ARKANSAS LEGISLATIVE AUDIT
REPORT ON:
DEPARTMENT OF HUMAN SERVICES
FOR THE YEAR ENDED JUNE 30, 2020

Finding 1:
Ark. Code Ann. § 19-4-1502 states that it is the responsibility of the executive head of each state agency to keep and maintain a record of all property of the agency belonging to the State of Arkansas. Regulation R1-19-4-1503 of the State Financial Management Guide states that all items transferred, lost, stolen, destroyed, or sold must be promptly removed from the detail of capital assets. While performing an observation of capital assets, we noted the following:

Of a sample of 60 equipment items:

- 3 equipment items could not be located for observation.
- 5 equipment items had no identifying serial number recorded in the Arkansas Administrative Statewide Information System (AASIS).
- 13 equipment items were not considered to be currently inventoried. The latest inventory dates noted in AASIS ranged from 2 years up to 6 years ago.

Recommendation:
We recommend the Agency perform inventory observations on a current basis, make any corrections needed for inaccurate or incomplete information in AASIS, and strengthen controls over capital assets by ensuring that management periodically reviews asset information for accuracy and completeness.

Agency Response:
DHS concurs with this finding. In Fiscal Year 2021, the agency completed physical asset sighting for 94% of its assets and updated the agency's asset listing in AASIS. This was accomplished through identifying and training asset coordinators and asset specialists and implementation of new asset tracking software. The agency will conduct internal investigations to identify the remaining assets and will complete regular audits to ensure compliance with DHS asset management policy. Expected Completion Date: 12/31/2021

Finding 2:
Ark. Code Ann. § 19-4-805 requires that agencies holding monies not deposited in the State Treasury, other than the institutions of higher learning, abide by the recommendations of the State Board of Finance. State Board of Finance policy states that all cash funds on deposit with a bank or financial institution that exceed FDIC deposit insurance coverage must be collateralized and the collateral pledged must be held by an unaffiliated third-party custodian in an amount at least equal to 105% of the cash funds on deposit. During our review of collateral, we noted that $3,674,330 of a bank account’s balance at June 30, 2020, was not properly collateralized. Collateral had been pledged against the bank account’s collected balance and not against the bank account’s ledger balance. The Agency has subsequently updated the collateral agreement with the bank. Beginning September 28, 2020, collateral will be pledged against the ledger balance.

Recommendation:
We recommend the Agency analyze deposits with financial institutions throughout the year to ensure compliance with State Board of Finance policy and Arkansas law.

Agency Response:
DHS concurs with this finding. DHS currently performs a monthly review of its bank accounts to confirm they are properly collateralized. If the agency identifies non-compliance with any account, the agency immediately contacts the bank to address the non-compliance. Completion Date: 12/11/2020

Finding 3:
Regulation R1-19-4-805 of the State Financial Management Guide states that bank activity should be recorded on a real-time basis in AASIS or, with approval from the Department of Finance and Administration, on a monthly basis for accounts held at multiple office locations. For 24 of 31 bank accounts reviewed, the Agency failed to properly record the banking activity monthly in AASIS. For the majority of these accounts, the banking activity for the year was all reported in AASIS in either period 12 or 13. Lack of timely reporting of banking activity in AASIS could lead to the misappropriation of state funds and misstatements of the Agency's financial statements.

Recommendation:
We recommend the Agency review and follow the cash management procedures established in Regulation R1-19-4-805 of the State Financial Management Guide regarding the timely reporting of banking activity in AASIS.

