency to perform current/timely monitoring of client account balances.

Additionally, we determined the total Arkansas ABLE investment amount at June 30, 2021, posted in the Arkansas Administrative Statewide Information System (AASIS), was under reported by $8,772 due to the third-party administrator's year-end report erroneously omitting three active client account balances.

Finally, upon auditor inquiry, it was discovered that the third-party administrator notifies the Agency routinely of the availability of monthly reports and quarterly statements; however, the Agency has failed to incorporate a process of reviewing the reports and/or statements to verify that all contributions sent have been applied against the intended client account.

Lack of due diligence in monitoring foster care client investment account contributions and corresponding balances could lead to misappropriation of funds entrusted to the Agency.

Recommendation:
We recommend the Agency implement policies and procedures regarding the monitoring of foster care client investment account assets as required by R1-19-4-505 of the State Financial Management Guide.

Agency Response:
DHS concurs with this finding. The Division of Children and Family Services (DCFS) Eligibility Unit has assigned staff to complete a monthly reconciliation of Arkansas ABLE investment accounts that will ensure funds are credited to the proper account, outstanding check items are addressed timely, and all client account balances are monitored. Monthly reports made available through the third-party administrator responsible for managing investments have been combined with existing agency reports to complete the monthly reconciliations.

Finding 5:
Ark. Code Ann. § 19-4-1502 states that it is the responsibility of the executive head of each state agency to keep and maintain a record of all property of the agency belonging to the State of Arkansas. Regulation R1-19-4-1503 of the State Financial Management Guide states that all items transferred, lost, stolen, destroyed, or sold must be promptly removed from the detail of capital assets. While performing an observation of assets from a current capital asset listing dated March 2, 2022, we noted 7 of 60 equipment items sampled, with a total purchase cost of $43,229, could not be located for observation. These items had inventory dates listed in AASIS as follows:

- 5 items were noted as last inventoried in May 2021 and/or June 2021.
- 1 item was noted as last inventoried in December 2020.
- 1 item had no inventory date listed.

None of these items were documented as lost, stolen, or obsolete prior to our sample testing.

Recommendation:
We recommend the Agency strengthen controls over capital assets by ensuring management periodically reviews asset information for accuracy and completeness.

Agency Response:
DHS concurs with this finding. The Agency continues to analyze and update its asset management procedures to ensure compliance with the State Financial Management Guide. Over the course of the last two fiscal years, the Agency has steadily increased the number of assets located and updated during inventory. In fiscal year 2022, the Agency located and updated 95% of its assets in AASIS. An internal investigation is being conducted to identify the 7 assets that could not be located for observation.

Finding 6:
DHS disbursed $4.7 million in Coronavirus Relief Funds for the Community Outreach Program within the Division of County Operations (DCO). During the approval process for granting the awards and in the corresponding issuance of the grant funds, DHS utilized a third-party administrator for vetting potential sub-grantees. In turn, the sub-grantees agreed to provide DHS-Office of Payment Integrity and Audit with supporting invoice/receipt documentation upon spending the funds received, as required per DHS' Proposal for Arkansas Coronavirus Relief Fund.

The third-party administrator awarded and disbursed 262 grants to approved sub-grantees in amounts ranging from $1,000 up to $450,000 per grant award. For our review, we selected the highest distributed grant award amount of $450,000 to the sub-grantee The Urban League of the State of Arkansas (ULSA).

ULSA's proposal/application for funding documented that it would serve 45 counties in need at $10,000 per county. ULSA subsequently contracted with Performance Tax Group (PTG) to distribute the funds to various organizations in the anticipated 45 counties. ULSA provided a summary listing of 17 organizations to whom PTG issued grant funds as well as the total amount paid to ULSA and PTG for administrative costs. Alongside bank statement documentation, we determined that $404,300 in grant funds was portrayed as distributed to the 17 organizations, with the remaining $45,700 retained by ULSA and PTG as allowable operating costs. Our review of the summary listing and detailed support provided for the 17 organizations' expending of the $404,300 grant funds revealed the following concerns:

- ULSA's summary listing of how the grant funds were disbursed did not match PTG's bank statement detail of disbursement. Although the summary listing totals the original $450,000 award, six of the payee amounts listed on the summary differed from the bank activity detail. It should be noted that two of the six payees with differing amounts were ULSA and PTG.
- The signed acknowledgement forms between ULSA and PTG with the applicable organizations to whom PTG disbursed the funds did not list the official amount of funding received by the organizations. Therefore, we do not consider the amounts documented as disbursed to be verified against the total amount received by each individual organization.
- PTG made nine cash withdrawals, totaling $165,750, in order to issue 36 cashier's checks among the 17 organizations. Supporting documentation provided by PTG for 26 of the cashier's checks, totaling $85,000, listed no identifying bank information; therefore, we question the validity of the cashier check.
- As required by the DHS Proposal for Arkansas Coronavirus Relief Fund, funding received by sub-grantees was to be used for its intended purpose and be adequately tracked and appropriately supported. The majority of the supporting documentation provided by the various organizations for expending the funding was considered inadequate and was un-readable and/or could not be deciphered by auditors and could not be reconciled with the amount noted as disbursed. We noted the following for three of the organizations:
    - A total of $21,250 was issued by electronic transfer to two separate organizations, owned by the same individual, that are not considered a food/meal service type vendor; therefore, we question why the organizations were granted the funds. Supporting documentation suggests the organizations further sub-granted the funds to various charitable groups to provide meals; however, the documentation was considered incomplete in detailing how all the funding was spent.
    - PTG distributed a total of $192,550 in grant funds to one organization to serve 21 counties. Information submitted as support for providing meals consisted of email correspondence among various county organizations and lists of people who were provided meals; however, not all 21 counties were represented in the information. Furthermore, we could not calculate/verify total amount spent for each county due to poor presentation of the information provided.

Due to these concerns, we question whether all the funds were distributed to the intended 17 organizations as well as whether the funds were spent to provide meals for all 45 counties, as required by the grant award.

During our testing for this grant award, the DHS-Office of Payment Integrity and Audit also performed an initial review of this grant award, resulting in various concerns.

Recommendation:
We recommend DHS continue monitoring this grant award, as required by the DHS Proposal for Arkansas Coronavirus Relief Fund, to determine whether the funds were used for their intended purpose.

Agency Response:
DHS concurs with this finding and continues to monitor the grant of this award. On June 20, 2022, the Agency referred the concerns noted by Legislative Audit and DHS-Office of Payment Integrity and Audit to the United States Attorney's Office for the Eastern District of Arkansas.

Finding Number:	**2021-014**
State/Educational Agency(s):	**Arkansas Department of Human Services** **Arkansas Department of Commerce – Arkansas Economic Development Commission**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**21.019 – COVID-19: Coronavirus Relief Fund**
Federal Awarding Agency:	**U.S. Department of Treasury**
Federal Award Number(s):	**Not Applicable**
Federal Award Year(s):	**2020**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed;** **Allowable Costs/Costs Principles;** **Period of Performance**
Type of Finding:	**Noncompliance and Significant Deficiency**

Repeat Finding:
Not applicable

Criteria:
The Coronavirus Relief Fund was required by Sec. 5001, as amended, of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) to be used to cover only those costs that were (1) necessary expenditures incurred due to the public health emergency with respect to Coronavirus Disease 2019 (COVID-19) and (2) incurred during the period that began March 1, 2020, and ended December 31, 2021. In accordance with guidance provided in the Federal Register by the United States Department of Treasury, the State of Arkansas was required to keep records sufficient to demonstrate that the funds were used in accordance with this federal legislation.

Furthermore, the State of Arkansas was responsible for determining the level and detail of documentation needed from subrecipients of small business assistance to satisfy compliance with this law.

Finally, in accordance with 2 CFR § 200.303, a non-federal entity must establish and maintain effective internal control over the federal award that provides reasonable assurance that the non-federal entity is managing the federal award in compliance with federal statutes, regulations, and the terms and conditions of the award.

Condition and Context:
Arkansas established various programs intended to reimburse beneficiaries or subrecipients for additional expenses incurred as a result of COVID-19. The State of Arkansas established a state-level committee that approved the programs and disbursements. The programs were established and administered at a departmental level. Each department was responsible for establishing controls and acquiring sufficient, appropriate evidence (supporting documentation) for expenditures. As such, ALA identified a risk of potential duplication of benefits for programs at more than one department level.

ALA performed select procedures to determine if duplication of benefits had occurred. Our review revealed the following exceptions:

- ALA staff reviewed 43 recipients that received payments under both the Arkansas Department of Human Services projects and the Arkansas Economic Development Commission (AEDC) Ready for Business Grant Program (RBGP). We identified six recipients that submitted duplicate expenditure documentation to both Agencies, totaling $47,488.
- ALA staff reviewed 40 recipients receiving funding from the Business Interruption Grant Program (BIG) and RBGP, both disbursed by AEDC. Three recipients provided inaccurate information regarding the amount of funding previously received under RBGP, a required disclosure on the application for BIG. The disclosure is key because the amount of RBGP received is used in calculating the award for BIG.

Statistically Valid Sample:
Not a statistically valid sample

Finding Number:	**2021-014 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services** **Arkansas Department of Commerce – Arkansas Economic Development Commission**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**21.019 – COVID-19: Coronavirus Relief Fund**
Federal Awarding Agency:	**U.S. Department of Treasury**
Federal Award Number(s):	**Not Applicable**
Federal Award Year(s):	**2020**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed; Allowable Costs/Costs Principles; Period of Performance**
Type of Finding:	**Noncompliance and Significant Deficiency**

Questioned Costs:
$47,488

Cause:
The Agencies failed to implement sufficient internal controls to identify and detect duplication of benefits between funded programs.

Effect:
The State of Arkansas could be subject to repayment of funds to the federal government.

Recommendation:
ALA staff recommend the Agencies strengthen internal controls over the awarding of funds to recipients, receipt of documentation from recipients, and reconciliation of submitted expense documentation to funds awarded to recipients to ensure that duplication of benefits between funded programs is prevented, detected, and corrected.

Views of Responsible Officials and Planned Corrective Action:
Arkansas Department of Human Services:
DHS concurs with this finding. DHS and AEDC will collaboratively investigate the six instances in which duplicate expenditure documentation was submitted to each agency. Both agencies will collaborate on appropriate action, including recoupment, for any payments confirmed as duplicates.

Anticipated Completion Date: August 31, 2022

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Arkansas Economic Development Commission:
(Joint Response from All Agencies):
Benefits under the Ready for Business Grant Program were provided to the eligible businesses as an advance, with the requirement that the business submit receipts at a later date to confirm that the grant amount was expensed for a permissible purpose as outlined in the grant program terms.

The potential for duplication of benefits with a program administered by DHS was not foreseen at the time the Ready for Business Grant Program was operational. AEDC will coordinate with DHS to recover the duplicate payments so that they are returned to the State.

Finding Number:	**2021-014 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services** **Arkansas Department of Commerce – Arkansas Economic Development Commission**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**21.019 – COVID-19: Coronavirus Relief Fund**
Federal Awarding Agency:	**U.S. Department of Treasury**
Federal Award Number(s):	**Not Applicable**
Federal Award Year(s):	**2020**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed; Allowable Costs/Costs Principles; Period of Performance**
Type of Finding:	**Noncompliance and Significant Deficiency**

Views of Responsible Officials and Planned Corrective Action (Continued):
Arkansas Economic Development Commission: (Continued)
(Joint Response from All Agencies) (Continued):
The Ready for Business Grant Program and the Business Interruption Grant Program (BIG) were both temporary programs that are no longer operational. This should fully mitigate future control issues.

