

ALC/JBC Budget Hearings
2020
AUDIT FINDINGS
For the
DEPARTMENT OF HUMAN SERVICES

.....
92nd GENERAL ASSEMBLY
OF THE STATE OF ARKANSAS

State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-001
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA Number(s) and Program Title(s): 10.558 – Child and Adult Care Food Program
10.560 – State Administrative Expenses for Child Nutrition
Federal Awarding Agency: U.S. Department of Agriculture
Federal Award Number(s): 6AR300322; 6AR300342; 6AR300302
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Cash Management
Type of Finding: Noncompliance and Material Weakness

Repeat Finding:

A similar issue was reported in prior-year finding 2018-002.

Criteria:

In accordance with 2 CFR § 200.400(b), a non-federal entity assumes responsibility for administering federal funds in a manner consistent with underlying agreements, program objectives, and the terms and conditions of the federal award.

Condition and Context:

The Agency receives the following grant awards for reimbursement payments to meal providers and sponsoring organizations:

- 1) CNP Block Consolidated (CFDA 10.555).
- 2) CNP CACFP Cash in Lieu (CFDA 10.558).
- 3) CNP CACFP Sponsor Administrative (CFDA 10.558).

The Agency receives the State Administrative Expenses (SAE) for Child Nutrition grant award (CFDA 10.560) for costs incurred to administer Child Nutrition programs, including CACFP.

Discussions with managerial accounting staff during the 2017 Statewide Single Audit revealed the practice of drawing funds for sponsor administrative and cash in lieu (CIL) expenditures from the CNP Block grant award and “repaying” the CNP Block grant award during the closeout period and when additional funds became available.

ALA correspondence with the federal awarding agency indicated that each grant award has a designated purpose, and funds are not to be used interchangeably among the grant awards. This correspondence was shared with the Agency’s managerial accounting staff on January 24, 2018, and with Agency management on February 8, 2018.

According to the Agency, corrective action was taken on or around October 1, 2018, to correct errors regarding the unallowable use of federal awards noted in the 2018 Single Audit.

ALA reviewed 39 cash draws that were completed in state fiscal year 2019 to determine if the Agency corrected its unallowable practices. The review of cash draws completed prior to October 1, 2018, revealed the following:

- \$164,969 of CIL expenditures, \$38,824 of sponsor administrative expenditures, and \$33,852 of state administrative expenditures were inappropriately drawn from the CNP Block grant award.

Additionally, the review of cash draws completed on or after October 1, 2018, revealed the following:

- \$246,959 of CIL expenditures and \$51,624 of sponsor administrative expenditures were inappropriately drawn from the CNP Block grant award.
- \$694,736 of meal reimbursement expenditures and \$16,668 sponsor administrative expenditures were inappropriately drawn from the CIL grant award.
- \$20,510 of CIL expenditures that occurred during federal fiscal year 2018 were inappropriately drawn from the federal fiscal year 2019 CIL grant award.

State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-001 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA Number(s) and Program Title(s): 10.558 – Child and Adult Care Food Program
10.560 – State Administrative Expenses for Child Nutrition
Federal Awarding Agency: U.S. Department of Agriculture
Federal Award Number(s): 6AR300322; 6AR300342; 6AR300302
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Cash Management
Type of Finding: Noncompliance and Material Weakness

Condition and Context (Continued):

Lastly, review of four cash draws from the SAE for Child Nutrition grant award revealed the following:

- \$238,973 of meal reimbursement expenditures and \$19,352 of sponsor administrative expenditures were inappropriately drawn from the SAE for Child Nutrition grant award.

ALA noted that managerial accounting staff prepared book entries to correct the erroneous drawing of funds from the CNP Block grant award for sponsor administrative expenditures and state administrative expenditures.

Statistically Valid Sample:

Not a statistically valid sample

Questioned Costs:

\$1,526,467

Cause:

The Agency did not establish procedures to ensure grant awards were adequately funded prior to processing federal cash draws.

Effect:

Funds were drawn for unallowable expenditures of the federal awards.

Recommendation:

ALA staff recommend the Agency establish procedures to ensure that staff properly monitor federal cash draws by reconciling with allowable expenditures and request additional funds when necessary.

Views of Responsible Officials and Planned Corrective Action:

DHS concurs with the finding. Subsequent to a similar finding in 2018, the agency corrected a programming error in its accounting dashboard system that was identified as the root cause of the error. For the current finding, the agency has identified the root cause of all the cash management issues as a result of incorrect fund mapping in the accounting dashboard system or adhoc draws that were incorrectly requested due to human error. The agency has worked with its contractor to create more specificity in the dashboard to link subaccounts to awards and program codes in order to prevent drawing from the wrong subaccount. Additionally, on January 29, 2020 the agency updated its Daily Draw Procedures and Policies to revise the process for completing adhoc draws.

Anticipated Completion Date: Complete

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State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-002
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1805AR5021; 05-1905AR5021
(Children’s Health Insurance Program)
05-1805AR5MAP; 05-1905AR5MAP
(Medicaid Cluster)
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Activities Allowed or Unallowed – Claims Payments
Type of Finding: Noncompliance and Material Weakness

Repeat Finding:

A similar issue was reported in prior-year finding 2018-007.

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 be in compliance 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.

This includes ensuring that claims paid because of manual or “forced” overrides are appropriate and sufficiently documented.

Condition and Context:

ALA requested the Agency’s written, “documented” procedures of controls over compliance for claims payments. Although the Agency provided documentation, it was dated subsequent to June 30, 2019. As a result, ALA concluded that written, “documented” procedures were not maintained during the audit period.

In addition, ALA staff reviewed 60 claims initially suspended in the Medicaid Management Information System (MMIS) but subsequently paid to determine if the claims were appropriately processed, in accordance with the established guidance in the Arkansas Resolution Manual (Manual). The Manual provides guidance regarding methods of correction for claims that are suspended due to system edits and audits. Methods of correction for claims include making manual adjustments to allow system processing, forcing the claim through the system for payment, or denying payment. Our review revealed the following deficiencies for four claims:

- One claim was suspended because it was identified as a duplicate. The Manual states that the appropriate method of correction is to deny the claim, but the Agency failed to follow the guidance in the Manual. Questioned costs totaled \$307. (Note: The Agency recouped this amount from the provider subsequent to ALA testing.)
- One claim was suspended because the recipient had coverage under a private health insurance policy during the dates of service of the claim. The Manual states that the appropriate method of correction is to deny the claim, but the Agency failed to follow the guidance in the Manual. Questioned costs totaled \$287. (Note: The Agency recouped this amount from the provider subsequent to ALA testing.)

State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-002 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1805AR5021; 05-1905AR5021
(Children’s Health Insurance Program)
05-1805AR5MAP; 05-1905AR5MAP
(Medicaid Cluster)
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Activities Allowed or Unallowed – Claims Payments
Type of Finding: Noncompliance and Material Weakness

Condition and Context (Continued):

- Two claims were suspended because they were missing a Medicare paid date. The Manual does not contain a method of correction directing a reviewer to manually override these claims. Questioned costs totaled \$450.

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
\$1,044 (Medicaid Cluster)

Cause:

The Agency has experienced staff turnover and did not develop or adequately document internal control procedures for its staff. These factors contributed to the Agency not having effective procedures in place to ensure that claims were being manually-processed for payment, in accordance with the documented, allowable methods contained in the Arkansas Resolution Manual.

Effect:

Failure to document and implement appropriate procedures for internal controls limits the Agency’s ability to adequately monitor the program for possible improper payments and noncompliance. For example, claims initially suspended and subsequently processed for payment could be unallowable.

Recommendation:

ALA staff recommend the Agency develop and document internal control procedures over claims payments to aid in ensuring compliance and proper payments.

In addition, ALA staff recommend the Agency specifically strengthen policies and procedures to ensure that the documented methods of correction included in the Arkansas Resolution Manual are complete and that the Agency adheres to these methods when manually forcing claims for payment.

Views of Responsible Officials and Planned Corrective Action:

DHS concurs with the finding. The agency has identified the root cause of the issue as human error. For two testing items, the agency noted that personnel at DXC, the contractor responsible for reviewing suspended claims in MMIS, had approved the claim in error. The payments for these claims have been recouped. Two of the claims were paid correctly and will not be recouped. Those payments were suspended as the result of a system error that has since been corrected by a CSR. The agency will develop a process to review a sample of claims that are suspended and then approved for payment by DXC. The agency will update its internal controls as necessary to comply with the guidelines of COSO or Greenbook.

Anticipated Completion Date: 5/10/2020

**State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019**

Finding Number: 2019-002 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1805AR5021; 05-1905AR5021
(Children’s Health Insurance Program)
05-1805AR5MAP; 05-1905AR5MAP
(Medicaid Cluster)
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Activities Allowed or Unallowed – Claims Payments
Type of Finding: Noncompliance and Material Weakness

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

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State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-003
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1805AR5021; 05-1905AR5021
(Children’s Health Insurance Program)
05-1805AR5MAP; 05-1905AR5MAP
(Medicaid Cluster)
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Activities Allowed or Unallowed;
Eligibility
Type of Finding: Noncompliance and Material Weakness

Repeat Finding:

A similar finding was reported in prior-year finding 2018-006.

Criteria:

In accordance with 45 CFR § 75.303, 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. These controls should be in compliance 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.

In addition, eligibility standards that all CHIP recipients must meet are defined by 42 CFR §§ 457.310, 457.315, and 457.320.

Condition and Context:

Similar deficiencies were discovered during our review of two compliance areas and are noted below. The claims data was provided by the Agency’s OPTUM Group.

Activities Allowed or Unallowed - ALA staff selected 60 CHIP recipients to determine if the associated claims were allowable, in accordance with the CHIP state plan and federal guidelines. Our review of the CURAM benefit history tab revealed that 8 of the 60 CHIP recipients, with claims totaling \$6,814, were shown as enrolled in Medicaid. However, the claims were being paid out of the CHIP federal award.

Eligibility - ALA staff selected 60 CHIP recipients to determine that the eligibility criteria were met. Our review of the CURAM benefit history tab revealed that 6 of the 60 CHIP recipients, with claims totaling \$2,396, were shown as enrolled in Medicaid. However, the claims were being paid out of the CHIP federal award.

ALA discussed these discrepancies with Division of County Operations (DCO) staff to determine why these claims were being paid out of the CHIP federal award. DCO staff stated that the recipients were determined to be retroactively eligible for Medicaid due to a change in circumstances during the audit period (i.e., change in household income).