Agency Response:
DHS concurs with this finding. The agency has implemented new monthly reconciliation procedures for all bank accounts. Banking activity is reported in AASIS following the completion of monthly reconciliations. Completion Date: 5/10/2021

Finding 4:
Regulation R4-19-4-501 of the State Financial Management Guide states that good internal controls dictate daily deposits to a commercial bank account, and weekly deposits are allowable if minimal amounts of cash and/or checks are received. Additionally, Conway Human Development Center (HDC) Canteen Policy No. IX-G-4 states that receipts are to be delivered to the business office each afternoon for accounting purposes and deposit. The Conway HDC Canteen bank account had monthly total deposits ranging from $10,341 to $16,121 in canteen sales, with a total of $154,135 for fiscal year 2020. As a result of our review of canteen sales, we determined the Agency consistently made deposits from 9 to 13 days after the original sales date, in noncompliance with R4-19-4-501 and Policy No. IX-G-4.

Regulation R4-19-4-501 further states that the use of mechanical receipting devices, such as cash registers, is acceptable and encouraged, and all cash receipts must be balanced daily by mode of payment to the total of the cash received against the cash register totals. The Agency implemented the use of an electronic point-of-sale system at the Conway HDC Canteen during fiscal year 2020, beginning in July 2019. The Agency failed to incorporate the use of the system's electronic sales reports in reconciling daily sales receipts. Instead, handwritten batch reports were prepared, and the mode of payment received (cash, check, etc.) was not segregated. Additionally, three deposits totaling $411 were not included on the handwritten batch reports.

Our review also revealed that $3,882 in daily canteen sales for June 2020 remained on hand at year-end and were not recorded in AASIS as a "cash on hand" asset. The total sales amount on hand pertained to daily canteen sales received from June 19, 2020 through June 30, 2020.

Delay in timely depositing of sales revenue as well as failure to use system sales reports in reconciliation of receipts could lead to misappropriation of funds.

Recommendation:
We recommend the Agency review and follow State Financial Management Guide regulation R4-19-4-501 and Conway HDC Canteen Policy No. IX-G-4 regarding the deposit and reconciliation of canteen daily sales. We also recommend the Agency record all undeposited cash receipts on hand as an asset in AASIS with any given year-end.

Agency Response:
DHS concurs with the finding. Conway HDC Canteen Policy No. IX-G-4 has been changed to require a deposit any day there is over $100.00 in cash on hand (i.e., in excess of daily cash drawer amount). The practical effect of this change is daily deposits will be made on Monday through Friday and not on the weekends when Canteen hours are limited and there are few transactions; however, it would require a weekend deposit on days where there was a higher than normal weekend day of business. The Conway HDC Business Manager will be personally responsible for ensuring daily Canteen receipts are deposited as required. Additionally, the electronic sales report produced by the Canteen point-of-sale system, which does break down purchases by mode of payment received, will be included as part of the daily reconciliation process. Completion Date: 8/31/2021

Finding 5:
Chapter 201, Section III (I), of the Agency's Administrative Procedures Manual states that a detailed subsidiary ledger of client transactions concerning personal funds shall be maintained and should be reconciled monthly to the applicable bank statement balance. Arkansas State Hospital (ASH) policy number 08.13.50 states that patient funds are to be returned to the patient upon discharge, or if after hours, the funds are to be mailed to the last known address provided during the discharge planning process.

During our review of the ASH Patients Money Fund bank account totaling $61,407, we noted the following:

- The Agency failed to perform monthly reconciliations of the patient subsidiary ledger against the monthly bank statement reconciliations for the full fiscal year 2020, in noncompliance with Chapter 201, Section III (I) of the Agency's Administrative Procedure Manual.

- The patient subsidiary ledger contained 21 accounts with negative balances totaling ($2,491), an increase in 4 additional negative account balances since reported in the fiscal year 2018 audit. We also noted that included in the 21 negative account balances was an account labeled "Miscellaneous," which carried a negative balance of ($566).

- It is common for ASH to receive Foster Care board payments for patients within the Foster Care program. Upon patient discharge, any balance of a foster care patient's account is to be returned to the Agency's Division of Children and Family Services. According to Agency personnel, as of June 7, 2021, the last time any Foster Care board payment monies were returned was during calendar year 2018.