Response from Arkansas Department of Parks, Heritage and Tourism (BIG Only)
The auto-calculation of a qualified applicant's BIG program award was based on the amount of other financial assistance received by the applicant, as reported in the program's online portal. The program's intent in using third-party records, as evidenced by the AEDC data, was to minimize fraud potential by gathering available and useable electronic data from other government sources to cross-check and auto-validate the information that the program's over 5,000 applicants submitted. Most of the program's auto-validation effort was employed during the initial application stage of the process to help ensure only qualified Arkansas businesses would be considered for possible awards. For example, during the application stage, the program extensively cross-checked identification data submitted by applicants with records received from the Arkansas Secretary of State's office. Tax identification numbers submitted by applicants were also verified by DF&A.

Due to the time constraints imposed by the then federal payment deadline of December 30, 2020, neither auto-validation nor a manual case-by-case review and resolution could be effectively employed in the latter stage of the program for the small percentage of cases where data inconsistency occurred. As for any data that could not be timely cross-checked or validated, the BIG program, like many other CARES Act assistance programs, had to necessarily rely upon self-certification by the applicant. In the BIG program, the applicant submitted its data under penalty of perjury and contractually agreed to a claw back provision whereby the state could recover any amounts erroneously awarded. In the three cases referenced, which represent 7.5% of the sample size, ADPHT does not have reason to believe fraud was committed. The award recipients in this finding misrepresented in total $6,000 in other financial assistance, a very low percentage in comparison to the $48 million to be awarded. The applicants were eligible, had qualified expenses and had a demonstrable need for this financial assistance. Due to the large amount of qualified expenses submitted by all qualified applicants, the average grant award was paid out at a rate of approximately $.12 on the dollar. Accordingly, we are confident that the awards paid to these three (3) recipients did cover qualified expenses and did not result in an unfair advantage or create a material disadvantage to all other awardees.

For planned corrective action, ADPHT will develop a plan to conduct further review of more grant recipients beyond the businesses reviewed in the audit sample. ADPHT will work with the Arkansas Department of Commerce to cross reference data collected from businesses including grant award amounts. This further review will allow ADPHT to ensure that the incorrect Ready for Business Grant award amounts reported was not a pervasive problem with the grant program. For future grant programs, with more time allowed for development and distribution, ADPHT will:

Finding Number:	**2021-014 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services** **Arkansas Department of Commerce – Arkansas Economic Development Commission**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**21.019 – COVID-19: Coronavirus Relief Fund**
Federal Awarding Agency:	**U.S. Department of Treasury**
Federal Award Number(s):	**Not Applicable**
Federal Award Year(s):	**2020**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed; Allowable Costs/Costs Principles; Period of Performance**
Type of Finding:	**Noncompliance and Significant Deficiency**

Views of Responsible Officials and Planned Corrective Action (Continued):
Response from Arkansas Department of Parks, Heritage and Tourism (BIG Only) (Continued)

1) Increase staff participation to assist in the review and assurance that applicants are in compliance with program requirements; and
2) Design a program with more controls in place that allows for more time with the application process and support of applicants to ensure accurate information and proper documentation is submitted with the grant application.

Anticipated Completion Date: August 31, 2022

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Finding Number:	**2021-015**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**21.019 – COVID-19: Coronavirus Relief Fund (COVID-19 Surge Capacity Enhancement Payment Program)**
Federal Awarding Agency:	**U.S. Department of Treasury**
Federal Award Number(s):	**Not Applicable**
Federal Award Year(s):	**2020**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed; Allowable Costs/Cost Principles**
Type of Finding:	**Noncompliance**

Repeat Finding:
Not applicable

Criteria:
The Coronavirus Relief Fund (CRF) was required by Sec. 5001, as amended, of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) to be used to cover only those costs that were (1) necessary expenditures incurred due to the public health emergency with respect to Coronavirus Disease 2019 (COVID-19) and (2) incurred during the period that began March 1, 2020, and ended December 31, 2021. In accordance with guidance provided in the Federal Register by the United States Department of Treasury, the State of Arkansas was required to keep records sufficient to demonstrate that the funds were used in accordance with this federal legislation.

Additionally, ineligible expenses from the CRF included workforce bonuses other than hazard pay or overtime, and corresponding guidance interpreting this prohibition included employees substantially dedicated to mitigating or responding to the COVID-19 public health emergency. Also, question #38, as published in the Federal Register in January 2021, specifically provided that across-the-board hazard pay for employees working during a state of emergency was not allowed.

Finally, an attestation form signed by the provider required the provider to submit records of expenses to the Arkansas Department of Human Services (DHS) by January 31, 2021. This documentation requirement (records of expenses by the providers) demonstrates that the expenses were for necessary expenditures during the allowable period. Furthermore, while the attestation form specifically prohibited workforce bonuses other than hazard pay or overtime, it allowed for "other workforce payments necessary to ensure continuity," which provided discretion to the providers/recipients that does not seem afforded by the guidance from the federal government.

Condition and Context:
Arkansas awarded approximately $50 million to hospitals and long-term care facilities to assist with additional expenses related to the COVID-19 surge in Arkansas in the fall of 2020. Funds for approved provider locations were disbursed by DHS, in full and in advance of the providers incurring allowable costs and submitting detailed support for the payment received.

Of 308 payments to providers, ALA staff reviewed a sample of 60 payments and requested the supporting documentation on hand with DHS to determine if sufficient, appropriate evidence (supporting documentation) was maintained to provide assurance that the payroll expenses were eligible. Our review revealed 16 provider payments contained ineligible expenses as follows:

- Sample item 35: $2 per hour extra for "COVID Pay," even though "COVID Hazard Payroll" was separately listed and reimbursed.
- Sample items 5, 7, 9, 20, 28, 30, 33, 39, 41, and 43: Payroll incentives for "essential admin incentives" and "management incentives."
- Sample items 19 and 32: "COVID-19 incentive" and no additional explanation.
- Sample items 31 and 56: "Hero pay" associated with positions including administrators, dietary supervisors, housekeeping supervisors, bookkeepers, and billing coordinators.
- Sample item 37: Described the additional payments as "employee payroll – appreciation and retention."

Finding Number:	**2021-015 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**21.019 – COVID-19: Coronavirus Relief Fund (COVID-19 Surge Capacity Enhancement Payment Program)**
Federal Awarding Agency:	**U.S. Department of Treasury**
Federal Award Number(s):	**Not Applicable**
Federal Award Year(s):	**2020**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed; Allowable Costs/Cost Principles**
Type of Finding:	**Noncompliance**

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
Unknown

Cause:
The Agency failed to ensure that the types of wage payments made to providers aligned with the corresponding federal guidance.

Effect:
The State of Arkansas could be subject to repayment of funds to the federal government.

Recommendation:
ALA staff recommend the Agency review the corresponding guidance regarding allowable wage payments, review the supporting documentation provided by the recipients for additional wage payments, and acquire additional support from the providers, where needed, to determine whether funds were appropriately utilized for allowable wage payments.

Views of Responsible Officials and Planned Corrective Action:
DHS concurs with this finding. The agency will request documentation from providers that support payments were made for eligible expenses. Any improperly expended funds will be recouped.

Anticipated Completion Date: August 31, 2022

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Finding Number:	**2021-016**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**21.019 – COVID-19: Coronavirus Relief Fund (COVID-19 Surge Capacity Enhancement Payment Program)**
Federal Awarding Agency:	**U.S. Department of Treasury**
Federal Award Number(s):	**Not Applicable**
Federal Award Year(s):	**2020**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed; Allowable Costs/Cost Principles; Period of Performance**
Type of Finding:	**Noncompliance and Significant Deficiency**

Repeat Finding:
Not applicable

Criteria:
The Coronavirus Relief Fund was required by Sec. 5001, as amended, of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) to be used to cover only those costs that were (1) necessary expenditures incurred due to the public health emergency with respect to Coronavirus Disease 2019 (COVID-19) and (2) incurred during the period that began March 1, 2020, and ended December 31, 2021. In accordance with guidance provided in the Federal Register by the United States Department of Treasury, the State of Arkansas was required to keep records sufficient to demonstrate that the funds were used in accordance with this federal legislation.

Furthermore, the State of Arkansas was responsible for determining the level and detail of documentation needed from subrecipients of small business assistance to satisfy compliance with this law. An attestation form signed by the provider required the provider to submit records of expenses to the Arkansas Department of Human Services (DHS) by January 31, 2021. This documentation requirement (records of expenses by the providers) demonstrates that the expenses were for necessary expenditures during the allowable period.

Finally, in accordance with 2 CFR § 200.303, a non-federal entity must establish and maintain effective internal control over the federal award that provides reasonable assurance that the non-federal entity is managing the federal award in compliance with federal statutes, regulations, and the terms and conditions of the award.

Condition and Context:
Arkansas awarded approximately $50 million to hospitals and long-term care facilities to assist with additional expenses related to the COVID-19 surge in Arkansas in the fall of 2020. Funds for approved provider locations were disbursed by DHS, in full and in advance. As reported in finding **2021-019**, DHS failed to implement sufficient controls to review supporting documentation under this Program.

Of 308 payments made to providers, ALA selected a sample of 60 payments and requested the supporting documentation on hand with DHS to determine if sufficient, appropriate evidence was maintained. Our review revealed 8 instances in which the documentation provided failed to demonstrate that the provider expended the entire payment during the allowed period as follows:

- Sample items 1, 21, 35, 48, and 54: Vendor account statements did not include supporting invoices or purchase detail on the accounting software expense summaries. In addition, quotes were provided rather than actual invoices for services rendered. Questioned costs totaled $206,416.
- Sample item 4: Supporting documentation had not been submitted for any expenses at the time of audit. DHS requested supporting documentation from the provider, who stated the intent to repay the funds received instead of providing documentation. Questioned costs totaled $50,992.
- Sample items 20, 21, 23, and 35: Documentation provided indicated that expenses incurred were less than the total funds received. One provider (sample item 23) specifically requested to return funds to DHS in January 2021, but the Agency failed to review the provider's submission; therefore, the request went unnoticed. As a result, the repayment had not been made as of the end of fieldwork. Questioned costs totaled $121,715.

Finding Number:	**2021-016 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**21.019 – COVID-19: Coronavirus Relief Fund (COVID-19 Surge Capacity Enhancement Payment Program)**
Federal Awarding Agency:	**U.S. Department of Treasury**
Federal Award Number(s):	**Not Applicable**
Federal Award Year(s):	**2020**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed; Allowable Costs/Cost Principles; Period of Performance**
Type of Finding:	**Noncompliance and Significant Deficiency**

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
$379,123

Cause:
The Agency failed to implement sufficient internal controls to monitor the timely submission, reconciliation, and review of provider expenses.

Effect:
The State of Arkansas could be subject to repayment of funds to the federal government.

Recommendation:
ALA staff recommend the Agency strengthen its internal controls regarding the awards to recipients, including the review of supporting expense documentation, to ensure compliance.

Views of Responsible Officials and Planned Corrective Action:
DHS concurs with this finding. The agency will request documentation from providers that support expenditures claimed. Any improperly expended funds will be recouped.