ALA also inquired of management about why the CHIP claims data was not adjusted to accurately reflect the activity. The Agency stated that management decided an adjustment was not necessary. However, CMS is requiring corrective action by the Agency because, during this time period, CHIP claims were federally reimbursed at 100% while Medicaid claims were federally reimbursed at a lower rate of 70.87% in the quarter ended September 30, 2018, and 70.51% in the remaining quarters ended December 31, 2018, March 31, 2019, and June 30, 2019.

Statistically Valid Sample:

Not a statically valid sample

State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-003 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1805AR5021; 05-1905AR5021
(Children’s Health Insurance Program)
05-1805AR5MAP; 05-1905AR5MAP
(Medicaid Cluster)
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Activities Allowed or Unallowed;
Eligibility
Type of Finding: Noncompliance and Material Weakness

Questioned Costs:
\$9,210

(Known questioned costs greater than \$25,000 are required to be reported. The auditor must also report known questioned costs when likely questioned costs are greater than \$25,000.)

Cause:

Adequate system processing controls have not been designed or implemented to ensure that claims for recipients are appropriately reflected.

Effect:

Claims cannot be confirmed as accurately reported to the federal awarding agency and cannot be confirmed as funded at the appropriate federal rate.

Recommendation:

ALA staff recommend the Agency immediately design and implement internal controls over compliance to ensure that CHIP and Medicaid recipients’ claims are accurately reported to the federal awarding agency.

Views of Responsible Officials and Planned Corrective Action:

DHS concurs with the finding. The Agency will develop a procedure to identify and adjust claims with a change in eligibility category caused by retroactive eligibility start dates.

Anticipated Completion Date: 4/30/2020

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State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-004
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1805AR5021; 05-1905AR5021
(Children’s Health Insurance Program)
05-1805AR5MAP; 05-1905AR5MAP
(Medicaid Cluster)
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Eligibility
Type of Finding: Material Weakness

Repeat Finding:
Not applicable

Criteria:

In accordance with 45 CFR § 75.303, 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. These controls should be in compliance 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.

Condition and Context:

The Public Assistance Reporting Information System, or PARIS, is a data matching service that helps detect improper payments by checking if recipients of public assistance receive duplicate benefits in two or more states. It is administered by an Office of the Administration for Children and Families (ACF) within the federal Department of Health and Human Services.

ALA selected two quarters from state fiscal year 2019 for review to ensure that the Agency participated in the interstate PARIS match and that there was adequate supporting documentation to demonstrate that the Agency adequately reviewed any matches identified and to determine if those individuals were no longer residents of the State and, therefore, no longer eligible to receive benefits.

Our testing revealed that the Agency participated in the PARIS match for the two quarters selected for testing. In addition, the Agency was able to show documentation that the matches identified were adequately reviewed in the CURAM eligibility system. However, there was no documentation provided to prove that matches were adequately reviewed in the Arkansas Networked System for Welfare Eligibility and Reporting, or ANSWER, eligibility system.

Statistically Valid Sample:

Not a statistically valid sample

Questioned Costs:

Unknown

Cause:

The process to review the matches in the ANSWER system is a manual one, and a breakdown occurred at some point in that process. Additional information regarding the specific breakdown is currently unknown.

State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-004 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1805AR5021; 05-1905AR5021
(Children’s Health Insurance Program)
05-1805AR5MAP; 05-1905AR5MAP
(Medicaid Cluster)
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Eligibility
Type of Finding: Material Weakness

Effect:

Failure to comprehensively review the PARIS interstate matches could result in the Agency not identifying timely those individuals who are no longer residents of the State and are, thus, ineligible for benefits. As a result, improper payments could be made on behalf of those ineligible recipients.

Recommendation:

ALA staff recommend the Agency develop and document procedures to ensure that the PARIS interstate matches are reviewed timely to aid in preventing benefits from being made on behalf of ineligible recipients.

Views of Responsible Officials and Planned Corrective Action:

DHS concurs with the finding. While the matches were not completed in the ANSWER system, the agency participated in the PARIS match and received match data. The DCO Reporting Unit processed the November 2018 and May 2019 PARIS match in the Curam eligibility system. Due to staff turnover, the agency was unable to complete the November 2018 and May 2019 PARIS match in the ANSWER eligibility system. The agency has implemented a new process to ensure the PARIS match is processed every quarter in ANSWER. The process has been documented and a schedule put in place to ensure timely completion of the match. The new match process will be documented in the Business Review Board bi-monthly report. DCO executive management staff will be responsible for monitoring completion of the match.

Anticipated Completion Date: Completed

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**State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019**

Finding Number: 2019-005
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1805AR5021; 05-1905AR5021
(Children’s Health Insurance Program)
05-1805AR5MAP; 05-1905AR5MAP
(Medicaid Cluster)
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Special Tests and Provisions – Provider Eligibility
Type of Finding: Noncompliance and 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 be in compliance 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.

Condition and Context:

ALA requested written documentation of the Agency’s internal controls in place over the Provider Eligibility compliance area. The documentation provided was developed by the Agency during the audit period ending June 30, 2019, and, therefore, could not have been in place and effective at the onset of the audit period (i.e., July 1, 2018). Additionally, the documentation provided did not adequately address all components required.

Statistically Valid Sample:

Not a statistically valid sample

Questioned Costs:

None

Cause:

The Agency has experienced staff turnover and did not develop or document internal control procedures for its staff.

Effect:

Failure to document and implement appropriate procedures for internal control limits the Agency’s ability to adequately monitor the Medicaid and CHIP programs for possible improper payments made to ineligible providers.

Recommendation:

ALA staff recommend the Agency develop and document internal controls to aid in ensuring that payments are only made to eligible providers.

**State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019**

Finding Number: 2019-005 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1805AR5021; 05-1905AR5021
(Children’s Health Insurance Program)
05-1805AR5MAP; 05-1905AR5MAP
(Medicaid Cluster)
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Special Tests and Provisions – Provider Eligibility
Type of Finding: Noncompliance and Material Weakness

Views of Responsible Officials and Planned Corrective Action:

DHS concurs with the finding. Effective May 31, 2019, DMS 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. The agency will update its existing internal control to provide a more comprehensive overview of provider eligibility and control activities currently in place. Additionally, the internal control will be updated to include the missing COSO or Greenbook elements of control environment, risk assessment, and monitoring activities. The updated internal control will be provided to necessary staff.

Anticipated Completion Date: 4/30/2020

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State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-006
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1805AR5021; 05-1905AR5021
(Children’s Health Insurance Program)
05-1805AR5MAP; 05-1905AR5MAP
(Medicaid Cluster)
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Special Tests and Provisions –
Provider Eligibility (Fee-for-Service)
Type of Finding: Material Noncompliance and Material Weakness

Repeat Finding:

A similar issue was reported in prior-year finding 2018-020.

Criteria:

According to 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:

ALA staff reviewed 60 paid providers to ensure sufficient, appropriate evidence was provided to support the determination of eligibility, including compliance with revalidation requirements. ALA review revealed deficiencies with 35 of the provider files as follows:

High-risk category:

- One provider did not have a license on file covering the entire enrollment period.
- One provider did not have a contract on file covering the entire enrollment period.
- Two providers did not have an application on file covering the entire enrollment period.
- One provider did not have disclosure forms on file covering the entire enrollment period.

State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-006 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1805AR5021; 05-1905AR5021
(Children’s Health Insurance Program)
05-1805AR5MAP; 05-1905AR5MAP
(Medicaid Cluster)
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Special Tests and Provisions –
Provider Eligibility (Fee-for-Service)
Type of Finding: Material Noncompliance and Material Weakness

Condition and Context (Continued):

- Seven providers did not comply with the site visit and fingerprint background check screening requirements.
- One provider did not comply with the database checks screening requirement.
- One provider did not revalidate timely, either by the September 26, 2016, extended deadline or within the five years since the provider last enrolled.

Moderate-risk category:

- Two providers did not have certifications on file covering the entire enrollment period.
- One provider did not have an application on file covering the entire enrollment period.
- Two providers did not have disclosure forms on file covering the entire enrollment period.
- Nine providers did not comply with the site visit screening requirement.
- One provider did not comply with the database checks screening requirement.
- For two providers, a revalidation has not been performed.

Limited-risk category:

- Two providers did not have a license on file covering the entire enrollment period.
- Two providers did not have a contract on file covering the entire enrollment period.
- Three providers did not have an application on file covering the entire enrollment period.
- Five providers did not have a W-9 form on file covering the entire enrollment period.
- Two providers did not have documentation on file covering the entire enrollment period that offered proof of participation in the Medicare program.
- Seven providers did not have disclosure forms on file covering the entire enrollment period.
- For one provider, there was no documentation provided proving eligibility.
- Seven providers did not comply with the database checks screening requirement.
- Eleven providers did not revalidate timely, either by the September 26, 2016, extended deadline or within the five years since they last enrolled.
- For five providers, a revalidation had not been performed.

Statistically Valid Sample:

Not a statistically valid sample

Questioned Costs:

\$8,864,004 (Medicaid)

\$1,046,663 (CHIP)

**State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019**

Finding Number: 2019-006 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1805AR5021; 05-1905AR5021
(Children’s Health Insurance Program)
05-1805AR5MAP; 05-1905AR5MAP
(Medicaid Cluster)
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Special Tests and Provisions –
Provider Eligibility (Fee-for-Service)
Type of Finding: Material Noncompliance and Material Weakness

Cause:

Although the Agency has internal control procedures to review provider files to ensure sufficient, appropriate evidence is provided to support the Agency’s determination of eligibility, certain areas still require continued communication with and training of the appropriate personnel.

Effect:

Claims paid to ineligible providers were processed and paid.

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 disputes in part and concurs in part with the finding. Effective May 31, 2019, DMS 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.

The following information requested by ALA was available but was not provided due to agency mistake:

- The agency does have licenses on file for the three providers noted to not have a license that covered fiscal year 2019
- Of the two providers that did not have certifications on file, one was terminated and the other had an updated license that the agency was able to verify using the CMS website
- The agency has contracts for three providers noted to not have a contract on file for fiscal year 2019
- The agency has applications, either completed through the portal or revalidation, for the six providers noted
- The agency has W-9 forms for three of the five providers noted
- The agency has documentation showing active participation in the Medicare program for the two providers noted
- The agency has eight of the ten disclosure forms, which were completed in Pecos, for the providers listed
- The agency has documentation proving eligibility for the one provider noted to be missing
- Regarding the seven high risk providers out of compliance with additional screening requirements, the agency received approval from CMS to change moderate and high-risk providers
- The agency completed two of the nine site visits noted for moderate risk providers
- The agency completed six of the nine database checks screening for the listed providers
- The agency has completed two of the seven required revalidations for the listed providers

**State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019**

Finding Number: 2019-006 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1805AR5021; 05-1905AR5021
(Children’s Health Insurance Program)
05-1805AR5MAP; 05-1905AR5MAP
(Medicaid Cluster)
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Special Tests and Provisions –
Provider Eligibility (Fee-for-Service)
Type of Finding: Material Noncompliance and Material Weakness

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

Prior to testing for the next Single Audit, DHS will provide ALA with training and access to the system (Interchange) in which all provider eligibility documentation is maintained.