- ASH has the capacity to hold 222 patients; the patient census data report at June 30, 2020, listed 201 admitted patients. On the same date, ASH's patient subsidiary ledger listed 620 patient accounts, of which 492 were not listed as current patients at year-end per the census data report. Of the 492 patient accounts, 473 carried positive balances totaling $31,477, and the remaining 19 carried negative balances totaling ($1,915). Further review revealed that patients associated with 370 of the positive accounts, totaling $21,908, were discharged 2 to 23 years ago, and patients associated with 16 of the negative accounts, totaling ($1,660) were discharged 4 to 18 years ago. The Agency did not properly return patient funds upon discharge, as required per ASH Policy Number 08.13.50.

Lack of due diligence in verifying patients' account balances, as well as improper accounting of and lag in prompt return of patient funds upon discharge, could lead to misappropriation of funds entrusted to the Agency.

Recommendation:
We recommend the Agency properly monitor and account for patient funds by implementing sound internal control procedures in documenting, recording, and reconciling patients' funds, in accordance with Chapter 201 Section III (I) of the Agency's Administrative Procedures Manual. We further recommend the Agency implement procedures to ensure prompt return of funds upon patient discharge, in compliance with ASH Policy Number 08.13.50, as well as ensure that account balances are not allowed to become negative.

Agency Response:
DHS concurs with this finding. DHS will develop internal processes to identify and return patient funds to patients or the Division of Children and Family Services, as appropriate, and DHS also will continue to train staff to ensure that all refunds are returned to the proper fund or account in a timely manner. In addition, DHS will review and update internal processes to prevent negative balances in patient accounts. DHS also will continue to train finance and facility staff to ensure that disbursements are not made from patient funds with insufficient balances.

Finding 6:
Regulation R4-19-4-501 of the State Financial Management Guide states that strict control should be maintained during the processing of cash receipts to ensure they are properly accounted for, and thorough management review and supervision should exist to help safeguard assets. Additionally, DHS Policy 1006 (I) states that DHS employees must avoid any potential conflict of interest or appearance of impropriety.

On April 5, 2010, the Arkansas State Hospital (ASH) Celebration Committee (Committee) was created by former ASH employees as a separate nonprofit entity in response to employee satisfaction surveys regarding employee morale. The Committee's by-laws state the purpose of the Committee is to recognize ASH employees for their service and to raise funds for awards and special events. Officers of the Committee currently consist of both former and current employees as well as non-salaried individuals performing services for the Agency. The Committee has a bank account that is not considered a bank account of the Agency; therefore, the banking activity and ending bank balance are not reported in AASIS.

During our testing of the ASH check receipt log, we noted one instance in which a monthly vending machine commission check for $600, payable to the Arkansas State Hospital, was deposited into the Committee bank account instead of the Agency's state treasury fund. ASH personnel stated that it has been common practice for many years for 2 of the 12 monthly commission checks to be deposited into the Committee's bank account, with the remaining 10 monthly commission checks deposited into the Agency's state treasury fund.

The ASH check receipt log also listed the receipt of a state-issued warrant for $710 payable to the Committee for a rental fee charged for one of ASH's state-owned parking lots. Further review revealed the warrant was deposited into the Committee bank account, along with $4,420 in cash generated by a fundraiser in which fees were charged for parking cars on ASH's other state-owned lots during War Memorial football games. We question the practice of ASH employees, alongside the Committee, using state-owned resources to generate private fundraiser monies.

Recommendation:
We recommend the Agency review and follow State Financial Management Guide regulation R4-19-4-501 to ensure that all items payable to the Agency are properly deposited into the Agency's state treasury fund and/or bank account. Furthermore, we recommend the Agency inform employees and individuals performing services for the Agency of DHS Policy 1006 (I) regarding ethical standards relating to conflicts of interest.