Anticipated Completion Date: **August 31, 2022**

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Finding Number:	**2021-017**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**21.019 – COVID-19: Coronavirus Relief Fund (DHS Hospital Proposal – Protect, Treat, and Transform During the COVID-19 Emergency Program)**
Federal Awarding Agency:	**U.S. Department of Treasury**
Federal Award Number(s):	**Not Applicable**
Federal Award Year(s):	**2020**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed; Allowable Costs/Cost Principles; Period of Performance**
Type of Finding:	**Noncompliance and Significant Deficiency**

Repeat Finding:
Not applicable

Criteria:
The Coronavirus Relief Fund was required by Sec. 5001, as amended, of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) to be used to cover only those costs that were (1) necessary expenditures incurred due to the public health emergency with respect to Coronavirus Disease 2019 (COVID-19) and (2) incurred during the period that began March 1, 2020, and ended December 31, 2021. In accordance with guidance provided in the Federal Register by the United States Department of Treasury, the State of Arkansas was required to keep records sufficient to demonstrate that the funds were used in accordance with this federal legislation.

Furthermore, the State of Arkansas was responsible for determining the level and detail of documentation needed from subrecipients of small business assistance to satisfy compliance with this law.

Finally, in accordance with 2 CFR § 200.303, a non-federal entity must establish and maintain effective internal control over the federal award that provides reasonable assurance that the non-federal entity is managing the federal award in compliance with federal statutes, regulations, and the terms and conditions of the award.

Condition and Context:
Arkansas awarded approximately $100 million to hospitals to recover unreimbursed costs associated with treating COVID-19 patients and other expenses necessary to ensure continued care during the Coronavirus pandemic. Funds for approved hospitals were disbursed by the Arkansas Department of Human Services (DHS). Payments were based on an initial attestation form where the provider chose either a formulaic maximum payment or a lesser amount. An additional cluster payment was provided if positive cases of COVID were known at the particular facility.

Subsequent to payment, each provider was required to submit a cost form designed to assist in identifying and quantifying qualifying expenses related to the formulaic payment. No additional documentation for expenses incurred was required.

Of 149 payments, ALA selected a sample of 16 payments made to hospitals to determine if sufficient, appropriate evidence (supporting documentation) was maintained. ALA review revealed that one provider received a $1,802,214 formula payment, but its cost form only identified expenses, totaling $1,568,812, indicating the provider was overpaid.

The cost form was certified by the Chief Executive Officer of the hospital as being correct, complete, and prepared from the books and records of the provider.

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
$233,402

Finding Number:	**2021-017 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**21.019 – COVID-19: Coronavirus Relief Fund (DHS Hospital Proposal – Protect, Treat, and Transform During the COVID-19 Emergency Program)**
Federal Awarding Agency:	**U.S. Department of Treasury**
Federal Award Number(s):	**Not Applicable**
Federal Award Year(s):	**2020**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed; Allowable Costs/Cost Principles; Period of Performance**
Type of Finding:	**Noncompliance and Significant Deficiency**

Cause:
The Agency failed to establish and implement sufficient internal controls to ensure that providers incurred sufficient eligible costs and that overpayments were recouped.

Effect:
The State of Arkansas could be subject to repayment of funds to the federal government.

Recommendation:
ALA staff recommend the Agency establish and implement internal controls to ensure overpayments are recognized and appropriate measures are taken to initiate the refund process.

Additional Information:
ALA staff reviewed a report prepared by the Arkansas Department of Inspector General – Office of Internal Audit (DIG - OIA) regarding this Program. Of the 91 hospitals that received funds, DIG - OIA reviewed a sample of 23 hospitals and requested hospital supporting documentation in addition to the cost forms (e.g., receipts or payroll journals).

Of the 23 hospitals reviewed, 3 elected to return excess funds, totaling $2,545,000, instead of supplying the requested documentation.

Views of Responsible Officials and Planned Corrective Action:
DHS concurs with this finding. The agency will request documentation from providers that support expenditures claimed. Any improperly expended funds will be recouped.

Anticipated Completion Date: August 31, 2022

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Finding Number:	**2021-018**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**21.019 – COVID-19: Coronavirus Relief Fund (Skilled Nursing Facility Payments Due to COVID-19 Emergency Program)**
Federal Awarding Agency:	**U.S. Department of Treasury**
Federal Award Number(s):	**Not Applicable**
Federal Award Year(s):	**2020**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed; Allowable Costs/Cost Principles; Period of Performance**
Type of Finding:	**Noncompliance and Significant Deficiency**

Repeat Finding:
Not applicable

Criteria:
The Coronavirus Relief Fund was required by Sec. 5001, as amended, of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) to be used to cover only those costs that were (1) necessary expenditures incurred due to the public health emergency with respect to Coronavirus Disease 2019 (COVID-19) and (2) incurred during the period that began March 1, 2020, and ended December 31, 2021. In accordance with guidance provided in the Federal Register by the United States Department of Treasury, the State of Arkansas was required to keep records sufficient to demonstrate that the funds were used in accordance with this federal legislation.

Furthermore, the State of Arkansas was responsible for determining the level and detail of documentation needed from subrecipients of small business assistance to satisfy compliance with this law. An example of ineligible expenditures in the Federal Register was workforce bonuses, other than hazard pay or overtime.

Funds for approved provider locations were disbursed by the Arkansas Department of Human Services (DHS) in two separate rounds. Round 1 was for expenses incurred from March 1, 2020 through June 30, 2020, and Round 2 was for expenses incurred from July 1, 2020 through October 31, 2020.

An attestation form signed by the provider required the provider to submit records of expenses to DHS by August 31, 2020, supporting Round 1 disbursements and by November 15, 2020, supporting Round 2 disbursements. Disbursements that were not reasonably supported were to be returned to DHS.

Finally, in accordance with 2 CFR § 200.303, a non-federal entity must establish and maintain effective internal control over the federal award that provides reasonable assurance that the non-federal entity is managing the federal award in compliance with federal statutes, regulations, and the terms and conditions of the award.

Condition and Context:
Arkansas awarded approximately $40.7 million to qualified skilled nursing facilities to maintain capacity and recover some of the costs associated with treating COVID-19 residents.

During the fall of 2021, DHS was performing the review of supporting expense documentation for Round 1 and had completed the initial review of Round 2. In addition, DHS planned to perform follow-up procedures with Round 2 recipients, during the first quarter of calendar year 2022, to confirm expenses were incurred by the provider because DHS had relied on quotes, proposals, and estimates during its initial review.

Of 373 payments made to providers, ALA selected a sample of 60 payments to determine if sufficient, appropriate evidence (supporting documentation) was maintained. ALA staff requested the attestation forms and provider receipts on hand with DHS. ALA's review revealed 21 instances in which the documentation failed to demonstrate that the provider had appropriate expenses incurred during the period allowed as follows:

- Sample items 1, 3, 7, 11, 25, 42, 43, 58, and 59 (Round 1): Documentation submitted included bonus payments or taxes on bonus payments. Questioned costs totaled $84,230.
- Sample items 11, 23, 39, 42, 43, and 56 (Round 1): Expense receipts were less than the total payment received by the provider. Questioned costs totaled $366,644.

Finding Number:	**2021-018 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**21.019 – COVID-19: Coronavirus Relief Fund (Skilled Nursing Facility Payments Due to COVID-19 Emergency Program)**
Federal Awarding Agency:	**U.S. Department of Treasury**
Federal Award Number(s):	**Not Applicable**
Federal Award Year(s):	**2020**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed; Allowable Costs/Cost Principles; Period of Performance**
Type of Finding:	**Noncompliance and Significant Deficiency**

Condition and Context (Continued):

- Sample item 47 (Round 1): Receipts had not been submitted at the time of the audit. Questioned costs totaled $125,000.
- Sample item 24 (Round 1): Documentation submitted only included general ledger summaries, not detailed invoices. Questioned costs totaled $111,560.
- Sample items 14, 19, 26, 34, 35, 55, and 57 (Round 2): Expense receipts were less than the total payment received by the provider. For example, the Agency had received quotes, not expense receipts, from some providers. Quotes are not considered sufficient, appropriate evidence (supporting documentation) for the actual expenses incurred. Questioned costs totaled $495,145.

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
$1,182,579

Cause:
The Agency failed to establish and implement sufficient internal controls to monitor the review of expense documentation submitted by the provider.

Effect:
The State of Arkansas could be subject to repayment of funds to the federal government.

Recommendation:
ALA staff recommend the Agency establish and implement internal controls for monitoring over the awards to ensure providers submit appropriate documentation for expenses incurred to demonstrate compliance.

Views of Responsible Officials and Planned Corrective Action:
DHS concurs with this finding. The agency will request documentation from providers that support expenditures claimed. Any improperly expended funds will be recouped.

Anticipated Completion Date: August 31, 2022

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Finding Number:	**2021-019**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**21.019 – COVID-19: Coronavirus Relief Fund (COVID-19 Surge Capacity Enhancement Payment Program)**
Federal Awarding Agency:	**U.S. Department of Treasury**
Federal Award Number(s):	**Not Applicable**
Federal Award Year(s):	**2020**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed; Allowable Costs/Cost Principles; Period of Performance**
Type of Finding:	**Significant Deficiency**

Repeat Finding:
Not applicable

Criteria:
The Coronavirus Relief Fund was required by Sec. 5001, as amended, of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) to be used to cover only those costs that were (1) necessary expenditures incurred due to the public health emergency with respect to Coronavirus Disease 2019 (COVID-19) and (2) incurred during the period that began March 1, 2020, and ended December 31, 2021. In accordance with guidance provided in the Federal Register by the United States Department of Treasury, the State of Arkansas was required to keep records sufficient to demonstrate that the funds were used in accordance with this federal legislation.

Furthermore, the State of Arkansas was responsible for determining the level and detail of documentation needed from sub-recipients of small business assistance to satisfy compliance with this law. An attestation form signed by the provider required the provider to submit records of expenses to the Arkansas Department of Human Services (DHS) by January 31, 2021. This documentation requirement (records of expenses by the providers) demonstrates that the expenses were for necessary expenditures during the allowable period.

Finally, in accordance with 2 CFR § 200.303, a non-federal entity must establish and maintain effective internal control over the federal award that provides reasonable assurance that the non-federal entity is managing the federal award in compliance with federal statutes, regulations, and the terms and conditions of the award.

Condition and Context:
Arkansas awarded approximately $50 million to hospitals and long-term care facilities to assist with additional expenses related to the COVID-19 surge in Arkansas in the fall of 2020. Funds for approved provider locations were disbursed by DHS, in full and in advance of the providers incurring allowable costs and submitting detailed expense support.

ALA review revealed that, of the 308 providers that received funding, 64 providers failed to submit any of the documentation required by the attestation form prior to ALA's inquiry in September 2021.

In addition, 10 of 60 providers sampled did not properly complete the attestation form, which would document acknowledgment of the Program requirements (e.g., checkboxes regarding Program restrictions were not completed).

As of the end of fieldwork, the Agency had not reviewed any supporting documentation for provider expenses.

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
None

Finding Number:	**2021-019 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**21.019 – COVID-19: Coronavirus Relief Fund (COVID-19 Surge Capacity Enhancement Payment Program)**
Federal Awarding Agency:	**U.S. Department of Treasury**
Federal Award Number(s):	**Not Applicable**
Federal Award Year(s):	**2020**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed; Allowable Costs/Cost Principles; Period of Performance**
Type of Finding:	**Significant Deficiency**

Cause:
DHS failed to establish and implement sufficient internal controls for monitoring provider expenses.

Effect:
The State of Arkansas could be subject to repayment to the federal government.