Anticipated Completion Date: 6/30/2020

Contact Person: Janet Mann
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Additional Comments from the Auditor:

The Agency stated it partially disputes and partially concurs with the finding. The portion of the finding it disputes is unclear.

State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-007
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1805AR5021; 05-1905AR5021
(Children’s Health Insurance Program)
05-1805AR5MAP; 05-1905AR5MAP
(Medicaid Cluster)
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Special Tests and Provisions –
Provider Eligibility (Managed Care Organizations)
Type of Finding: Material Noncompliance and Material Weakness
Repeat Finding:
Not applicable

Criteria:

According to 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 60 paid provider files 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 40 of the provider files as follows:

High-risk category:

- Three providers did not comply with the site visit and fingerprint background check screening requirements.
- Two providers did not have certifications on file covering the entire enrollment period.

State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-007 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1805AR5021; 05-1905AR5021
(Children’s Health Insurance Program)
05-1805AR5MAP; 05-1905AR5MAP
(Medicaid Cluster)
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Special Tests and Provisions –
Provider Eligibility (Managed Care Organizations)
Type of Finding: Material Noncompliance and Material Weakness

Condition and Context (Continued):

- For one provider, a revalidation had not been performed.

Moderate-risk category:

- Four providers did not comply with the site visit screening requirement.

Limited-risk category:

- Eight providers did not have a license on file covering the entire enrollment period.
- Four providers did not have certifications on file covering the entire enrollment period.
- Two providers did not have a contract on file covering the entire enrollment period.
- Five providers did not have an application on file covering the entire enrollment period.
- Five providers did not have a W-9 form on file covering the entire enrollment period.
- Thirteen providers did not have disclosure forms on file covering the entire enrollment period.
- Eleven providers did not comply with the database checks screening requirement.
- Fifteen providers did not revalidate timely, either by the September 26, 2016, extended deadline or within the five years since they last enrolled.
- For fourteen providers, a revalidation had not been performed.

The following payments were made by the managed care entities to the providers identified above with deficiencies:

Dental managed care:
\$1,366,460 (Medicaid)
\$ 396,257 (CHIP)

PASSE
\$494,713 (Medicaid)
\$ 16,948 (CHIP)

(NOTE: Because these providers are participating in the managed care portion of the Medicaid program, 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.)

Statistically Valid Sample:
Not a statistically valid sample

State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-007 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1805AR5021; 05-1905AR5021
(Children’s Health Insurance Program)
05-1805AR5MAP; 05-1905AR5MAP
(Medicaid Cluster)
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Special Tests and Provisions –
Provider Eligibility (Managed Care Organizations)
Type of Finding: Material Noncompliance and Material Weakness

Questioned Costs:
Unknown

Cause:

Although the Agency has internal control procedures to review provider files to ensure sufficient, appropriate evidence is provided to support the Agency’s determination of eligibility, certain areas still require continued communication with and training of the appropriate personnel.

Effect:

Claims to ineligible providers were processed and paid by the managed care entities.

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 disputes in part and concurs in part the finding. Effective May 31, 2019, DMS 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.

The following information requested by ALA was available but was not provided due to agency mistake:

- The agency has two of the eight licenses for the noted providers
- Of the six providers noted to have missing certifications, the agency has certifications for two providers
- The agency does not have certifications for the remaining providers, which are therapy groups and pharmacies, because certifications are not required for those provider types
- The agency has the two provider contracts that were noted to be missing; the contracts were submitted through the portal
- The agency has applications and W9 forms for the five providers noted to be missing that documentation for the fiscal year
- The agency has four of the thirteen disclosure forms noted to be missing from provider files
- The agency conducted one of the four site visits noted
- The agency completed nine of the eleven database checks screening noted to be missing from provider files.
- The agency has completed nine of the fifteen revalidations noted to not have been performed

Prior to testing for the next Single Audit, DHS will provide ALA with training and access to the system (Interchange) in which all provider eligibility documentation is maintained.

State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-007 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1805AR5021; 05-1905AR5021
(Children’s Health Insurance Program)
05-1805AR5MAP; 05-1905AR5MAP
(Medicaid Cluster)
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Special Tests and Provisions –
Provider Eligibility (Managed Care Organizations)
Type of Finding: Material Noncompliance and Material Weakness

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

Anticipated Completion Date: 6/30/2020

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Additional Comments from the Auditor:

The Agency stated it partially disputes and partially concurs with the finding. The portion of the finding it disputes is unclear.

State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-008
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1705AR0301; 05-1805AR5021; 05-1905AR5021
Federal Award Year(s): 2017, 2018, and 2019
Compliance Requirement(s) Affected: Period of Performance
Type of Finding: Noncompliance and 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 be in compliance 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.

Condition and Context:

The Agency failed to establish written procedures over the period of performance compliance requirement area. As a result, ALA was unable to determine if the Agency’s federal award management was effective or efficient.

Statistically Valid Sample:

Not a statistically valid sample

Questioned Costs:

None

Cause:

Although the Agency was notified over four years ago to establish written procedures over compliance for all federal awards, it continues to fail to prioritize this task for some compliance requirement areas.

Effect:

Failure to establish written procedures over compliance requirement areas limits the Agency’s ability to manage the awards effectively.

Recommendation:

ALA staff recommend the Agency promptly establish written procedures over compliance areas, as required by Uniform Guidance.

Views of Responsible Officials and Planned Corrective Action:

DHS concurs with the finding. The agency will document the controls it already has in place into written procedures that comply with COSO or Greenbook guidelines to ensure CHIP funds are not expended beyond the period of performance.

**State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019**

Finding Number: 2019-008 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1705AR0301; 05-1805AR5021; 05-1905AR5021
Federal Award Year(s): 2017, 2018, and 2019
Compliance Requirement(s) Affected: Period of Performance
Type of Finding: Noncompliance and Material Weakness

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

Anticipated Completion Date: 4/30/2020

Contact Person: Sara Bradley
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State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-009
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA Number(s) and Program Title(s): 93.778 – Medical Assistance Program
(Medicaid Cluster)
Federal Awarding Agency: US Department of Health and Human Services
Federal Award Number(s): 05-1805AR5ADM; 05-1905AR5ADM
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Activities Allowed or Unallowed –
Administration and Training
Type of Finding: Noncompliance and Material Weakness
Repeat Finding:
Not applicable

Criteria:

In accordance with 45 CFR § 75.303, 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. These controls should be in compliance 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.

Additionally, 45 CFR § 75.430 states that charges to federal awards for salaries and wages must be based on records that accurately reflect the work performed. These records must:

- Be supported by a system of internal control which provides reasonable assurance that the charges are accurate, allowable, and properly allocated.
- Be incorporated into the official records of the non-federal entity.
- Reasonably reflect the total activity for which the employee is compensated by the non-federal entity (not exceeding 100%).
- Comply with established accounting policies and practices of the non-federal entity.
- Support the distribution of the employee's salary among specific activities if the employee works on more than one activity (federal program, non-federal program, direct activity, non-direct activity, unallowable activity, etc.).

Condition and Context:

The Agency uses the Direct Employee Certification system to ensure employees with salaries that are directly charged to a federal program complete a semi-annual direct employee certification. Certifications must be completed within 30 days of the end of the certification period. The system generates weekly reports that identify incomplete, pending, or rejected certifications. These weekly reports are provided to division CFOs as applicable, and the CFO is responsible for addressing any deficiencies.

ALA selected nine weeks for review to determine if the Direct Employee Certification system was operating effectively. Our review revealed that for all nine weeks, sufficient, appropriate evidence was not provided or maintained by the Agency that demonstrated review or any action by division CFOs.

Additionally, ALA selected 60 employees whose salary expenditures were paid solely from Medicaid funds to determine if certifications were completed timely and salaries were properly charged to the Medicaid program. Our review revealed nine instances in which the certifications were not completed timely. In one specific instance, we noted 100% of an employee's time, totaling \$8,962, was incorrectly charged solely to the Medicaid program.

State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-009 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA Number(s) and Program Title(s): 93.778 – Medical Assistance Program
(Medicaid Cluster)
Federal Awarding Agency: US Department of Health and Human Services
Federal Award Number(s): 05-1805AR5ADM; 05-1905AR5ADM
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Activities Allowed or Unallowed –
Administration and Training
Type of Finding: Noncompliance and Material Weakness

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
\$8,962

Cause:
The Agency failed to fully implement controls or follow internal control policies to ensure expenditures were directly coded to the Medicaid program appropriately.

Effect:
The Agency failed to correct salary and other expenditures inappropriately charged directly to the Medicaid program.

Recommendation:
ALA staff recommend the Agency continue to strengthen internal controls and provide adequate oversight to ensure internal control policies in place are being followed.

Views of Responsible Officials and Planned Corrective Action:

DHS concurs with the finding. Affected agency employees automatically receive Direct Certification notices. OFA staff will begin running Direct Employee Certification reports on a bi-weekly basis to check for missing or rejected certifications. The bi-weekly reports will cover the two-week period immediately preceding the date the report is ran and will be forwarded to affected divisions and staff will be retrained on the importance of timely completion of the certification. Reports that generate no results for the time period run will be screen-captured and filed accordingly. When a report shows a certification rejection, the rejection will be confirmed by the employee's manager. If confirmed, the appropriate salary and/or position corrections will be made.

Anticipated Completion Date: 4/30/2020

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State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-010
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1805AR5ADM; 05-1905AR5ADM
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Activities Allowed or Unallowed - Contracts
Type of Finding: Noncompliance and Material Weakness

Repeat Finding:
Not applicable

Criteria:

In accordance with 42 CFR § 433.116(j), expenditures for the operation of an eligibility and enrollment system for Medicaid are eligible for reimbursement at the federal financial participation (FFP) rate of 75%.

Expenditures for the design, development, installation, or enhancement of an eligibility and enrollment system for Medicaid are eligible for reimbursement at the FFP rate of 90%, as stated by 42 CFR § 433.112(c)(1).