Agency Response:
DHS concurs with this finding. The agency will collaborate with the ASH Celebration Committee on developing fundraising efforts that are in compliance with the State Financial Management Guide and the DHS Ethics Policy. Expected Completion Date: October 15, 2021

Finding 7:
R1-19-4-2004 of the State Financial Management Guide states that monies lost through improper redemption of checks shall be reported to Arkansas Legislative Audit (ALA), the Attorney General's office, and local law enforcement. Ark. Code Ann. § 25-1-124(b)(1)&(2) states that a public employee with supervisory fiduciary responsibility over all fiscal matters of a public employer shall report to ALA the apparent theft or misappropriation of public funds within five business days upon the learning of the theft.

The Agency properly notified ALA and authorities of the following occurrences related to fraudulent activity:

- During performance of a bank reconciliation of the Conway Human Development Center Personal Funds Account, the Agency discovered that a fraudulent check in the amount of $2,900 cleared the bank on October 15, 2020. The original check number was issued during August 2020 in the amount of $133. The Agency filed a police report, and the bank subsequently refunded the full amount of $2,900 on November 13, 2020. Furthermore, ALA reviewed fiscal year 2020 activity for this bank account during the departmental audit and noted no fraudulent activity during the year ending June 30, 2020.

- A Supplemental Nutrition Assistance Program (SNAP) recipient sent in eight personal checks totaling $10,946 as reimbursement to the Agency for an excess SNAP monies received. The eight checks were deposited in the Agency's central office US Bank General Account on June 9, 2020. The Agency later determined the recipient had over-reimbursed $4,433 and issued a refund check on June 10, 2020, from the US Bank General Account. Subsequently, on June 11, 2020, all of the eight personal checks totaling $10,946 were returned by the bank due to insufficient funds (NSF). The refund check for $4,433 was cashed, clearing the bank on July 10, 2020. The Agency filed a police report, and as of report date, the funds had not been recovered. We reviewed subsequent NSF check amounts on this account totaling $664 for the period July 2020 through March 2021 and noted no fraudulent activity. The Agency has subsequently implemented procedures concerning the proper monitoring of NSF checks.

- The Agency contracts out the electronic disbursement of Medicaid Providers' claims payments with a fiscal intermediary (contractor). On January 15, 2021, the contractor notified the Agency of an Electronic Funds Transfer wire fraud totaling $3,330,507 disbursed from the Agency's Bank of America Medicaid Funding Account. On January 7, 2021, a fraudulent e-fax request to change a valid Medicaid Provider's bank account information was processed by the contractor, in accordance with internal procedures. On January 14, 2021, the weekly Medicaid payment amount due to the Provider was processed appropriately but disbursed to the fraudulent bank account. On January 20, 2021, Bank of America recovered the full amount of $3,330,507 due to the fraudulent bank account being closed. The Agency notified the Office of Medicaid Inspector General and the Medicaid Fraud Control Unit of the Arkansas Attorney General's Office of this fraudulent activity. Furthermore, we reviewed fiscal year 2020 activity for this bank account during our departmental audit and noted no fraudulent activity for the year ending June 30, 2020.

Recommendation:
We recommend the Agency continue to report any possible fraudulent activity to ALA, in accordance with R1-19-4-2004 of the State Financial Management Guide and Ark. Code Ann. § 25-1-124.

Agency Response:
DHS concurs with this finding. The agency has updated procedures and controls to lessen agency exposure to theft of public funds and will continue to report fraudulent activity in accordance with Ark. Code Ann. 25-l-124(b)(l) (2).

Finding 8:
Regulation R4-19-4-501 of the State Financial Management Guide states that strict control over the processing of cash receipts should be maintained to ensure they are properly accounted for and supervisory review and authorization of all voided/deleted receipts must be performed weekly. Our review of deleted receipt transactions in AASIS revealed that weekly supervisory review did not occur for the full fiscal year 2020. Lack of proper review of voided receipt transactions could lead to the theft and misappropriation of funds.