Recommendation:
ALA staff recommend the Agency establish and implement internal controls for monitoring the awards to ensure providers submit appropriate documentation for expenses incurred to demonstrate compliance.

Views of Responsible Officials and Planned Corrective Action:
DHS concurs with this finding. The agency has developed a multi-level control procedure for reviewing future attestations.

Anticipated Completion Date: Complete

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Finding Number:	**2021-023**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.767 – Children's Health Insurance Program** **93.778 – Medical Assistance Program (Medicaid Cluster)**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-2005AR5021; 05-2105AR5021 (Children's Health Insurance Program)** **05-2005AR5MAP; 05-2105AR5MAP (Medicaid Cluster)**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Allowable Costs/Cost Principles – Managed Care Medical Loss Ratio (PASSE and Dental)**
Type of Finding:	**Noncompliance and Material Weakness**

Repeat Finding:
A similar issue was reported in prior-year finding **2020-016**.

Criteria:
In a final rule, published in the Federal Register on May 6, 2016 (81 FR 27498), the Centers for Medicare and Medicaid Services (CMS) adopted Medical Loss Ratio (MLR) requirements for Medicaid and Children's Health Insurance Program (CHIP) managed care programs. One of the requirements is that a state must require each Medicaid managed care plan to calculate and report an MLR for rating periods starting on or after July 1, 2017. Each CHIP managed care plan is required to calculate and report an MLR for rating periods for state fiscal years beginning on or after July 1, 2018.

Also, per 42 CFR § 438.5(c)(1) states must provide audited financial reports to the actuary, who determines capitation rates, for the three most recent and complete years for the managed care entities. These reports must be specific to the Medicaid contract and in accordance with generally accepted accounting principles and generally accepted auditing standards.

Finally, with regard to capitation rate setting for certain Managed Care Organization (MCO) plans, **prior** approval must be obtained as required, in accordance with the regulations below:

- 42 CFR § 438.4(b) - Capitation rates for MCOs must be reviewed and approved by CMS as actuarially sound and must be provided to CMS in an approved format and within a timeframe that meets the requirements defined by 42 CFR § 438.7.
- 42 CFR § 438.7(a) - States must submit all MCO rate certifications concurrent with the review and approval process for contracts as specified in 42 CFR § 438.3(a).
- 42 CFR § 438.3(a) - CMS must review and approve all contracts, including those contracts that are not subject to the prior approval requirements in 42 CFR § 438.806. For states seeking approval of contracts prior to a specific effective date, proposed final contracts must be submitted to CMS for review no later than 90 days prior to the effective date of the contract.
- 42 CFR § 438.3(c) - The capitation rate and the receipt of capitation payments under the contract must be specifically identified in the applicable contract submitted for CMS review and approval.
- 42 CFR § 438.806(b) - For MCO contracts, **prior approval by CMS** is a condition of Federal Financial Participation (FFP) under any MCO contract that has a value equal to or greater than the following threshold amounts: $1,000,000 for 1998 (the value for all subsequent years is increased by the percentage increase in the consumer price index). FFP is not available in an MCO contract that does not have prior approval from CMS.

Condition and Context:
ALA reviewed the Dental Managed Care program and the Provider-Led Arkansas Shared Savings Entity (PASSE) managed care program for compliance with the various managed care MLR requirements. As a result of procedures performed, the following deficiencies were noted:

Finding Number:	**2021-023 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.767 – Children's Health Insurance Program** **93.778 – Medical Assistance Program (Medicaid Cluster)**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-2005AR5021; 05-2105AR5021 (Children's Health Insurance Program)** **05-2005AR5MAP; 05-2105AR5MAP (Medicaid Cluster)**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Allowable Costs/Cost Principles – Managed Care Medical Loss Ratio (PASSE and Dental)**
Type of Finding:	**Noncompliance and Material Weakness**

Condition and Context (Continued):
Dental Managed Care:

- Audited financial reports were not provided to the actuary for the three most recent and complete years prior to the reporting period. As the Dental Managed Care program was effective beginning on January 1, 2018, audited financial reports from calendar years 2018 and 2019 should have been provided.

PASSE:

- Audited financial reports were not provided to the actuary for the three most recent and complete years prior to the reporting period. As the PASSE managed care program was effective beginning on March 1, 2019, an audited financial report from calendar year 2019 should have been provided.
- No documentation was provided to substantiate that the Agency received **prior** approval from CMS for the calendar year 2021 rates prior to implementing the rates in January 2021. (Approval was subsequently received on August 17, 2021.)
- No documentation was provided to substantiate that the Agency received **prior** approval from CMS for the updated PASSE contracts that were effective January 1, 2021. (Approval was subsequently received on August 17, 2021.)

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
Unknown

Cause:
The Agency did not adequately develop or implement procedures to ensure that the various managed care MLR requirements were met.

Effect:
Failure to adequately develop and implement appropriate internal control procedures limits the Agency's ability to adequately monitor the program to ensure compliance.

Recommendation:
ALA staff recommend the Agency immediately develop and implement control procedures for managed care MLR requirements for both the Dental and PASSE managed care programs to ensure the required audited financial reports are provided and that current capitation rates paid received prior approval from CMS as required.

Finding Number:	**2021-023 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.767 – Children's Health Insurance Program** **93.778 – Medical Assistance Program (Medicaid Cluster)**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-2005AR5021; 05-2105AR5021 (Children's Health Insurance Program)** **05-2005AR5MAP; 05-2105AR5MAP (Medicaid Cluster)**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Allowable Costs/Cost Principles – Managed Care Medical Loss Ratio (PASSE and Dental)**
Type of Finding:	**Noncompliance and Material Weakness**

Views of Responsible Officials and Planned Corrective Action:
DHS concurs with this finding. The agency will update its documented controls to ensure appropriate review of audited financial reports for PASSE and Dental Managed Care, and timely submission of PASSE rates and contracts to CMS.

Anticipated Completion Date: Complete

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Finding Number:	**2021-024**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.767 – Children's Health Insurance Program** **93.778 – Medical Assistance Program (Medicaid Cluster)**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-2005AR5021; 05-2105AR5021 (Children's Health Insurance Program)** **05-2005AR5MAP; 05-2105AR5MAP (Medicaid Cluster)**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Matching, Level of Effort, Earmarking**
Type of Finding:	**Material Noncompliance and Material Weakness**

Repeat Finding:
A similar issue was reported in prior-year findings **2020-017** and **2019-017**.

Criteria:
In accordance with 45 CFR § 95.507(4), the Agency's established Cost Allocation Plan is required to contain sufficient information in such detail to permit the Director - Division of Cost Allocation, after consulting with the Operating Divisions, to make an informed judgment on the correctness and fairness of the State's procedures for identifying, measuring, and allocating all costs to each of the programs operated by the Agency.

42 CFR § 433.10 and § 433.15 established rates to be used to calculate non-administrative and administrative state match and require that the state pay part of the costs for providing and administering the Medical Assistance Program (MAP).

In addition, 45 CFR § 75.303 states that a non-federal entity must "*take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings*."

Condition and Context:
Procedures implemented by the Agency to monitor state general revenues and other non-federal revenues used to "match" the federal grant award monies are not sufficiently detailed to determine the state match requirements were met for the MAP and the Children's Health Insurance Program (CHIP).

As a result, the Agency was again unable to provide sufficient documentation for ALA to complete testing to determine if the State met the required match in accordance with federal regulations.

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
Unknown

Cause:
The Agency does not maintain documentation identifying the original source of revenues for the category "*other non-federal.*" Additionally, the Agency utilizes an outside accounting system, Lotus 1-2-3, to maintain and trace *state general revenue* and *other non-federal* funds available. Agency staff manually key information into this system daily; however, no reviews or other controls are in place to ensure the accuracy of the funding category balances. Agency procedures implemented to monitor the use of *state general revenue* and *other non-federal* funding sources are completed at the Division level and are not broken out to the federal program level.

Effect:
The Agency's inadequate controls result in a failure to document the required State match and could limit the Agency's resources to ensure the State can continue to provide benefits.

Finding Number:	**2021-024 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.767 – Children's Health Insurance Program** **93.778 – Medical Assistance Program (Medicaid Cluster)**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-2005AR5021; 05-2105AR5021 (Children's Health Insurance Program)** **05-2005AR5MAP; 05-2105AR5MAP (Medicaid Cluster)**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Matching, Level of Effort, Earmarking**
Type of Finding:	**Material Noncompliance and Material Weakness**

Recommendation:
ALA staff recommend the Agency immediately implement appropriate controls to allow the Agency to track funding sources used to meet state match requirements for federal programs.

Views of Responsible Officials and Planned Corrective Action:
DHS disputes, in part, and concurs, in part, with this finding. While the agency maintains documentation identifying funds classified as "other non-federal" in its fund control ledgers, the funds could be documented with greater specificity. The agency is in the process of operationalizing its new general ledger system, which will provide greater specificity in tracking general revenue and "other non-federal" funds.

Anticipated Completion Date: June 15, 2022

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Finding Number:	**2021-025**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.767 – Children's Health Insurance Program** **93.778 – Medicaid Assistance Program (Medicaid Cluster)**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-2005AR5021; 05-2105AR5021 (Children's Health Insurance Program)** **05-2005AR5MAP; 05-2105AR5MAP (Medicaid Cluster)**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Reporting**
Type of Finding:	**Noncompliance and Significant Deficiency**

Repeat Finding:
A similar issue was reported in prior-year finding **2020-024**.

Criteria:
42 CFR 430.30(c) requires submission of a quarterly statement of expenditures report (CMS-64) for the Medical Assistance Program (MAP). Amounts reported on the CMS-64 must be an accurate and complete accounting of actual expenditures.

Condition and Context:
ALA staff performed testing of expenditures reported on the CMS-64 for the quarters ending September 30, 2020, and December 31, 2020, to confirm accuracy and completeness with the expenditures recorded in the Agency's financial management system. ALA review revealed the following errors:

- From the September 30, 2020, CMS-64 report, 24 line items totaling $1,521,563,513 and representing 89.09% of MAP expenditures were selected. ALA identified an uncorrected error on one item, resulting in an **overstatement** of the federal portion of expenditures totaling $853,817.
- From the December 31, 2020, CMS-64 report, 26 line items totaling $1,726,378,270 and representing 90.89% of MAP expenditures were selected. ALA identified an uncorrected error on one item, resulting in an **overstatement** of the federal portion of expenditures totaling $1,067,478.

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
$1,921,295

Cause:
The State portion for some Medicaid and CHIP expenditures is paid from tobacco settlement funds. At the time these funds are used, all expenditures are recorded in the Agency's financial systems as Medicaid expenditures. During the reporting process, the Agency identifies the CHIP portion of these expenditures and manually adjusts the amount reported on the CMS-21 report. When making this adjustment, the Agency erroneously adjusted MCHIP expenditures reported on the CMS-64.21U form instead of adjusting the MAP expenditures reported on the CMS-64.9 base form.

Effect:
Expenditure amounts reported on the quarterly statement of expenditures report (CMS-64) were overstated for the Medical Assistance Program and understated for the MCHIP program; therefore, federal funding for the expenditures was received from the incorrect grant award and at the incorrect rate.

Finding Number:	**2021-025 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.767 – Children's Health Insurance Program** **93.778 – Medicaid Assistance Program (Medicaid Cluster)**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-2005AR5021; 05-2105AR5021 (Children's Health Insurance Program)** **05-2005AR5MAP; 05-2105AR5MAP (Medicaid Cluster)**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Reporting**
Type of Finding:	**Noncompliance and Significant Deficiency**

Recommendation:
ALA staff recommend the Agency perform a thorough review of the supporting documentation for all manual adjustments and verify the accuracy of these adjustments. ALA further recommends the Agency correct identified errors by entering prior period adjustments on subsequent CMS-64 reports.