Condition and Context:

ALA staff reviewed two invoices paid under the ESystems, Inc., contract for the state's existing eligibility and enrollment system. One of the invoices reviewed indicated an application operations and production support (AOPS) charge of \$715,870 that was reimbursed at the 90% FFP rate instead of the 75% FFP rate, resulting in an excess unallowed reimbursement totaling \$107,381.

Statistically Valid Sample:

Not a statistically valid sample

Questioned Costs:

\$107,381

Cause:

Management review in the approval process failed to identify the coding error when the invoice was paid using the internal order of HELX0018 instead of HE8X0018.

Effect:

The Agency was over-reimbursed by CMS at 90% of cost instead of the appropriate 75% of cost.

Recommendation:

ALA staff recommend the Agency be more diligent in the review of invoices prior to payment to ensure the appropriate reimbursement rate is utilized concerning the state's eligibility and enrollment system.

Views of Responsible Officials and Planned Corrective Action:

DHS concurs with the finding. The agency has implemented a new process to ensure that invoices are paid using the correct internal order. DMS Finance will review copies of all IT related APD's and require that they indicate on the invoice approval the internal order number to which each line should be charged. DMS Finance will review the approval to ensure that it matches the APD. If any inconsistencies are found or other questions arise, DMS Finance will contact the vendor approver for clarification. Additionally, when the purchase order is initially set up, DMS Finance will meet with IT staff to review the purchase orders and ensure the coding is correct.

Anticipated Completion Date: 4/30/2020

**State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019**

Finding Number:	2019-010 (Continued)
State/Educational Agency(s):	Arkansas Department of Human Services
Pass-Through Entity:	Not Applicable
CFDA 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):	05-1805AR5ADM; 05-1905AR5ADM
Federal Award Year(s):	2018 and 2019
Compliance Requirement(s) Affected:	Activities Allowed or Unallowed - Contracts
Type of Finding:	Noncompliance and Material Weakness

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

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State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-011
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1805AR5MAP; 05-1905AR5MAP
Federal Award Year(s): 2018 and 2019
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 finding 2018-013.

Criteria:

Prior to January 1, 2019, the ARChoices waiver was governed by Section 212.300 of the ARChoices provider manual. It stated that each beneficiary must have an individualized Person-Centered Service Plan (PCSP) and that attendant care hours are based on the Resource Utilization Group (RUG) score produced from the ARPath assessment. Services must be provided according to the beneficiary's PCSP, with reimbursement limited to the amount and frequency authorized in the PCSP.

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 PCSP. Attendant care hours are determined utilizing the Task and Hour Standards (THS), which is the written methodology used by 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 amount and frequency authorized on the PCSP.

Condition and Context:

ALA staff selected 60 beneficiaries for review to determine 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:

- 44 beneficiaries had at least one claim for a date of service that was not covered by a valid agreement. Questioned costs totaled \$279,209.
- Attendant care services for 4 beneficiaries exceeded the amount authorized in an agreement. Questioned costs totaled \$279.

Statistically Valid Sample:

Not a statistically valid sample

Questioned Costs:

\$279,488

Cause:

The Agency failed to ensure that attendant care hour claims for ARChoice wavier beneficiaries were adequately supported by current and valid agreements (PCSP, RUG score, or ARIA assessment). Additionally, the Agency failed to ensure that there were adequate controls in the claims payment system to both identify and deny claims, as applicable, if the amount billed exceeded the amount authorized.

Effect:

Amounts paid were in excess of amounts authorized.

State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-011 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1805AR5MAP; 05-1905AR5MAP
Federal Award Year(s): 2018 and 2019
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 its policies and procedures and take necessary corrective action to ensure that all amounts paid are in accordance with amounts authorized and that amounts authorized are supported by both a current and valid PSCP 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 the finding. The agency determined there were several causal areas for this finding including a State-court injunction that prevented the agency from using its approved CMS assessment method, issues that occurred within the agency's billing system, and deficiencies within the agency's waiver re-evaluation process. All deficiencies noted in the finding will be corrected with the improvement of the waiver re-evaluation process. Current activities are underway to improve the re-evaluation process including realigning resources and activities within one management division, value stream mapping to eliminate unnecessary administrative tasks, and development of a workflow management system to track and report re-evaluation activities. In addition, a Level 2 Review process will be added to handle special needs cases, such as Appeals, so supervisory reviews are completed without delaying processing of other evaluations.

Anticipated Completion Date: 6/1/2020

Contact Person: Patricia Gann
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State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-012
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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
Federal Award Year(s): 2019
Compliance Requirement(s) Affected: Activities Allowed or Unallowed –
Managed Care
Type of Finding: Noncompliance and Material Weakness

Repeat Finding:
Not applicable

Criteria:

The Provider-Led Arkansas Shared Savings Entity (PASSE) program transitioned to a full-risk Managed Care Organization (MCO) model on March 1, 2019. The program covers services for behavioral health (BH) recipients and developmentally disabled (DD) recipients. To receive services through PASSE, an individual must have an independent assessment performed that designates him or her at the appropriate level of need to participate in the program.

The 1915(c) Home and Community-Based waiver, applicable to the DD population, requires that an independent assessment be performed at least every three years. Section 1915(i) of the Social Security Act, which is applicable to the BH population and provides states with the option to offer home and community-based services through the state's plan, requires that than an independent assessment be performed at least every 12 months. 42 CFR §441.720(b) states that for reassessments, the independent assessment of need must be conducted at least every 12 months and as needed when the individual's support needs or circumstances change significantly, in order to revise the service plan.

Condition and Context:

ALA selected 60 PASSE recipients (56 BH recipients and 4 DD recipients) to determine if the following attributes were met:

- There was an open eligibility segment for the recipient during the dates of service covered.
- There was a valid independent assessment on file for the dates of service covered.
- The appropriate amount was paid based upon the actuarially determined rates.

Our review revealed PASSE payments, totaling \$58,894, for 23 BH recipients were made for dates of services outside the date range covered by the recipients' independent assessment.

In addition, an unallowable fee-for-service claim, totaling \$145, was discovered. Fee-for-service claims should not be paid for individuals who are covered under PASSE. (There are a few exceptions including, but not limited to, certain school-based services that are provided by school employees.)

The discovery of an unallowable fee-for-service claim prompted ALA to retrieve all fee-for-service claims for all individuals with PASSE payments during state fiscal year 2019 to determine if additional unallowable fee-for-service claims had been paid. After filtering and removing the claims that could be allowable (as previously mentioned), the remaining fee-for-service claims totaled \$2,575,426. These claims will require a review by the Agency to determine if the fee-for-service claim or PASSE payment should be recouped.

Statistically Valid Sample:

Not a statistically valid sample

Questioned Costs:
\$58,894

State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-012 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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
Federal Award Year(s): 2019
Compliance Requirement(s) Affected: Activities Allowed or Unallowed –
Managed Care
Type of Finding: Noncompliance and Material Weakness

Cause:

The PASSE full-risk managed care program was a new program in state fiscal year 2019. According to the Agency, the bulk of the initial BH assessments was performed in a five-month period during the spring of 2018. In 2019, the reassessments were spread over the full 12 months.

In addition, the Agency is still in the process of identifying and working out any edits that need to be added or updated in the MMIS claims payment system to ensure that there are no unallowable fee-for-service claims paid on behalf of PASSE recipients.

Effect:

The independent assessments for the BH population were not consistently performed within the required 12-month time frame, and unallowable fee-for-service claims were paid during the time when the individuals were already covered under the PASSE program.

Recommendation:

ALA staff recommend the Agency develop and document procedures to ensure that independent assessments are completed timely and that there are appropriate edits in the MMIS claims payments system to prevent unallowable fee-for-service claims paid being paid for recipients who are already covered under the PASSE managed care program.

Views of Responsible Officials and Planned Corrective Action:

DHS concurs with the finding. The agency has updated its independent assessment process to ensure timely completion of annual assessments. The agency determined that the fee-for-service claims were paid for individuals covered under PASSE due to a DXC product finding that has now been corrected. As a result, the agency has implemented a new process for running fee-for-service claims data for PASSE members to determine if any claims were improperly paid. Any claim for an excluded service or excluded service provider will be removed from this review. Edits and system updates will be performed as necessary to prevent and/or correct system errors. The agency has reviewed the fee-for-service claims totaling \$2,575,426 and determined them to be unallowable. DHS will recoup the claims and instruct providers to submit clean claims to the PASSE for payment.

Anticipated Completion Date: 4/30/2020

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State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-013
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1805AR5MAP; 05-1905AR5MAP
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Activities Allowed or Unallowed –
Managed Care (Dental)
Type of Finding: Noncompliance and 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 be in compliance 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.

Condition and Context:

ALA requested written documentation of the Agency's internal controls in place over the Managed Care – Dental program. The only information provided by the Agency was the provider manuals developed by the two participating entities. There was no written documentation of the Agency's internal control procedures over the Managed Care – Dental program.

In addition, the Agency asserted that its management utilizes information included in monthly Division of Medicare and Medicaid Services (DMS) reports as a monitoring tool to identify areas that may require further analysis. However, documentation supporting the actual use of these reports could not be provided for the four months ALA selected for testing.

Statistically Valid Sample:

Not a statistically valid sample

Questioned Costs:

None

Cause:

The Agency has experienced staff turnover and did not develop or document internal control procedures for its staff.

Effect:

Failure to document and implement appropriate procedures for internal control limits the Agency's ability to adequately monitor the program for possible improper payments and noncompliance.

Recommendation:

ALA staff recommend the Agency develop and document internal controls over the Managed Care – Dental program to aid in ensuring compliance and proper payments.

**State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019**

Finding Number: 2019-013 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1805AR5MAP; 05-1905AR5MAP
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Activities Allowed or Unallowed –
Managed Care (Dental)
Type of Finding: Noncompliance and Material Weakness

Views of Responsible Officials and Planned Corrective Action:

DHS concurs with this finding. DMS has internal control procedures in place to monitor 1915(b) Waiver and Dental Managed Care contract compliance. DMS will document the internal control procedures to comply with COSO or Greenbook guidelines.

Anticipated Completion Date: 4/30/2020

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State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-014
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA Number(s) and Program Title(s): 93.778 – Medical Assistance Program
(Medicaid Cluster)
Federal Awarding Agency: US Department of Health and Human Services
Federal Award Number(s): 05-1805AR5MAP; 05-1905AR5MAP
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Allowable Costs and Cost Principles
Type of Finding: Noncompliance and 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 be in compliance 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.

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.