Views of Responsible Officials and Planned Corrective Action:
DHS concurs with this finding. The agency corrected the error made for the Tobacco Funded Adjustment in its CMS-64 workbook and will make a prior period adjustment on the CMS-64 to correct the overstatement of expenditures.

Anticipated Completion Date: July 31, 2022

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Finding Number:	**2021-026**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.767 – Children's Health Insurance Program** **93.778 – Medical Assistance Program (Medicaid Cluster)**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-2005AR5021; 05-2105AR5021 (Children's Health Insurance Program)** **05-2005AR5MAP; 05-2105AR5MAP (Medicaid Cluster)**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Special Tests and Provisions – Managed Care Medical Loss Ratio (PASSE and Dental)**
Type of Finding:	**Noncompliance and Material Weakness**

Repeat Finding:
Not applicable

Criteria:
In a final rule, published in the Federal Register on May 6, 2016 (81 FR 27498), CMS adopted Medical Loss Ratio (MLR) requirements for Medicaid and Children's Health Insurance Program (CHIP) managed care programs. One of the requirements is that a state must require each Medicaid managed care plan to calculate and report an MLR for rating periods starting on or after July 1, 2017. Each CHIP managed care plan is required to calculate and report an MLR for rating periods for state fiscal years beginning on or after July 1, 2018.

42 CFR § 438.8 contains various requirements related to the MLR report, including that that managed care entities attest to the accuracy of the MLR reports. In addition, MLR reports must contain the 13 required data elements noted below:

(i) Total incurred claims.
(ii) Expenditures on quality improving activities.
(iii) Fraud prevention activities as defined at 42 CFR § 438.8 (e) (4).
(iv) Non-claims costs.
(v) Premium revenue.
(vi) Taxes, licensing, and regulatory fees.
(vii) Methodology for allocation of expenditures.
(viii) Any credibility adjustment applied.
(ix) The calculated MLR.
(x) Any remittance owed to the State, if applicable.
(xi) A comparison of the information reported in this paragraph with the audited financial report required under 42 CFR § 438.3 (m).
(xii) A description of the aggregation method used under 42 CFR § 438.8 (i).
(xiii) The number of member months.

Condition and Context:
ALA reviewed the Dental Managed Care program and the Provider-Led Arkansas Shared Savings Entity (PASSE) managed care program for compliance with the various managed care MLR requirements. As result of procedures performed, the following deficiencies were noted:

Finding Number:	**2021-026 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.767 – Children's Health Insurance Program** **93.778 – Medical Assistance Program (Medicaid Cluster)**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-2005AR5021; 05-2105AR5021 (Children's Health Insurance Program)** **05-2005AR5MAP; 05-2105AR5MAP (Medicaid Cluster)**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Special Tests and Provisions – Managed Care Medical Loss Ratio (PASSE and Dental)**
Type of Finding:	**Noncompliance and Material Weakness**

Condition and Context (Continued):
Dental Managed Care:

- The MLR report submission, for both entities that participate in the Dental Managed Care program, did not contain 4 of the 13 data elements required. Items (iii), (vii), (xi), and (xii) were missing.
- One of the Dental Managed Care entities submitted a revised MLR calculation, but the new MLR did not include a new attestation of accuracy.

PASSE:

- The MLR report submission, for the 3 entities that participate in the PASSE managed care program, did not contain 4 of the 13 data elements required. Items (iii), (vii), (xi), and (xii) were missing.

Statistically Valid Sample:
Not applicable

Questioned Costs:
Unknown

Cause:
The Agency did not adequately develop or implement procedures to ensure that the various managed care MLR requirements were met.

Effect:
Failure to develop and implement appropriate internal control procedures limits the Agency's ability to adequately monitor the programs to ensure compliance.

Recommendation:
ALA staff recommend the Agency develop and implement control procedures for managed care MLR requirements for both the Dental and PASSE managed care programs to ensure compliance.

Views of Responsible Officials and Planned Corrective Action:
DHS concurs with this finding. The agency will update the MLR report used by PASSE and Dental Managed Care entities to include all required data elements and an attestation of accuracy.

Finding Number:	**2021-026 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.767 – Children's Health Insurance Program** **93.778 – Medical Assistance Program (Medicaid Cluster)**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-2005AR5021; 05-2105AR5021 (Children's Health Insurance Program)** **05-2005AR5MAP; 05-2105AR5MAP (Medicaid Cluster)**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Special Tests and Provisions – Managed Care Medical Loss Ratio (PASSE and Dental)**
Type of Finding:	**Noncompliance and Material Weakness**

Views of Responsible Officials and Planned Corrective Action (Continued):

Anticipated Completion Date: Complete

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Finding Number:	**2021-027**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.767 – Children's Health Insurance Program** **93.778 – Medical Assistance Program (Medicaid Cluster)**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-2005AR5021; 05-2105AR5021 (Children's Health Insurance Program)** **05-2005AR5MAP; 05-2105AR5MAP (Medicaid Cluster)**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Special Tests and Provisions – Managed Care Financial Audits (PASSE and Dental)**
Type of Finding:	**Noncompliance and Material Weakness**

Repeat Finding:
Not applicable

Criteria:
42 CFR § 438.3 (m) states that managed care contracts must require Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), and Prepaid Ambulatory Health Plans (PAHPs) to submit audited financial reports conducted in accordance with generally accepted accounting principles and generally accepted auditing standards specific to the Medicaid contract on an annual basis.

In addition, 42 CFR § 438.602 (e) states that an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, any MCO, PIHP, or PAHP must be conducted at least every three years.

Condition and Context:
ALA performed testing to ensure that both the annual audited financial reports as well as the periodic reviews were performed for the applicable managed care program entities and that the reports and reviews were in compliance with federal regulations.

Three managed care organizations participated in the Provider-Led Arkansas Shared Savings Entity (PASSE) managed care program, and two dental managed care entities that participated in the Dental Managed Care program.

The results of our testing revealed that although audited financial reports were provided by all of the PASSE and Dental Managed Care entities, they were not in accordance with generally accepted accounting principles. In addition, the audits for the two dental managed care entities were not specific to the Medicaid contract.

Finally, the periodic reviews for the two dental managed care entities completed by the external quality review organization did not include the required financial data.

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
None

Cause:
The Agency did not adequately monitor the submission of reports to ensure they complied with federal regulations.

Effect:
Failure to monitor the adequacy of the reports submitted led to the Agency not identifying that the reports received did not comply with federal regulations.

Finding Number:	**2021-027 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.767 – Children's Health Insurance Program** **93.778 – Medical Assistance Program (Medicaid Cluster)**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-2005AR5021; 05-2105AR5021 (Children's Health Insurance Program)** **05-2005AR5MAP; 05-2105AR5MAP (Medicaid Cluster)**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Special Tests and Provisions – Managed Care Financial Audits (PASSE and Dental)**
Type of Finding:	**Noncompliance and Material Weakness**

Recommendation:
ALA staff recommend the Agency strengthen monitoring controls to ensure that all reports received are in compliance with requirements included in the federal regulations.

Views of Responsible Officials and Planned Corrective Action:
DHS concurs with this finding. The agency has updated the Dental Managed Care (DMC) contract to require DMC entities to perform and provide financial audit reports that have been audited in accordance with GAAP. The agency will update financial reporting templates used by PASSE and DMC entities to include an attestation that the financial reports were audited in accordance with GAAP. The agency will also provide the EQRO and its contracted actuary with the audited financial statements for both PASSE and DMC entities.

Anticipated Completion Date: July 1, 2022

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Finding Number:	**2021-028**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.767 – Children's Health Insurance Program** **93.778 – Medical Assistance Program (Medicaid Cluster)**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-2005AR5021; 05-2105AR5021 (Children's Health Insurance Program)** **05-2005AR5MAP; 05-2105AR5MAP (Medicaid Cluster)**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Special Tests and Provisions – Managed Care Financial Audits (PASSE and Dental)**
Type of Finding:	**Material Weakness**

Repeat Finding:
Not applicable

Criteria:
In accordance with 45 CFR § 75.302(b)(7), a non-federal entity must establish written procedures to implement and determine the allowability of costs in accordance with Uniform Administrative Requirements, Cost Principles, and Audit Requirements, as well as the terms and conditions of the federal award.

In addition, 45 CFR § 75.303 states that a non-federal entity must:

- Establish and maintain effective internal control over the federal award that provides reasonable assurance that the non-federal entity is managing the federal award in compliance with federal statutes, regulations, and the terms and conditions of the award. These controls should comply with Green Book or COSO guidance.
- Evaluate and monitor its compliance with the award.
- Take prompt action when instances of noncompliance are identified, including noncompliance identified in audit findings.

Finally, 42 CFR § 438.3 (m) states that managed care contracts must require Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), and Prepaid Ambulatory Health Plans (PAHPs) to submit audited financial reports conducted in accordance with generally accepted accounting principles (GAAP) and generally accepted auditing standards (GAAS) specific to the Medicaid contract on an annual basis.

Condition and Context:
The Agency failed to establish documented internal controls for this compliance area.

In addition, ALA performed testing to determine if there was sufficient, adequate language in the managed care contracts and agreements for PASSE and Dental Managed Care regarding audited financial reports. Our review revealed that adequate language was not included in the Dental Managed Care contract requiring that the annual financial audit be performed.

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
None

Cause:
The Agency did not adequately develop or document internal control procedures for its staff or ensure that adequate language was contained in the Dental Managed Care contract regarding audited financial reports.

Finding Number:	**2021-028 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.767 – Children's Health Insurance Program** **93.778 – Medical Assistance Program (Medicaid Cluster)**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-2005AR5021; 05-2105AR5021 (Children's Health Insurance Program)** **05-2005AR5MAP; 05-2105AR5MAP (Medicaid Cluster)**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Special Tests and Provisions – Managed Care Financial Audits (PASSE and Dental)**
Type of Finding:	**Material Weakness**

Effect:
Failure to adequately document and implement appropriate procedures for internal control limits the Agency's ability to adequately monitor the programs for possible noncompliance.

Recommendation:
ALA staff recommend the Agency develop and document internal controls for Managed Care Financial Audits for both PASSE and Dental Managed Care to aid in ensuring compliance. In addition, the Agency should update the language in the Dental Managed Care contract to require audited financial reports, in accordance with 42 CFR § 438.3 (m).

Views of Responsible Officials and Planned Corrective Action:
DHS concurs with this finding. The agency has updated the dental managed care (DMC) contract to require DMC entities to perform and provide financial audit reports that have been audited in accordance with GAAP. The agency will update financial reporting templates used by PASSE and DMC entities to include an attestation that the financial reports were audited in accordance with GAAP.

Anticipated Completion Date: July 1, 2022

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Finding Number:	**2021-029**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.767 – Children's Health Insurance Program**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-2005AR5021; 05-2105AR5021**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Special Tests and Provisions – Provider Eligibility (Fee-for-Service)**
Type of Finding:	**Noncompliance and Material Weakness**

Repeat Finding:
A similar issue was reported in prior-year findings **2020-019** and **2019-006**.

Criteria:
According to Provider Manual Section 140.000, Provider Participation, any provider of health services must be enrolled in the Arkansas Medicaid Program prior to reimbursement for any services provided to Arkansas Medicaid beneficiaries. Enrollment is considered complete when a provider has signed and submitted the following forms:

- Application.
- W-9 tax form.
- Medicaid provider contract.
- PCP agreement, if applicable.
- EPSDT agreement, if applicable.
- Change in ownership control or conviction of crime form.
- Disclosure of significant business transactions form.
- Specific license or certification based on provider type and specialty, if applicable.
- Participation in the Medicare program, if applicable.

42 CFR § 455.414 (effective March 25, 2011, with an extended deadline of September 25, 2016, for full compliance) states that the State Medicaid Agency must revalidate the enrollment of all providers at least every five years. Revalidation includes a new application; satisfactory completion of screening activities; and if applicable, fee payment. Screening activities vary depending on the risk category of the provider as follows:

- The limited-risk category includes database checks.
- The moderate-risk category includes those required for limited plus site visits.
- The high-risk category includes those required for moderate plus fingerprint background checks.

Condition and Context:
From a population of 5,853 providers, ALA staff reviewed files of 40 providers to ensure sufficient, appropriate evidence was provided to support the determination of eligibility, including compliance with revalidation requirements. Our review revealed deficiencies with 7 of the provider files as follows:

Moderate-risk category:

- Sample item 23: The Agency failed to perform the additional screening requirement (site visit). In addition, the Agency did not provide documentation of the provider's licensure that covered the entire enrollment period. Questioned costs totaled $264.
- Sample item 35: The provider's revalidation was due by September 25, 2016, but was not performed until December 10, 2020. The Agency also failed to perform the additional screening requirement (site visit). In addition, the Agency did not provide documentation of the provider's contract, application, W-9, licensure, disclosure forms, or background check that covered the entire enrollment period. Questioned costs totaled $1,346.

Finding Number:	**2021-029 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.767 – Children's Health Insurance Program**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-2005AR5021; 05-2105AR5021**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Special Tests and Provisions – Provider Eligibility (Fee-for-Service)**
Type of Finding:	**Noncompliance and Material Weakness**

Condition and Context (Continued):

- Sample item 40: The Agency failed to perform the additional screening requirement (site visit). In addition, the Agency did not provide documentation of the provider's certification that covered the entire enrollment period. Questioned costs totaled $7,422.

Limited-risk category:

- Sample item 7: The provider's revalidation was due by September 25, 2016, but was not performed until April 12, 2021. In addition, the Agency did not provide documentation of the provider's W-9 form, disclosure forms, or background check that covered the entire enrollment period. Questioned costs totaled $254.
- Sample item 13: The provider's revalidation was due by September 25, 2016, but was not performed until April 18, 2019. Questioned costs totaled $1,631.
- Sample item 14: The provider's revalidation was due by September 25, 2016, but was not performed until January 13, 2020. Questioned costs totaled $713.
- Sample item 15: The provider's revalidation was due by September 25, 2016, but was not performed until April 15, 2021. In addition, the Agency did not provide documentation of the provider's disclosure forms or a background check that covered the entire enrollment period. Questioned costs totaled $194.

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
$11,824

Due to the Coronavirus pandemic, the Centers for Medicare and Medicaid Services (CMS), under section 1135(b)(1)(B) of the Social Security Act, **approved Arkansas's request to temporarily cease revalidation**, including screening requirements, of providers who are located in Arkansas or are otherwise directly impacted by the emergency. This was effective beginning March 1, 2020, and continues until the termination of the public health emergency, including any extensions. **As a result, questioned costs were not calculated for the errors regarding late or overdue revalidations for those payments made to providers on or after March 1, 2020.**

Cause:
The Agency had asserted that, effective May 31, 2019, it established and implemented new procedures to improve the following areas of provider enrollment: maintenance of provider enrollment application documents, provider revalidation, site visits, and fingerprint background requirements. However, due to the timing of implementation of the new procedures, deficiencies continued to exist during fiscal year 2021.

Effect:
Claims were processed and paid to providers that did not meet all the required elements and, therefore, were ineligible.

Recommendation:
ALA staff recommend the Agency review and strengthen controls to ensure required enrollment documentation is maintained to support provider eligibility.

Finding Number:	**2021-029 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.767 – Children's Health Insurance Program**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-2005AR5021; 05-2105AR5021**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Special Tests and Provisions – Provider Eligibility (Fee-for-Service)**
Type of Finding:	**Noncompliance and Material Weakness**

Views of Responsible Officials and Planned Corrective Action:
DHS concurs, in part, and disputes, in part, this finding.

Effective May 31, 2019, DMS established and implemented new procedures to improve the following areas of provider enrollment: maintenance of provider application documents, provider revalidation, site visits and fingerprint background requirements. Three of the seven deficient provider files relate to non-compliance with revalidation requirements pre-dating May 31, 2019. The deficiencies noted that occurred prior to May 31, 2019, will be corrected upon revalidation of the provider. The DHS Office of Payment Integrity and Internal Audit also conducts regular provider eligibility compliance reviews and reports its findings to DMS.

Two of the seven deficient providers did not submit an application for revalidation or updated proof of certification. The agency sent multiple notifications to the provider concerning the requirement to revalidate and provide proof of certification. DHS has not terminated the providers due to the suspension of terminations during the COVID-19 federal public health emergency.

The agency disputes two deficiencies in which it was noted that the agency failed to provide disclosure forms and proof of background checks for providers. In these two instances, the agency relied upon screening of the providers performed by Medicare as permitted by 42 CFR §455.410(c)(1).

Anticipated Completion Date: Complete

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Finding Number:	**2021-030**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.767 – Children's Health Insurance Program**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-2005AR5021; 05-2105AR5021**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Special Tests and Provisions – Provider Eligibility (Managed Care Organizations)**
Type of Finding:	**Noncompliance and Material Weakness**

Repeat Finding:
A similar issue was reported in prior-year findings **2020-020** and **2019-007**.

Criteria:
According to Provider Manual Section 140.000, Provider Participation, any provider of health services must be enrolled in the Arkansas Medicaid Program prior to reimbursement for any services provided to Arkansas Medicaid beneficiaries. Managed Care Network providers must also be enrolled in the Arkansas Medicaid Program. Enrollment is considered complete when a provider has signed and submitted the following forms:

- Application.
- W-9 tax form.
- Medicaid provider contract.
- PCP agreement, if applicable.
- EPSDT agreement, if applicable.
- Change in ownership control or conviction of crime form.
- Disclosure of significant business transactions form.
- Specific license or certification based on provider type and specialty, if applicable.
- Participation in the Medicare program, if applicable.

42 CFR § 455.414 (effective March 25, 2011, with an extended deadline of September 25, 2016, for full compliance) states that the State Medicaid Agency must revalidate the enrollment of all providers at least every five years. Revalidation includes a new application; satisfactory completion of screening activities; and if applicable, fee payment. Screening activities vary depending on the risk category of the provider as follows:

- The limited-risk category includes database checks.
- The moderate-risk category includes those required for limited plus site visits.
- The high-risk category includes those required for moderate plus fingerprint background checks.

Condition and Context:
To determine if Managed Care Network providers met all necessary criteria to participate in the Medicaid program, ALA staff selected 40 provider files from a population of 2,843 for review. The providers selected participated in the Dental Managed Care program, commonly referred to as Healthy Smiles, and the Provider-Led Arkansas Shares Savings Entity, or PASSE, managed care program. ALA review revealed deficiencies with 7 of the provider files as follows:

Moderate-risk category:

- Sample item 21: The Agency did not perform the additional screening requirement (site visit). In addition, the Agency did not provide documentation of the required disclosure forms that covered the entire enrollment period. Ineligible costs totaled $1,503.
- Sample item 24: The Agency did not perform the additional screening requirement (site visit). In addition, the Agency did not provide documentation of the application that covered the entire enrollment period. Ineligible costs totaled $93.

Finding Number:	**2021-030 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.767 – Children's Health Insurance Program**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-2005AR5021; 05-2105AR5021**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Special Tests and Provisions – Provider Eligibility (Managed Care Organizations)**
Type of Finding:	**Noncompliance and Material Weakness**

Condition and Context (Continued):

- Sample item 31: The Agency did not perform the additional screening requirement (site visit). In addition, the Agency did not provide documentation of the provider's certification that covered the entire enrollment period. Ineligible costs totaled $2,075.

Limited-risk category:

- Sample item 4: The provider's revalidation was due by September 25, 2016, but was not performed until April 12, 2021. In addition, the Agency did not provide documentation of the required W-9 form, disclosure forms, or the background check that covered the entire enrollment period. Ineligible costs totaled $100.
- Sample item 12: The provider's revalidation was due by September 25, 2016, but was never performed. In addition, the Agency did not provide documentation of the disclosure forms or the background check that covered the entire enrollment period. Ineligible costs totaled $97.
- Sample item 25: The provider's revalidation was due by September 25, 2016, but was never performed. In addition, the Agency did not provide documentation of the disclosure forms or the background check that covered the entire enrollment period. Ineligible costs totaled $119.
- Sample item 28: The provider's revalidation was due by December 7, 2016, but was not completed until September 5, 2019. In addition, the Agency did not provide documentation of the provider's licensure covering the entire enrollment period. Ineligible costs totaled $781.

All ineligible costs identified above were PASSE payments totaling $4,768.

NOTE: Because these providers are participating in the managed care portion of CHIP, providers are reimbursed by the managed care organizations, not the Agency. The managed care organizations receive a predetermined monthly payment from the Agency in exchange for assuming the risk for the covered recipients.

These monthly payments are actuarially determined based, in part, upon historical costs data. Accordingly, the failure to remove unallowable cost data from the amounts utilized by the actuary would lead to overinflated future rates, which will be directly paid by the Agency.

In addition, due to the Coronavirus pandemic, the Centers for Medicare and Medicaid Services (CMS), under section 1135(b)(1)(B) of the Social Security Act, approved Arkansas's request to temporarily cease revalidation, including screening requirements, of providers who are located in Arkansas or are otherwise directly impacted by the emergency. This was effective as of March 1, 2020, and will continue until the termination of the public health emergency, including any extensions.

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
Unknown

Finding Number:	**2021-030 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.767 – Children's Health Insurance Program**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-2005AR5021; 05-2105AR5021**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Special Tests and Provisions – Provider Eligibility (Managed Care Organizations)**
Type of Finding:	**Noncompliance and Material Weakness**

Cause:
The Agency had asserted that, effective May 31, 2019, it established and implemented new procedures to improve the following areas of provider enrollment: maintenance of provider enrollment application documents, provider revalidation, site visits, and fingerprint background requirements. However, due to the timing of the implementation of the new procedures, deficiencies continued to exist during fiscal year 2021.

Effect:
Claims were processed and paid to providers that did not meet all the required criteria.

Recommendation:
ALA staff recommend the Agency strengthen controls to ensure required enrollment documentation is maintained to support provider eligibility.

Views of Responsible Officials and Planned Corrective Action:
DHS concurs, in part, and disputes, in part, this finding.

Effective May 31, 2019, DMS established and implemented new procedures to improve the following areas of provider enrollment: maintenance of provider application documents, provider revalidation, site visits and fingerprint background requirements. Three of the seven deficient provider files relate to non-compliance with revalidation requirements pre-dating May 31, 2019. The deficiencies noted that occurred prior to May 31, 2019, will be corrected upon revalidation of the provider. The DHS Office of Payment Integrity and Internal Audit also conducts regular provider eligibility compliance reviews and reports its findings to DMS.