Under Section 6506 of the Affordable Care Act (42 USC 1396b(d)(2)), states have up to one year from the date of discovery of an overpayment for Medicaid services to recover, or attempt to recover, such overpayment before making an adjustment to refund the federal share of the overpayment. Except in the case of overpayments resulting from fraud, the adjustment to refund the federal share must be made no later than the deadline for filing the quarterly CMS-64 report for the quarter in which the one-year period ends, regardless of whether the state recovers the overpayment.

The date of discovery for fraudulent overpayments is the date of the final written notice of the state's overpayment determination. When the state is unable to recover an overpayment from a provider within one year from the date of discovery because a final determination of the amount has not been made under an administrative or judicial process, no adjustment shall be made to the quarterly expenditure report until 30 days after the date on which a final judgment is made (including final determination on an appeal).

Condition and Context:

The Agency failed to establish and document internal control procedures over the escheated warrants and overpayments compliance requirement. As a result, ALA met with DHS reporting staff and accounts receivable staff, as well as Navigant staff, to gain an understanding of controls that may be in place but not documented. ALA was unable to identify any controls that were in place to ensure compliance with federal regulations.

Overpayments may be identified by DHS, the Office of Medicaid Inspector General (OMIG), or the Medicaid Fraud Control Unit (MFCU) of the Office of the Attorney General. DHS is responsible for completion of the required quarterly expenditure reports for the Medicaid program (CMS-64) and, therefore, for obtaining information needed to properly report overpayments on these reports.

Overpayments identified by OMIG: OMIG notifies DHS of identified overpayments (a) when the provider repays the identified amount or fails to respond to the finding letter or (b) after all possible appeals have been exhausted. For cases under appeal, OMIG does not notify DHS of the initial "discovery date"; therefore, some uncollected overpayments may not be reported by the required deadline.

State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-014 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA Number(s) and Program Title(s): 93.778 – Medical Assistance Program
(Medicaid Cluster)
Federal Awarding Agency: US Department of Health and Human Services
Federal Award Number(s): 05-1805AR5MAP; 05-1905AR5MAP
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Allowable Costs and Cost Principles
Type of Finding: Noncompliance and Material Weakness

Condition and Context (Continued):

Additionally, OMIG utilizes a “claim log” to monitor identified overpayments and collections related to the overpayments. ALA reviewed the fiscal year 2018 claim log to determine whether uncollected balances were collected or reported in fiscal year 2019 and reviewed the fiscal year 2019 claim log to determine whether payments collected by OMIG were included on the proper CMS-64 report. ALA was unable to determine if outstanding balances on the 2018 claim log were reported on the state fiscal year 2019 CMS-64 reports and was unable to trace six payments totaling \$5,713 (federal portion \$4,033) to internal reports used to calculate total overpayments for the quarterly CMS-64 reports for state fiscal year 2019.

Overpayments identified by MFCU: Discussions with both MFCU and DHS staff revealed MFCU does not report identified overpayments to DHS until a payment is received. As a result, uncollected overpayments resulting from fraud are not included on the quarterly CMS-64 reports as required.

Additionally, payments forwarded to DHS directly from MFCU are generally not included on internal reports used to calculate total overpayments for the quarterly CMS-64 reports. As a result, these payments may not be reported as collected overpayments, as required.

Statistically Valid Sample:

Not a statistically valid sample

Questioned Costs:

Unknown

Cause:

The Agency failed to establish adequate controls to ensure compliance with federal regulations related to reporting of identified overpayments. Additionally, individuals involved in collecting and reporting overpayments are not familiar with the federal regulations governing the reporting of identified overpayments.

Effect:

DHS failed to report all identified overpayments and may not have reported some overpayments timely. Per 42 CFR §433.320(a)(4), if a state fails to refund overpayments in accordance with this section, the state will be liable for interest, at the Current Value of Funds Rate, on the federal portion of the non-recovered, non-refunded overpayment amount. Interest will begin to accrue on the day after the one-year period following discovery until the last day of the quarter for which the state submits a CMS-64 report refunding the federal share of the overpayment.

Recommendation:

ALA staff recommend the Agency contact CMS to obtain an understanding of reporting requirements for overpayments identified by OMIG and MFCU. ALA further recommend the Agency design and implement controls to ensure all identified overpayments are included on the CMS-64 report and are reported timely.

Views of Responsible Officials and Planned Corrective Action:

DHS concurs with the finding. The agency has updated and documented its procedures for processing and reporting overpayments received from OMIG and MFCU. Once received, the overpayments are coded to identify the source and if federal funds are associated with the identified overpayment. This information will be used to report overpayments on the CMS-64. The six payments totaling \$5,713 that ALA was unable to trace to internal reports were included on reports for FFY Q1 2019 and FFY Q4 2019.

State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-014 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA Number(s) and Program Title(s): 93.778 – Medical Assistance Program
(Medicaid Cluster)
Federal Awarding Agency: US Department of Health and Human Services
Federal Award Number(s): 05-1805AR5MAP; 05-1905AR5MAP
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Allowable Costs and Cost Principles
Type of Finding: Noncompliance and Material Weakness

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

Anticipated Completion Date: Complete

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**State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019**

Finding Number: 2019-015
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1805AR5MAP; 05-1905AR5MAP
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Allowable Costs and Cost Principles – Non-Disproportionate Share Hospital Supplemental Payments
Type of Finding: Noncompliance and Significant Deficiency

Repeat Finding:
Not applicable

Criteria:

In accordance with 45 CFR § 75.303, 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. These controls should be in compliance 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.

Condition and Context:

ALA requested the Agency's documented internal controls over compliance for the non-disproportionate share hospital supplemental payments compliance area. The documentation provided by the Agency only included the procedures for processing upper payment limit (UPL) payments to eligible hospitals. ALA determined the Agency's documented controls are incomplete and do not meet the required criteria.

Statistically Valid Sample:

Not a statistically valid sample

Questioned Costs:

None

Cause:

The Agency failed to establish written documentation of controls that address all elements of effective internal controls.

Effect:

Failure to establish and document adequate controls could result in errors in determination of supplemental payments and failure to identify errors timely.

Recommendation:

ALA staff recommend the Agency review and document controls in place for properly determining non-disproportionate share hospital payments to ensure the Agency's controls adequately address all internal control elements in accordance with COSO and/or the Green Book.

Views of Responsible Officials and Planned Corrective Action:

DHS concurs with the finding. DMS has internal controls in place for processing of upper payment limit (UPL) payments. The agency will update its existing procedure for processing UPL payments to meet the guidelines of COSO or Greenbook.

**State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019**

Finding Number: 2019-015 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1805AR5MAP; 05-1905AR5MAP
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Allowable Costs and Cost Principles –
Non-Disproportionate Share
Hospital Supplemental Payments
Type of Finding: Noncompliance and Significant Deficiency

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

Anticipated Completion Date: 3/31/2020

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State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-016
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1405AR5MAP; 05-1505AR5MAP; 05-1605AR5MAP; 05-1705AR5MAP; 05-1805AR5MAP; 05-1905AR5MAP
Federal Award Year(s): 2014, 2015, 2016, 2017, 2018, and 2019
Compliance Requirement(s) Affected: Eligibility
Type of Finding: Noncompliance and Material Weakness

Repeat Finding:

A similar issue was reported in prior-year finding 2018-014.

Criteria:

It is the State's responsibility to determine that Medicaid applicants meet the eligibility criteria as specified in the approved State Plan. Eligibility requirements for the Medicaid Program are outlined in the Arkansas Medical Services (MS) manual. The MS manual is specific to Medicaid eligibility policies and procedures and is, in addition to the approved State Plan, required in accordance with 45 CFR § 75.206.

In addition, case documentation is governed by 42 CFR § 435.913, which states, "The Agency must include in each application record facts to support the Agency's decision..."

Guidance for timely eligibility determinations is outlined in 42 CFR § 435.912, which states that initial determinations should be made within 45 days unless the applicant is applying upon the basis of disability; in that case, the initial determination should be made within 90 days. Also, 42 CFR § 435.916 states that eligibility redeterminations are to be performed at least once every 12 months.

Condition and Context:

ALA staff reviewed 23 traditional Medicaid recipient files in the ANSWER system and 37 Modified Adjusted Gross Income (MAGI) Medicaid recipient files in the Curam system to ensure sufficient, appropriate evidence was provided to support the Agency's determination of eligibility. The review revealed deficiencies as summarized below:

- One client file, with 588 claims totaling \$39,892, did not contain a DCO-704 signed by a registered nurse verifying medical necessity, affecting 58 claims. Questioned costs totaled \$3,142.
The annual reevaluation was also not completed timely. The 2019 reevaluation, due in January 2019, was not completed until February 26, 2019. (Disabled Tax Equity and Fiscal Responsibility Act [TEFRA] Child) (Non-MAGI/ANSWER)
- One client file, with 49 claims totaling \$903, did not contain a DCO-704 signed by a registered nurse verifying medical necessity, affecting 25 claims. Questioned costs totaled \$456.
The annual reevaluation was also not completed timely. The 2019 reevaluation, due in December 2018, was not completed until February 5, 2019. (Aid to the Aged) (Non-MAGI/ANSWER)
- One client file, with 112 claims totaling \$7,073, did not contain a DCO-704 signed by a registered nurse verifying medical necessity, affecting 3 claims. Questioned costs totaled \$727. (Disabled Tax Equity and Fiscal Responsibility Act [TEFRA] Child) (Non-MAGI/ANSWER)
- One client file, with 52 claims totaling \$655, did not contain a DCO-704 signed by a registered nurse verifying medical necessity, affecting 4 claims. Questioned costs totaled \$28. (Disabled Tax Equity and Fiscal Responsibility Act [TEFRA] Child) (Non-MAGI/ANSWER)
- One client file, with 173 claims totaling \$10,784, did not contain a DCO-704 signed by a registered nurse verifying medical necessity and did not contain documentation supporting the income and resources criteria, affecting 73 claims. Questioned costs totaled \$3,347.
The annual reevaluation was also not completed timely. The 2019 reevaluation, due in December 2018, was not completed until February 1, 2019. (AR Choices) (Non-MAGI/ANSWER)

State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-016 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1405AR5MAP; 05-1505AR5MAP; 05-1605AR5MAP; 05-1705AR5MAP; 05-1805AR5MAP; 05-1905AR5MAP
Federal Award Year(s): 2014, 2015, 2016, 2017, 2018, and 2019
Compliance Requirement(s) Affected: Eligibility
Type of Finding: Noncompliance and Material Weakness

Condition and Context (Continued):