Three of the seven deficient providers did not submit an application for revalidation or updated proof of certification. The agency sent multiple notifications to the provider concerning the requirement to revalidate and provide proof of certification. DHS has not terminated the providers due to the suspension of terminations during the COVID-19 federal public health emergency.

The agency disputes one deficiency in which it was noted that the agency failed to provide disclosure forms and a proof of background check for the provider. In this instance, the agency relied upon screening of the provider performed by Medicare as permitted by 42 CFR §455.410(c)(1).

Anticipated Completion Date: Complete

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Finding Number:	**2021-031**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.778 – Medical Assistance Program (Medicaid Cluster)**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-2005AR5MAP; 05-2105AR5MAP**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed – Home and Community-Based Services (ARChoices Waiver)**
Type of Finding:	**Noncompliance and Material Weakness**

Repeat Finding:
A similar issue was reported in prior-year findings **2020-021** and **2019-011**.

Criteria:
On January 1, 2019, the Arkansas Independent Assessment (ARIA) tool was used to determine the ARChoices level of care and aided in developing the beneficiary Patient-Centered Service Plan (PCSP). Attendant Care hours are determined utilizing the Task and Hour Standards (THS), which is the written methodology used by the Arkansas Department of Human Services (DHS) Registered Nurses (RNs) as the basis for calculating the number of attendant care hours that are reasonably and medically necessary. In addition, an Individual Service Budget (ISB) sets the maximum dollar amount for all waiver services received by an individual. Services must be provided according to the beneficiary's PCSP, with reimbursement limited to the monthly provision reflected on the PCSP.

Condition and Context:
ALA staff reviewed data for 40 beneficiaries to determine if a valid PCSP was in effect for all dates of service for which claims were paid and if attendant care services were provided in accordance with the beneficiary's PCSP and did not exceed the frequency or the maximum amount allowed. Our review revealed the following deficiencies regarding 14 beneficiaries:

- Sample item 3: Claims totaling $13,096 were paid without a valid PCSP for dates of service beginning June 1, 2020 through January 27, 2021.
- Sample item 4: Claims totaling $685 were paid without a valid PCSP for dates of service beginning June 8, 2020 through July 31, 2020.
- Sample item 9: Claims totaling $16,879 were paid without a valid PCSP for dates of service beginning June 15, 2020 through June 4, 2021.
- Sample item 12: Claims totaling $10,655 were paid without a valid PCSP for dates of service beginning June 15, 2020 through June 11, 2021.
- Sample item 14: Claims totaling $918 were paid without a valid PCSP for dates of service beginning January 1, 2021 through May 7, 2021.
- Sample item 17: Claims totaling $3,928 were paid without a valid PCSP for dates of service beginning June 25, 2020 through September 11, 2020.
- Sample item 20: Claims totaling $1,314 were paid without a valid PCSP for dates of service beginning June 1, 2020 through June 29, 2020.
- Sample item 21: Claims totaling $31,375 were paid without a valid PCSP for dates of service beginning June 14, 2020 through February 28, 2021.
- Sample item 22: Claims totaling $16,159 were paid without a valid PCSP for dates of service beginning May 31, 2020 through June 10, 2021.
- Sample item 26: Claims totaling $ 4,766 were paid without a valid PCSP for dates of service beginning June 16, 2020 through August 11, 2020.
- Sample item 28: Claims totaling $3,418 were paid without a valid PCSP for dates of service beginning June 22, 2020 through March 15, 2021.

Finding Number:	**2021-031 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.778 – Medical Assistance Program (Medicaid Cluster)**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-2005AR5MAP; 05-2105AR5MAP**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed – Home and Community-Based Services (ARChoices Waiver)**
Type of Finding:	**Noncompliance and Material Weakness**

Condition and Context (Continued):

- Sample item 29: Claims totaling $1,653 were paid without a valid PCSP for dates of service beginning June 15, 2020 through March 15, 2021.
- Sample item 36: Claims totaling $6,573 were paid without a valid PCSP for dates of service beginning June 15, 2020 through October 24, 2020.
- Sample item 39: Claims totaling $15,524 were paid without a valid PCSP for dates of service beginning April 1, 2020 through November 27, 2020.

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
In accordance with the Families First Coronavirus Response Act (FFCRA), states must provide continuous coverage, through the end of the month in which the emergency period ends, to all Medicaid beneficiaries who were enrolled in Medicaid on or after March 18, 2020, regardless of any changes in circumstances or redeterminations at scheduled renewals that otherwise would result in termination. As a result, questioned costs were not calculated for the claims paid without a valid PCSP.

Cause:
Prior to January 1, 2021, the Division of Aging, Adult, and Behavioral Health Services (DAABHS) provided OPTUM, the Agency contractor responsible for performing the independent assessments for the ARChoices program, with the referrals for the ARIAs based upon the month of expiration. Once the ARIAs were completed by OPTUM, they were forwarded to the Office of Long Term Care (OLTC) under Provider Services & Quality Assurance so that a DHS RN could review the assessment results to determine if the individual's assessed needs were consistent with services available through the ARChoices program. This determination was documented on a DHS Form 704. This form was then forwarded onto the Division of County Operations (DCO) to aid in determining recipient eligibility (medical necessity). Once this was done, the DHS Form 704 was then sent to DAABHS so that the process for completing a new PCSP could be started.

Effective January 1, 2021, unless identified as needed, ARIAs are not required to be performed for existing ARChoices recipients in order to develop a new PCSP. Reevaluations will continue to be performed on at least an annual basis, with the functional eligibility reaffirmed or revised and a written determination issued by the Office of Long Term Care, and an updated PCSP will be generated.

Delays in requesting, performing, and utilizing the information necessary to complete the PCSP as described above contributed to deficiencies noted with the beneficiaries' PCSP.

Effect:
Amounts paid were in excess of amounts authorized.

Finding Number:	**2021-031 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.778 – Medical Assistance Program (Medicaid Cluster)**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-2005AR5MAP; 05-2105AR5MAP**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed – Home and Community-Based Services (ARChoices Waiver)**
Type of Finding:	**Noncompliance and Material Weakness**

Recommendation:
ALA staff recommend the Agency review and strengthen its policies and procedures to ensure that all amounts paid are in accordance with amounts authorized and that amounts authorized are supported by both a current and valid PCSP and the CMS approved assessment tools, which are currently the ARIA assessment and THS.

Views of Responsible Officials and Planned Corrective Action:
DHS concurs with this finding. The agency has implemented a workflow management system and strategy to track and report re-evaluation activities that will ensure timely completion of Person-Centered Service Plan for ARChoices beneficiaries. Assessments are also being documented electronically, which allows for more effective tracking and planning.

Anticipated Completion Date: Complete

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Finding Number:	**2021-032**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.778 – Medical Assistance Program (Medicaid Cluster)**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-2005AR5MAP; 05-2105AR5MAP (Medicaid Cluster)**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Special Tests and Provisions – Provider Eligibility (Fee-for-Service)**
Type of Finding:	**Noncompliance and Material Weakness**

Repeat Finding:
A similar issue was reported in prior-year findings **2020-026** and **2019-006**.

Criteria:
According to Provider Manual Section 140.000, Provider Participation, any provider of health services must be enrolled in the Arkansas Medicaid Program prior to reimbursement for any services provided to Arkansas Medicaid beneficiaries. Enrollment is considered complete when a provider has submitted the following forms:

- Application.
- W-9 tax form.
- Medicaid provider contract.
- PCP agreement, if applicable.
- EPSDT agreement, if applicable.
- Change in ownership control or conviction of crime form.
- Disclosure of significant business transactions form.
- Specific license or certification based on provider type and specialty, if applicable.
- Participation in the Medicare program, if applicable.

42 CFR § 455.414 (effective March 25, 2011, with an extended deadline of September 25, 2016, for full compliance) states that the State Medicaid Agency must revalidate the enrollment of all providers at least every five years. Revalidation includes a new application; satisfactory completion of screening activities; and, if applicable, fee payment. Screening activities vary depending on the risk category of the provider as follows:

- The limited-risk category includes database checks.
- The moderate-risk category includes those required for limited, plus site visits.
- The high-risk category includes those required for moderate, plus fingerprint background checks.

Condition and Context:
From a population of 10,664, ALA staff reviewed files of 40 providers to ensure sufficient, appropriate evidence was provided to support the determination of eligibility, including compliance with revalidation requirements. Our review revealed deficiencies with 10 of the provider files as follows:

High-risk category:

- Sample item 38: The Agency failed to perform the additional screening requirements (site visit or fingerprint background check). In addition, the Agency did not provide documentation of the provider's professional certification that covered the entire engagement period. *Questioned costs totaled $105*.
- Sample item 40: The Agency failed to perform the additional screening requirements (site visit or fingerprint background check). In addition, the Agency did not provide documentation of the provider's professional certification that covered the entire engagement period. *Questioned costs totaled $45,640*.

Finding Number:	**2021-032 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.778 – Medical Assistance Program (Medicaid Cluster)**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-2005AR5MAP; 05-2105AR5MAP (Medicaid Cluster)**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Special Tests and Provisions – Provider Eligibility (Fee-for-Service)**
Type of Finding:	**Noncompliance and Material Weakness**

Condition and Context (Continued):
Moderate-risk category:

- Sample item 16: The Agency failed to perform the additional screening requirement (site visit) that coincided with the revalidation performed on September 18, 2015. *Questioned costs totaled $8,529*.
- Sample item 21: The Agency failed to perform the additional screening requirement (site visit) that was due by September 25, 2016, until the revalidation was performed on November 5, 2019. *Questioned costs totaled $371*.
- Sample item 24: The Agency failed to perform the additional screening requirement (site visit) that was due by September 25, 2016, until the revalidation was performed on May 14, 2019. *Questioned costs totaled $56*.
- Sample item 30: The Agency failed to perform the additional screening requirement (site visit) that coincided with its 2017 enrollment. *Questioned costs totaled $53*.
- Sample item 32: The provider's revalidation was due by September 25, 2016, but was not performed until January 3, 2020. *Questioned costs totaled $24*.
- Sample item 35: The provider's revalidation was due by September 25, 2016, but was not performed until March 20, 2020. *Questioned costs totaled $11,336*.

Limited-risk category:

- Sample item 8: The provider's revalidation was due by September 25, 2016, but was not performed until May 2, 2019. *Questioned costs totaled $65*.
- Sample item 31: The provider's revalidation was due by September 25, 2016, but was not performed until September 10, 2020. In addition, disclosure forms and standard background checks that covered the entire engagement period were not provided. *Questioned costs totaled $5,435*.

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
$71,614

Due to the Coronavirus pandemic, the Centers for Medicare and Medicaid Services (CMS), under section 1135(b)(1)(B) of the Social Security Act, **approved Arkansas's request to temporarily cease revalidation**, including screening requirements, of providers who are located in Arkansas or are otherwise directly impacted by the emergency. This was effective beginning March 1, 2020, and continues until the termination of the public health emergency, including any extensions. **As a result, questioned costs were not calculated for the errors regarding late or overdue revalidations for those payments made to providers on or after March 1, 2020.**

Finding Number:	**2021-032 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.778 – Medical Assistance Program (Medicaid Cluster)**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-2005AR5MAP; 05-2105AR5MAP (Medicaid Cluster)**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Special Tests and Provisions – Provider Eligibility (Fee-for-Service)**
Type of Finding:	**Noncompliance and Material Weakness**

Cause:
The Agency had asserted that, effective May 31, 2019, it established and implemented new procedures to improve the following areas of provider enrollment: maintenance of provider enrollment application documents, provider revalidation, site visits, and fingerprint background requirements. However, due to the timing of the implementation of the new procedures, deficiencies continued to exist during fiscal year 2021.