- One client file, with 22 claims totaling \$2,818, did not contain a DCO-704 signed by a registered nurse verifying medical necessity and did not contain documentation supporting the income and resources criteria, affecting 22 claims. Questioned costs totaled \$1,997.
 In addition, 103 claims paid in 2018 were also affected. Questioned costs totaled \$3,323.
 The annual reevaluation was also not completed timely. The 2018 reevaluation, due in August 2017, was not completed. (Aid to the Aged) (Non-MAGI/ANSWER)
- One client file, with 113 claims totaling \$7,827, did not contain a DCO-704 signed by a registered nurse verifying medical necessity, affecting 26 claims. Questioned costs totaled \$1,305. (AR Choices) (Non-MAGI/ANSWER)
- One client file, with 15 claims totaling \$24,715, did not contain a DCO-704 signed by a registered nurse verifying medical necessity, affecting 10 claims. Questioned costs totaled \$10,347.
 The annual reevaluation was also not completed timely. The 2019 reevaluation, due in January 2019, was not completed until March 29, 2019. (Assisted Living/ Living Choices) (Non-MAGI/ANSWER)
- One client file, with 143 claims totaling \$50,790, did not contain documentation proving resource eligibility, affecting 18 claims. Questioned costs totaled \$8,053.
 The annual reevaluation was also not completed timely. The 2019 reevaluation, due in April 2019, was not completed until November 1, 2019, after the recipient's file was selected for review. (Aid to the Aged) (Non-MAGI/ANSWER)
- One client file, with 29 claims totaling \$5,633, did not contain a DCO-704 signed by a registered nurse verifying medical necessity, documentation supporting the resources or income criteria, disability verification, institutional status, or proof of assignment of medical rights by the recipient to DHS, affecting all 29 claims. Questioned costs totaled \$3,972.
 In addition, 137 claims paid in 2018, 2017, 2016, 2015, and 2014 were also affected. Questioned costs totaled \$325, \$76, \$193, \$362, and \$71, respectively.
 The annual reevaluations were also not completed timely. The 2014 reevaluation, due in April 2014, had not been completed at the conclusion of audit fieldwork, and there were no reevaluations for 2015, 2016, 2017, 2018, or 2019. (Aid to the Disabled) (Non-MAGI/ANSWER)
- One client file, with 13 claims totaling \$3,539, did not contain documentation proving income eligibility, affecting all 13 claims. Questioned costs totaled \$2,496. (Adult Expansion) (MAGI/CURAM)
- One client file, with 10 claims totaling \$116, did not contain documentation proving the recipient had assigned medical rights to DHS, affecting all 10 claims. Questioned costs totaled \$82. (ARKids A) (MAGI/CURAM)

Additional deficiencies related to eligible recipients with late re-determinations. Although no questioned costs are associated with these recipients, the total amount of claims paid (state and federal) as of fieldwork date of December 2, 2019, for dates of services between the time the reevaluation was due and the day before it was performed is noted below in order to show what could have been paid in error if the recipient had ultimately been deemed ineligible:

State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-016 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1405AR5MAP; 05-1505AR5MAP; 05-1605AR5MAP;
05-1705AR5MAP; 05-1805AR5MAP; 05-1905AR5MAP
Federal Award Year(s): 2014, 2015, 2016, 2017, 2018, and 2019
Compliance Requirement(s) Affected: Eligibility
Type of Finding: Noncompliance and Material Weakness

Condition and Context (Continued):

- One client file did not have a timely reevaluation, as it was due in December 2018 but was not completed until February 20, 2019. The claims paid for dates of services between when the reevaluation was due and the day before it was performed totaled \$13,178 in state fiscal year 2019. (Aid to the Aged) (Non-MAGI/ANSWER)
- One client file did not have a timely reevaluation, as it was due in February 2019 but was not completed until March 6, 2019. The claims paid for dates of services between when the reevaluation was due and the day before it was performed totaled \$5,262 in state fiscal year 2019. (Aid to the Disabled) (Non-MAGI/ANSWER)
- One client file did not have a timely reevaluation, as it was due in July 2018 but was not completed until August 12, 2018. The claims paid for dates of services between when the reevaluation was due and the day before it was performed totaled \$434 in state fiscal year 2019. (Adult Expansion) (MAGI/CURAM)

Statistically Valid Sample:

Not a statistically valid sample

Questioned Costs:

State Fiscal Year 2019 - \$35,952
State Fiscal Year 2018 - \$3,648
State Fiscal Year 2017 - \$76
State Fiscal Year 2016 - \$193
State Fiscal Year 2015 - \$362
State Fiscal Year 2014 - \$71

Cause:

Although the Agency has designed internal control procedures to review recipient files to ensure sufficient, appropriate evidence is provided to support the Agency's determination of eligibility, certain areas still require continued communication to and training of the appropriate Agency personnel.

Effect:

Payments to providers were made on behalf of ineligible recipients.

Recommendation:

ALA staff recommend the Agency continue providing adequate communication with and training to appropriate personnel to ensure compliance with all program requirements as defined in the MS manual.

Views of Responsible Officials and Planned Corrective Action:

DHS concurs with the finding. The agency noted that the root cause of the error resulted from DAABHS and the agency's contractor, Optum, being unable to complete the reassessments timely. A new business process is being developed to ensure timely medical eligibility determination. Current activities are underway to improve the re-evaluation process including realigning resources and activities within one management division, value stream mapping to eliminate unnecessary administrative tasks, and development of a workflow management system to track and report re-evaluation activities. Eligibility staff have been instructed on the process. The program eligibility analysts and area directors will monitor the process.

State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-016 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1405AR5MAP; 05-1505AR5MAP; 05-1605AR5MAP;
05-1705AR5MAP; 05-1805AR5MAP; 05-1905AR5MAP
Federal Award Year(s): 2014, 2015, 2016, 2017, 2018, and 2019
Compliance Requirement(s) Affected: Eligibility
Type of Finding: Noncompliance and Material Weakness

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

Anticipated Completion Date: 6/1/2020

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State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-017
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1805AR5MAP; 05-1905AR5MAP
Federal Award Year(s): 2018 and 2019
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 finding 2018-015.

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 State 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:

To verify that state general revenues and other non-federal funding sources used to "match" the federal grant award monies were from an appropriate source of funding, ALA selected 25 daily draw dates and traced the daily draw amount recorded in AASIS to the Agency's supporting draw packet. The following issues were noted:

- The Agency did not maintain documentation identifying the original source of revenues identified as *other non-federal*.
- The Agency utilizes an outside accounting system, Lotus 1-2-3, to maintain and track *State General Revenue* and *other non-federal* fund balances available. Agency staff manually key information into this system daily. However, there are no reviews or other controls in place to ensure the accuracy of the funding category balances.
- Accounting records maintained in the Lotus 1-2-3 system include one-sided adjustments to *State General Revenue* and *other non-federal* funds, causing the ending balances of both funding categories to be inaccurate.

Additionally, to confirm the Agency was properly monitoring its state match, we requested the reconciliations the Agency indicated it used to track, compare, and verify state match requirements.

Although reconciliations were provided for the first three quarters of 2019, they contained numerous errors, and the Agency failed to provide the reconciliation for the fourth quarter ending June 30, 2019. ALA attempted to perform alternative procedures; however, because of the issues noted above, we were unable to verify that the Agency met the match requirements.

(NOTE: The Agency's reported state match for all active Medicaid grants was \$1,677,981,874.)

Statistically Valid Sample:

Not a statistically valid sample

Questioned Costs:

Unknown

State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-017 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1805AR5MAP; 05-1905AR5MAP
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Matching, Level of Effort, Earmarking
Type of Finding: Material Noncompliance and Material Weakness

Cause:

The Agency did not adhere to its documented internal control policies and procedures by preparing adequate quarterly comparisons. Additionally, no established procedures were in place to verify the Agency met the state match requirements or that the funds used toward the state match were from allowable sources.

Effect:

Inadequate controls for effectively monitoring the match compliance requirement could result in failure to meet match and also limits the Agency's ability to effectively manage the grant.

Recommendation:

ALA staff recommend the Agency adhere to its established internal control policies and procedures over matching to ensure appropriate state match. ALA further recommends the Agency 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 the finding. The agency does maintain documentation identifying sources of revenues through the certification of income from the divisions. Each program is assigned an internal order, fund, and source of funding. This is maintained on the Coding Validation Table. When monies are received through accounts receivable, transfers, and draws, they are split in the funds control ledgers by the funding split designated on the CVT (coding validation table). The general ledger account numbers also designate the source of revenue (transfers). AASIS does not separate the internal orders (program codes) by funding source and we balance to AASIS. The monies are deposited into designated fund as one total. While the agency maintains documentation identifying "other non-federal" revenues, the funds and sources could be documented with greater specificity. The agency will update its process to provide greater specificity in tracking "other non-federal" revenues.

Controls are imbedded in the ledgers and Lotus program which ensure accuracy of funding category balances, if funds or accounts are not balanced an error message is given and reason is researched and corrected before allowed to move on to next step. Controls are in place by when a transfer document is created in AASIS it is reviewed by another person then posted if approved (the same person cannot post). If requests for transfers are made to DFA they must be approved by a manager.

Adjustments made in Lotus are not one-sided. Adjustments are made to ledgers to true-up State, Federal, and Other based on Cost Allocation. Our daily expenditures are posted to our ledgers daily based on the internal order in the indirect worksheet. These percentages are trued up quarterly when cost allocation runs. Therefore, an adjustment is needed to true up the splits on our ledgers between, State, Federal and Other. It does not change the balance in the fund.

Due to the limitation of AASIS not separating fund splits, we are not able to provide the level of detail for each program code as asked for by ALA. However, we maintain that State General Revenue and Other sources are certified by directors and used as certified per state and federal laws. We maintain that we balance our funds to AASIS and state general revenue reports from DFA therefore are accurate.

State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-017 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1805AR5MAP; 05-1905AR5MAP
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Matching, Level of Effort, Earmarking
Type of Finding: Material Noncompliance and Material Weakness

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

Anticipated Completion Date: 6/30/2020

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Additional Comments from the Auditor:

Since the Agency was unable to provide documentation that state match requirements were met during state fiscal year 2019, ALA met with Agency employees on several occasions to obtain an understanding of the funding process. ALA performed a walkthrough of the “State” and “Other” funds draw process for one of the dates selected for testing. During this walkthrough, auditors had multiple discussions with Agency staff, including Tina Coutu (Assistant Deputy Director for Managerial Accounting), Sherry Gresham (Budget Specialist, Managerial Accounting), and Donna Reed (Budget Specialist, Managerial Accounting).