Effect:
Claims were processed and paid to providers that did not meet all the required elements and, therefore, were ineligible.

Recommendation:
ALA staff recommend the Agency strengthen controls to ensure required enrollment documentation is maintained to support provider eligibility.

Views of Responsible Officials and Planned Corrective Action:
DHS concurs with this finding. Effective May 31, 2019, DMS established and implemented new procedures to improve the following areas of provider enrollment: maintenance of provider application documents, provider revalidation, site visits and fingerprint background requirements. Eight of the ten deficient provider files relate to non-compliance with revalidation requirements pre-dating May 31, 2019. The deficiencies noted that occurred prior to May 31, 2019, will be corrected upon revalidation of the provider. The DHS Office of Payment Integrity and Internal Audit also conducts regular provider eligibility compliance reviews and reports its findings to DMS.

One of the ten deficient providers revalidated after the established revalidation deadline in SFY20. This provider submitted an application for revalidation which was not able to be processed by the revalidation deadline, due to incomplete information on the application. The provider was not terminated as the missing documentation was submitted to the agency.

One of the ten deficient providers did not submit an application for revalidation or proof of licensure and certification. The agency sent multiple notifications to this provider concerning the requirement to revalidate and produce proof of licensure and certification. DHS has not terminated the provider due to the suspension of terminations during the COVID-19 federal public health emergency.

Anticipated Completion Date: May 31, 2019

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Finding Number:	**2021-033**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.778 – Medical Assistance Program (Medicaid Cluster)**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-1905AR5MAP; 05-2005AR5MAP**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Special Tests and Provisions – Provider Eligibility (Managed Care Organizations)**
Type of Finding:	**Noncompliance and Material Weakness**

Repeat Finding:
A similar issue was reported in prior-year findings **2020-027** and **2019-007**.

Criteria:
According to Provider Manual Section 140.000, Provider Participation, any provider of health services must be enrolled in the Arkansas Medicaid Program prior to reimbursement for any services provided to Arkansas Medicaid beneficiaries. Managed Care Network providers must also be enrolled in the Arkansas Medicaid Program. Enrollment is considered complete when a provider has submitted the following forms:

- Application.
- W-9 tax form.
- Medicaid provider contract.
- PCP agreement, if applicable.
- EPSDT agreement, if applicable.
- Change in ownership control or conviction of crime form.
- Disclosure of significant business transactions form.
- Specific license or certification based on provider type and specialty, if applicable.
- Participation in the Medicare program, if applicable.

42 CFR § 455.414 (effective March 25, 2011, with an extended deadline of September 25, 2016, for full compliance) states that the State Medicaid Agency must revalidate the enrollment of all providers at least every five years. Revalidation includes a new application; satisfactory completion of screening activities; and if applicable, fee payment. Screening activities vary depending on the risk category of the provider as follows:

- The limited-risk category includes database checks.
- The moderate-risk category includes those required for limited, plus site visits.
- The high-risk category includes those required for moderate, plus fingerprint background checks.

Condition and Context:
To determine if Managed Care Network providers met all necessary criteria to participate in the Medicaid program, ALA staff selected 40 provider files from a population of 5,912 for review. The providers selected participated in the Dental Managed Care program, commonly referred to as Healthy Smiles, and the Provider-Led Arkansas Shared Savings Entity (PASSE) managed care program. ALA review revealed deficiencies with 6 of the provider files as follows:

Moderate-risk category:

- Sample item 21: The provider's revalidation was due by September 25, 2016, but was not performed until March 3, 2020. In addition, the Agency failed to perform the additional screening requirement (site visit) until the revalidation was performed on March 3, 2020, and did not provide documentation of the provider's certification that covered the entire engagement period. Ineligible costs totaled $4,377.

Finding Number:	**2021-033 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.778 – Medical Assistance Program (Medicaid Cluster)**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-1905AR5MAP; 05-2005AR5MAP**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Special Tests and Provisions – Provider Eligibility (Managed Care Organizations)**
Type of Finding:	**Noncompliance and Material Weakness**

Condition and Context (Continued):
Limited-risk category:

- Sample item 1: The provider's revalidation was due by September 25, 2016, but was not performed until April 5, 2019. In addition, the Agency could not provide the required W-9 that covered the entire enrollment period. Ineligible costs totaled $2,015.
- Sample item 8: The provider's revalidation was due by September 25, 2016, but was never performed. In addition, the Agency could not provide the required W-9, disclosure forms, or documentation of a standard background check for review. Ineligible costs totaled $23.
- Sample item 14: The provider's revalidation was due by September 25, 2016, but was not performed until May 23, 2019. In addition, the Agency could not provide the required W-9 that covered the entire enrollment period. Ineligible costs totaled $9,669,741.
- Sample item 23: The provider's revalidation was due by September 25, 2016, but was not performed until September 5, 2019. In addition, The Agency could not provide documentation of provider licensure that covered the entire enrollment period. Ineligible costs totaled $2,766.
- Sample item 38: The provider's revalidation was due by September 25, 2016, but was never performed. In addition, the Agency could not provide the required disclosure forms or documentation of a standard background check that covered the entire enrollment period. Ineligible costs totaled $292.

All ineligible costs identified above were PASSE payments totaling $9,679,214.

NOTE: Because these providers are participating in the managed care portion of Medicaid, providers are reimbursed by the managed care organizations, not the Agency. The managed care organizations receive a predetermined monthly payment from the Agency in exchange for assuming the risk for the covered recipients.

These monthly payments are actuarially determined based, in part, upon historical costs data. Accordingly, the failure to remove unallowable cost data from the amounts utilized by the actuary would lead to overinflated future rates, which will be directly paid by the Agency.

In addition, due to the Coronavirus pandemic, the Centers for Medicare and Medicaid Services (CMS), under section 1135(b)(1)(B) of the Social Security Act, approved Arkansas's request to temporarily cease revalidation, including screening requirements, of providers who are located in Arkansas or are otherwise directly impacted by the emergency. This was effective as of March 1, 2020, and will continue until the termination of the public health emergency, including any extensions.

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
Unknown

Finding Number:	**2021-033 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.778 – Medical Assistance Program (Medicaid Cluster)**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-1905AR5MAP; 05-2005AR5MAP**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Special Tests and Provisions – Provider Eligibility (Managed Care Organizations)**
Type of Finding:	**Noncompliance and Material Weakness**

Cause:
The Agency had asserted that, effective May 31, 2019, it established and implemented new procedures to improve the following areas of provider enrollment: maintenance of provider enrollment application documents, provider revalidation, site visits, and fingerprint background requirements. However, due to the timing of the implementation of the new procedures, deficiencies continued to exist during fiscal year 2021.

Effect:
Claims were processed and paid to providers that did not meet all the required elements.

Recommendation:
ALA staff recommend the Agency strengthen controls to ensure required enrollment documentation is maintained to support provider eligibility.

Views of Responsible Officials and Planned Corrective Action:
DHS concurs, in part, and disputes, in part, this finding.

Three of the six deficient providers did not submit an application for revalidation or updated proof of certification. The agency sent multiple notifications to the provider concerning the requirement to revalidate and provide proof of certification. DHS has not terminated the providers due to the suspension of terminations during the COVID-19 federal public health emergency.

The agency disputes three deficiencies in which it was noted that the agency failed to provide disclosure forms and proof of licensure for providers. In these three instances, the agency relied upon screening of the providers performed by Medicare as permitted by 42 CFR §455.410(c)(1).

Anticipated Completion Date: Complete

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Finding Number:	**2021-034**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.778 – Medical Assistance Program (Medicaid Cluster)**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-2005AR5MAP; 05-2105AR5MAP**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Special Tests and Provisions – Medicaid Fraud Control Unit**
Type of Finding:	**Noncompliance and Significant Deficiency**

Repeat Finding:
A similar issue was reported in prior-year findings **2020-014** and **2019-014**.

Criteria:
42 CFR § 433, Subpart F, establishes requirements for identifying overpayments to Medicaid providers and for refunding the federal portion of identified overpayments to the federal awarding agency. The provisions apply to overpayments discovered by a state, by a provider and made known to the state, or through federal review.

Also, in accordance with 42 CFR § 433.320, an agency must refund the federal share of overpayments that are subject to recovery by recording a credit on its Quarterly Statement of Expenditures (Form CMS-64). An agency must credit the federal share of overpayments on the earlier of (1) the CMS-64 submission due for the quarter in which the overpayment is recovered from the provider or (2) the quarter in which the one-year period following discovery, established in accordance with 42 CFR § 433.316, ends. A credit on the CMS-64 must be made whether or not the state has recovered the overpayment from the provider.

Additionally, as stated in a CMS letter to the State Health Official, SHO #08-004, in accordance with Sections 1903(d)(2)(A) and (d)(3)(A) of the Social Security Act, states are required to return "the federal share of Medicaid overpayments, damages, fines, penalties, and any other component of a legal judgment or settlement when a State recovers pursuant to legal action under its State False Claims Act (SFCA)."

Condition and Context:
ALA performed procedures to verify overpayments identified by the Medicaid Fraud Control Unit (MFCU) were properly reported on the quarterly CMS-64 report. The following errors were discovered:

- Payment for one settlement was made directly to the U.S. Department of Justice (DOJ). DOJ subsequently transferred the State's portion of the settlement, totaling $680,847, to the Agency. In error, the Agency applied the FMAP and reported $527,180 in overpayments on its CMS-64 report. As a result, the federal portion of MFCU related overpayments reported was overstated.
- Payment for one settlement, totaling $1,544,368, was not included on the CMS-64 report. The federal share that should have been reported for MFCU related overpayments was $1,195,804, resulting in an understatement.
- Payment representing a fine for a criminal conviction, totaling $250, was not reported on the CMS-64 report. The federal share that should have been reported for MFCU related overpayments was $194, resulting in an understatement.
- Unpaid restitution balances from previous fiscal years, totaling $270,201, were not included on the CMS-64. The federal share that should have been reported was $209,217, resulting in an understatement.

The net effect of the errors is an understatement totaling $878,035.

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
$878,035

Finding Number:	**2021-034 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
AL Number(s) and Program Title(s):	**93.778 – Medical Assistance Program (Medicaid Cluster)**
Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-2005AR5MAP; 05-2105AR5MAP**
Federal Award Year(s):	**2020 and 2021**
Compliance Requirement(s) Affected:	**Special Tests and Provisions – Medicaid Fraud Control Unit**
Type of Finding:	**Noncompliance and Significant Deficiency**

Cause:
The Agency's Accounts Receivable staff, who are responsible for monitoring balances and payments received representing Medicaid overpayments, do not have a full understanding of the reporting requirements. As a result, supporting documents compiled for the MFCU overpayments were not properly prepared.

Effect:
The Agency failed to report all required restitution and other judgments on its CMS-64 reports.

Recommendation:
ALA staff recommend the Agency review and strengthen its accounts receivable procedures and provide adequate training to all individuals involved in the collecting, recording, and reporting of provider overpayments identified by MFCU.

Views of Responsible Officials and Planned Corrective Action:
DHS concurs with this finding. The agency is updating its process for tracking Medicaid provider overpayments and will begin tracking all overpayments and corresponding collections in the Medicaid Management Information System, which will provide greater continuity in overpayment tracking, collection, and reporting.

Anticipated Completion Date: June 30, 2022

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