During these discussions, Agency staff explained that AASIS does not include functionality to identify funding source (Federal, State, or Other); therefore, the Agency utilizes the Lotus 1-2-3 system to identify the balance of available funds from these sources. Information from AASIS is uploaded into an Access database to identify the proper funding splits. Reports are generated from this database, and information from these reports is manually keyed into the Lotus 1-2-3 system. According to Donna Reed, the Agency does not have a review process in place to ensure amounts from the Access database are properly entered into Lotus 1-2-3.

Additionally, on multiple occasions, Agency staff told ALA that the balances included in Lotus 1-2-3 represent an accumulation of funds over several years, and the Agency was unable to specifically identify the source of these funds. As a result, ALA was unable to determine the source of funds available for payment of Medicaid expenditures.

Furthermore, while performing the walkthrough, the auditor noted “adjustments” on the ledger reports printed from the Lotus 1-2-3 system that reduced the total needed funding for the specified source of funds. According to Donna Reed, if payment of expenditures will result in a negative balance for state general revenue funds, an “adjustment” is made to the ledger report to reclassify a portion of the “Other” funds to the “State” category. In reviewing these adjustments, ALA noted the “State” category was reduced, but no adjustment was made to the “Other” category. Also, during review of monthly funding reports from the Lotus 1-2-3 system, ALA noted multiple instances of negative balances for “State” or “Other” funds at month-end.

Finally, according to Donna Reed, the Agency performs quarterly “true-ups” of the balances. Based on review of “true-up” procedures obtained from the Agency, ALA was unable to determine how this process ensures that funds used to meet state match requirements are appropriate.

State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-018
State/Educational Agency(s): Department of Human Services
Pass-Through Entity: Not Applicable
CFDA Number(s) and Program Title(s): 93.778 – Medical Assistance Program
(Medicaid Cluster)
Federal Awarding Agency: US Department of Health and Human Services
Federal Award Number(s): 05-1805AR5MAP; 05-1905AR5MAP;
05-1805AR5ADM, 05-1905AR5ADM
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Reporting
Type of Finding: Noncompliance and Material Weakness

Repeat Finding:

A similar finding was reported in the year finding 2018-009.

Criteria:

42 CFR 430.30(c) requires submission of a quarterly statement of expenditures report (CMS-64) for the Medical Assistance Program (MAP) no later than 30 days after the end of each quarter. To ensure compliance, the Agency maintains policies and procedures for the preparation of the CMS-64 report. One procedure specifically states that the Agency will prepare quarterly reconciliations, as well as review, investigate, and provide explanations for identified variances. Reconciliations, along with the variance explanations, should be included as supporting documentation for the CMS-64.

Condition and Context:

ALA requested the quarterly reconciliations between expenditures recorded in its financial management system and expenditures reported to the federal awarding agency. The Agency provided reconciliations for portions of the CMS-64 reports to “payout” reports but did not complete reconciliations for the report as a whole. Payout reports are created by DMS staff and represent the 13 weekly funding requests for each quarter. The Agency utilizes an Excel workbook to combine the claims data included in each week’s funding request to create the payout reports. However, the reconciliations provided did not include reconciliations to the Agency’s financial management systems (AASIS and Allocap).

ALA staff also performed testing of expenditures reported on the CMS-64 for the quarters ended December 31, 2018, and March 31, 2019, to confirm accuracy and completeness with the expenditures recorded in the Agency’s financial management system. ALA review revealed the following errors:

From the December 31, 2018, report:

- Twenty-three line items totaling \$1,322,346,159 and representing 86% of MAP expenditures were selected. An error was identified in one line item, resulting in an **overstatement** of the federal portion of expenditures totaling \$477,042.
- Nine line items totaling \$91,932,560 and representing 94% of administrative expenditures were selected. Errors were identified in four line items, resulting in an **overstatement** of the federal portion of expenditures totaling \$29,870.

From the March 31, 2019, report:

- Twenty-one line items totaling \$1,499,993,497 and representing 85% of MAP expenditures were selected. Two errors were identified, resulting in an **understatement** of the federal portion of expenditures totaling \$939.
- Eight line items totaling \$72,862,882 and representing 92% of administrative expenditures were selected. Errors were identified in four line items, resulting in an **overstatement** of the federal portion of expenditures totaling \$119,695.

Statistically Valid Sample:

Not a statistically valid sample

Questioned Costs:

Unknown

State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-018 (Continued)
State/Educational Agency(s): Department of Human Services
Pass-Through Entity: Not Applicable
CFDA Number(s) and Program Title(s): 93.778 – Medical Assistance Program
(Medicaid Cluster)
Federal Awarding Agency: US Department of Health and Human Services
Federal Award Number(s): 05-1805AR5MAP; 05-1905AR5MAP;
05-1805AR5ADM, 05-1905AR5ADM
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Reporting
Type of Finding: Noncompliance and Material Weakness

Cause:

In an effort to reduce reporting errors, the Agency has continued to review and adjust reporting procedures for MAP expenditures. The error in MAP expenditures on the December 31, 2018, report occurred when an adjustment was entered on the wrong line in the Agency's workbook.

For state fiscal year 2019, the Agency implemented a new cost allocation system. The Agency's Excel workbook used to report administrative expenditures was not completely updated to properly allocate expenditures to the appropriate CMS-64 line item (and federal financial participation rate) using the cost allocation system reports.

Effect:

The Agency failed to accurately report expenditures for the selected quarters.

Recommendation:

ALA staff recommend the Agency implement additional procedures and controls over the reporting process to ensure reports are accurate and complete prior to certification.

Views of Responsible Officials and Planned Corrective Action:

DHS concurs with this finding. Effective with the December 31, 2019 submission of the CMS-64 reports, DHS is utilizing the services of a contractor to assist in the compiling, analyzing, data entry and reconciliation of the CMS-64 reports. For the quarter ending December 31, 2019, the contractor completed a reconciliation to the payout and cost allocation reports for the following:

- All Waiver authority medical service expenditures;
- All Medicaid administrative claiming expenditures;
- All CHIP expenditures,
- All Medicaid expansion expenditures;
- All State plan expenditures;
- Total computable amounts reported in MBES for Medicaid collections and overpayments were reconciled to the workpapers used to support Medicaid collections and overpayments.

The agency is in the process of working with the contractor to develop and implement a quarterly reconciliation to include the payout reports, cost allocation (Allocap) and the state's financial management system (AASIS). When the reconciliation process has been finalized, written procedures on the reconciliation process will be documented.

Anticipated Completion Date: 6/30/2020

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State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-019
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1505AR5MAP; 05-1605AR5MAP;
05-1705AR5MAP; 05-1805AR5MAP;
05-1905AR5MAP
Federal Award Year(s): 2015, 2016, 2017, 2018, and 2019
Compliance Requirement(s) Affected: Special Tests and Provisions –
Claims Paid Subsequent to Recipient Death
Type of Finding: Noncompliance and Significant Deficiency

Repeat Finding:

A similar issue was reported in prior-year finding 2018-021.

Criteria:

It is the State's responsibility to ensure that claims are only paid for eligible Medicaid recipients and that any changes to a recipient's eligibility be updated timely. According to Section I-600 of the Medical Service Policy Manual, DHS is required to act on any change that may alter eligibility within 10 days of receiving the change. One of the changes listed that could affect eligibility is death of the recipient. Additionally, Section I-610 of the manual indicates that a recipient loses eligibility upon death.

Condition and Context:

The Arkansas Department of Health provided ALA with a list of deceased individuals, which ALA used to identify individuals who had claims or capitation payments paid or adjusted in state fiscal year 2019 with dates of service after their date of death. The resulting population was split into those related to claims payments and those related to capitation payments.

ALA staff review of 60 recipients with claims paid for dates of service subsequent to the date of death revealed the following:

- Nine recipients had claims paid for dates of service after their date of death. One recipient's claims, totaling \$576, were for dates of service seven months after the date of death. These claims had not been recouped as of fieldwork date October 14, 2019. Questioned costs totaled \$689 and \$8 for state fiscal years 2019 and 2018, respectively.
- For nine recipients, the Medicaid Management Information System (MMIS) did not have a date of death recorded or the date of death was not correct as of fieldwork date November 22, 2019.

ALA staff review of 60 recipients with capitation payments for dates of service subsequent to the date of death revealed the following:

- Fifty-seven recipients had capitation payments paid for dates of service after their date of death. These claims had not been recouped as of fieldwork date October 14, 2019. Questioned costs totaled \$722, \$435, \$183, \$141, and \$37 for state fiscal years 2019, 2018, 2017, 2016 and 2015, respectively.
- For nine recipients, MMIS did not have a date of death recorded, or the date of death was not correct as of fieldwork date November 22, 2019.
- For 10 recipients, capitation payments were paid more than six months past the date of death and ranged from 7 to 54 months.

Statistically Valid Sample:

Not a statistically valid sample

State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-019 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1505AR5MAP; 05-1605AR5MAP;
05-1705AR5MAP; 05-1805AR5MAP;
05-1905AR5MAP
Federal Award Year(s): 2015, 2016, 2017, 2018, and 2019
Compliance Requirement(s) Affected: Special Tests and Provisions –
Claims Paid Subsequent to Recipient Death
Type of Finding: Noncompliance and Significant Deficiency

Questioned Costs:

State Fiscal Year 2015 - \$37
State Fiscal Year 2016 - \$141
State Fiscal Year 2017 - \$183
State Fiscal Year 2018 - \$443
State Fiscal Year 2019 - \$1,411

Cause:

Although the Agency has designed internal control procedures to ensure recipient files are updated upon the death of a recipient, certain areas still require continued communication with and training of the appropriate Agency personnel.

Effect:

Claims and capitation payments were made on behalf of deceased recipients.

Recommendation:

ALA staff recommend the Agency strengthen controls to ensure recipient files are updated timely when a recipient dies so that claims for dates of service subsequent to the date of death are not paid.

Views of Responsible Officials and Planned Corrective Action:

DHS concurs with this finding. Claims and capitation payments were paid subsequent to the date of death due to the agency not receiving timely notification of death and the span of time required to confirm date of death after receiving notification. An automatic retrospective review is completed in the MMIS to identify claims for recoupment that were paid subsequent to date of death. In some cases, eligibility is closed for another reason prior to receiving notification of date of death and the date of death is not updated in MMIS causing the claims to not be recouped. The Agency is currently reviewing all date of death discrepancies between eligibility systems and MMIS and updating the systems to reflect the reported date of death. Additionally, root causes of date for date of death discrepancies will be identified and system updates will be made to correct the discrepancies. System updates will be made as root causes are identified.

Claims were also not recouped for some capitated payments made after date of death due to a delay in completion of NET and PCCM reconciliations. Those claims will be recouped upon the completion of the reconciliations.

Anticipated Completion Date: 6/30/2020

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State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-020
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA Number(s) and Program Title(s): 93.778 – Medical Assistance Program
(Medicaid Cluster)
Federal Awarding Agency: US Department of Health and Human Services
Federal Award Number(s): 05-1805AR5MAP; 05-1905AR5MAP
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Special Tests and Provisions –
Inpatient Hospital and Long-Term
Care Facility Audits
Type of Finding: Material Weakness

Repeat Finding:
Not applicable

Criteria:

In accordance with 45 CFR § 75.303, 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. These controls should be in compliance 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.

To ensure long-term care facility rates are appropriate, the Agency performs periodic audits of the financial and statistical records of participating providers.

Condition and Context:

During our review of the Agency's internal controls and procedures regarding cost report reviews and audits of nursing facilities and intermediate care facilities, ALA discovered the Agency utilized a consultant, Myers and Stauffer, to create new procedures for desk and expanded reviews and to perform reviews of long-term care facility cost reports during the year ended June 30, 2019.

ALA requested a copy of the Myers and Stauffer contract, which revealed that Myers and Stauffer was subcontracted with DXC (fiscal agent and MMIS interchange contract). Further review revealed the DXC contract did not include deliverables for the services being provided by Myers and Stauffer. As a result, the Agency does not have an enforceable contract to ensure the reviews are completed adequately or completed timely or to ensure compliance with federal regulations concerning the completion of cost reports and rate setting for these providers.

Statistically Valid Sample:

Not a statistically valid sample

Questioned Costs:

None

Cause:

The Agency failed to amend the contract with DXC to include deliverables for developing cost report review procedures and performing cost report reviews.

Effect:

The Agency does not have an enforceable contract in place to ensure required audits are completed timely or at all.

State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-020 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA Number(s) and Program Title(s): 93.778 – Medical Assistance Program
(Medicaid Cluster)
Federal Awarding Agency: US Department of Health and Human Services
Federal Award Number(s): 05-1805AR5MAP; 05-1905AR5MAP
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Special Tests and Provisions –
Inpatient Hospital and Long-Term
Care Facility Audits
Type of Finding: Material Weakness

Recommendation:

ALA staff recommend the Agency amend the contract to include deliverables for developing cost report audit procedures and for performance of cost report audits in accordance with federal regulations.

Views of Responsible Officials and Planned Corrective Action:

DHS disputes this finding. The terms and conditions for the referenced contract state the contractor is fully responsible for all work performed under the contract and may enter into written subcontracts for performance of its functions under the contract. The contract deliverables require the contractor to hire and utilize staff to provide Business Process Outsourcing (BPO) services for third party liability and long-term care facility programs. These services included multiple Business Processes, such as nursing facility desk reviews and calculation of nursing facility rates. These services are further defined in the proposed scope of work submitted to DHS by DXC. In the proposed scope, DXC details the completion of nursing facility desk reviews and long-term care cost facility reports. The proposed scope, once approved by DHS, became part of the scope of work between DXC and Myers and Stauffer, the subcontractor DXC hired to perform the work in compliance with the Contract Performance Indicators. If Myers and Stauffer had failed to perform their obligations as subcontractor, DHS would have legal recourse against DXC as the primary contractor.

Anticipated Completion Date: Completed

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Additional Comments from the Auditor:

DHS staff commented at the preliminary exit conference that ALA had not been communicating with procurement staff concerning the contract referenced in Finding 2019-020. However, ALA had discussed the finding with individuals the Agency had identified as points of contact, as noted below. Additionally, Agency staff did not voice any concerns regarding this finding or provide any explanation that supports the Agency's official response, either during or subsequent to the final exit conference.

As a result of these factors and to establish additional context, a timeline of ALA's communication with Agency staff regarding the contract and the related finding is provided below.

State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-020 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA Number(s) and Program Title(s): 93.778 – Medical Assistance Program
(Medicaid Cluster)
Federal Awarding Agency: US Department of Health and Human Services
Federal Award Number(s): 05-1805AR5MAP; 05-1905AR5MAP
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Special Tests and Provisions –
Inpatient Hospital and Long-Term
Care Facility Audits
Type of Finding: Material Weakness

Additional Comments from the Auditor (Continued):
Communication Timeline

August 6, 2019 – ALA first discovered the relationship between Myers & Stauffer and DXC. At that time, ALA requested copies of DXC contract amendments, which included the work performed by Myers & Stauffer regarding long-term care (LTC) facility cost report reviews.

August 7, 2019 – The Agency provided ALA with a Word document describing services to be provided by DXC. No official contract documents were included, so ALA promptly requested additional clarification to determine if the Word document was from an official contract amendment or an amendment request. The Agency did not provide the additional information requested.

During discussions with Lynn Burton (Business Operations Manager, Shared Services Office of Finance – Provider Reimbursement), ALA was informed that the original contract between DXC and DHS did not include the performance of LTC cost report reviews as a deliverable, but the Agency had requested an amendment to include these reviews. Consequently, auditors reviewed contract documents previously provided but were unable to locate the deliverables in any contracts or amendments.

August 12, 2019 – At the Agency’s request, ALA utilized a **JIRA request** to update the Agency regarding the status of this contract issue and asked that the Agency provide documentation for inclusion of the deliverable in the contract and any amendments.

August 13, 2019 – ALA met with Lynn Burton and Maggie Newton (Business Operations Manager, DMS – Promulgation & Compliance, Contract Oversight), who again stated that the original contract did not include the performance of LTC cost report reviews in the deliverables and that they were unable to find addition of the reviews in any subsequent amendments.

August 19, 2019 – The Agency provided ALA with 14 additional attachments to the original contract, with no guidance regarding where ALA would find deliverables related to the cost report reviews. ALA reviewed the files and found an area regarding Provider Reimbursement that referenced an RFP attachment the Agency had not provided.

August 20, 2019 – ALA requested the RFP attachment.

August 21, 2019 – The Agency provided 21 additional documents (671 total pages) related to the contract, including the RFP attachment. However, again, the Agency provided no guidance as to where ALA would find deliverables related to the review of LTC cost reports.

August 29, 2019 – ALA notified the Agency (through JIRA) that auditors had reviewed the documentation provided; were unable to locate the deliverables in the contract; and as a result, would issue an internal control finding (i.e., Finding 2019-020). **The Agency provided no additional response to ALA from August 29 through the end of audit field work on December 27, 2019.** As a result, Finding 2019-020 was issued based on the information provided to ALA as of the end of field work.

January 8, 2020 – ALA met with Brett Hays (DHS Chief Security and Compliance Officer) and Kristen Green (Attorney Specialist, Shared Services – Office of Security and Compliance) to discuss Single Audit findings in preparation for the preliminary exit conference for the Medicaid and CHIP programs.

State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-020 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA Number(s) and Program Title(s): 93.778 – Medical Assistance Program
(Medicaid Cluster)
Federal Awarding Agency: US Department of Health and Human Services
Federal Award Number(s): 05-1805AR5MAP; 05-1905AR5MAP
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Special Tests and Provisions –
Inpatient Hospital and Long-Term
Care Facility Audits
Type of Finding: Material Weakness

Additional Comments from the Auditor (Continued):

January 22, 2020 – At the preliminary exit conference, ALA again presented each audit finding related to the Medicaid and CHIP programs. Numerous Agency staff were present, including Cindy Gillespie (Secretary of Arkansas Human Services), Dawn Stehle (Deputy Director/Medicaid Director), Janet Mann (DMS Director), and Brett Hays. Regarding Finding 2019-020, Ms. Gillespie commented that ALA had not been communicating with Agency procurement staff concerning the contract. In response, ALA informed Ms. Gillespie that auditors asked for contract information using the JIRA system, as the Agency requested, and were not in control of how the Agency retrieved or provided the information.

February 10, 2020 – ALA met with Agency staff for the final exit conference for all major programs administered by DHS. The Agency expressed no concerns, during or subsequent to the final exit conference, regarding Finding 2019-020 and offered no explanation to support the official response provided by Mary Kathryn Williams (Chief Procurement Officer).

State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019

Finding Number: 2019-021
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1805AR5MAP; 05-1905AR5MAP
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Special Tests and Provisions –
Utilization Control and Program Integrity and
Medicaid Fraud Control Unit
Type of Finding: Noncompliance and Material Weakness

Repeat Finding:
Not applicable

Criteria:

In accordance with 42 CFR § 438.350, each state that contracts with a Managed Care Organization (MCO) or Prepaid Ambulatory Health Plan (PAHP) must ensure that an annual external quality review (EQR) is performed for each MCO or PAHP.

In addition, 42 CFR § 438.364 states that the EQR results must be included in an annual technical report that must be finalized by April 30 of each year.

Condition and Context:

The Healthy Smiles Waiver, Arkansas's dental managed care program, is a PAHP and became effective on January 1, 2018. Two entities participate in the dental managed care program: Delta Dental and MCNA Dental. An EQR is required for both entities and was due by April 30, 2019.

ALA inquiry and request for the annual report revealed that as of October 28, 2019, the Agency had yet to retain a vendor to perform the EQR and was still working on the RFP (request for proposal) to select the vendor.

Statistically Valid Sample:

Not a statistically valid sample

Questioned Costs:

None

Cause:

The Agency has experienced staff turnover and did not develop or document internal control procedures for the dental managed care program for its staff.

Effect:

Failure to document and implement appropriate procedures for internal control limits the Agency's ability to adequately monitor the program for noncompliance, such as the noncompliance with the EQR requirements for the dental managed care program noted above.

Recommendation:

ALA staff recommend the Agency develop and document internal controls over the dental managed care program to aid in ensuring compliance with the program, including those related to EQRs.

Views of Responsible Officials and Planned Corrective Action:

DHS concurs with the finding. The agency has begun the process to secure a vendor to perform the reviews. The contract for this service was posted for bid on January 31, 2020 and a contract start date of July 1, 2020.

**State of Arkansas
Schedule of Findings and Questioned Costs
For the Year Ended June 30, 2019**

Finding Number: 2019-021 (Continued)
State/Educational Agency(s): Arkansas Department of Human Services
Pass-Through Entity: Not Applicable
CFDA 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): 05-1805AR5MAP; 05-1905AR5MAP
Federal Award Year(s): 2018 and 2019
Compliance Requirement(s) Affected: Special Tests and Provisions –
Utilization Control and Program Integrity and
Medicaid Fraud Control Unit
Type of Finding: Noncompliance and Material Weakness

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

Anticipated Completion Date: 7/1/2020

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