Recommendation:
We recommend the Agency review and follow State Financial Management Guide regulation R4-19-4-501 regarding the requirement of performing weekly reviews of deleted receipt transactions in AASIS.

Agency Response:
DHS concurs with this finding. The agency has developed new procedures and trained staff on the review of deleted receipt transactions. Completion Date: 5/31/21

Finding Number:	**2020-013**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
CFDA Number(s) and Program Title(s):	**93.659 – Adoption Assistance**
Federal Awarding Agency:	**U.S. Department of Human Services**
Federal Award Number(s):	**2001ARADPT; 1901ARADPT; 1801ARADPT**
Federal Award Year(s):	**2018, 2019, and 2020**
Compliance Requirement(s) Affected:	**Eligibility**
Type of Finding:	**Significant Deficiency**

Repeat Finding:
Not applicable

Criteria:
In accordance with 42 USC § 673(a)(4)(A) and (B), a payment may not be made to parents, with respect to a child, if the state determines that the parents are no longer legally responsible for the support of the child or the child is no longer receiving any support from the parents. Parents who have been receiving adoption assistance payments shall keep the state responsible for administering the program informed of circumstances that would make them ineligible for the payments.

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:
When an adoptive parent is no longer legally responsible for the support of the child (i.e., death of parent, termination of parental rights, child no longer receiving support from parent), the Adoption Unit must be notified in order to end the adoption subsidy. However, the notifications are not always timely, and the required information entered into the Children's Reporting and Information System (CHRIS) is delayed, resulting in payments made to parents past the subsidy end date. As a result, the Agency established internal control procedures to identify these types of payments and forward the overpayment information to the accounts receivable department for collection.

ALA obtained a report from CHRIS staff that contained all subsidy overpayments for the year ended June 30, 2020. The report contained subsidy overpayments for 33 clients. ALA reviewed documentation for 5 clients to ensure the overpayments were researched and properly submitted for collection.

The following deficiencies were noted:

- For 2 clients, the adoption subsidy continued for six months following the death of the adoptive parent. Agency staff were unaware that the six monthly checks had been cashed and did not perform research procedures to determine if the accounts receivable department should be notified of an overpayment. *Questioned costs totaled $3,610.*
- For 2 clients, the Agency was not notified timely that parental rights had been terminated. Additionally, when the termination was discovered, the overpayment information sent to the accounts receivable department was not complete because it did not include the entire overpayment period, voided warrants, or uncashed warrants. *Questioned costs totaled $10,467.*

Further discussion with the Agency revealed that required overpayment adjustments have not been made on the quarterly federal financial reports or communicated with the federal awarding agency.

In addition, the Agency acknowledged that its documented internal control procedures have not been updated since 2015.

Finding Number:	**2020-013 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services**
Pass-Through Entity:	**Not Applicable**
CFDA Number(s) and Program Title(s):	**93.659 – Adoption Assistance**
Federal Awarding Agency:	**U.S. Department of Human Services**
Federal Award Number(s):	**2001ARADPT; 1901ARADPT; 1801ARADPT**
Federal Award Year(s):	**2018, 2019, and 2020**
Compliance Requirement(s) Affected:	**Eligibility**
Type of Finding:	**Significant Deficiency**

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
State fiscal year 2020 - $5,604
State fiscal year 2019 - $5,492
State fiscal year 2018 - $2,981

Cause:
The internal control process for identifying, researching, calculating, and submitting overpayments to accounts receivable is inadequate. Additionally, the Adoption Unit is not notified timely of events requiring an adoption subsidy to end.

Effect:
The Agency does not have an adequate process in place to accurately identify and calculate overpayments and properly notify the accounts receivable department that an overpayment has occurred. Additionally, the federal awarding agency may require a refund.

Recommendation:
ALA staff recommend the Agency immediately update its documented internal control procedures regarding the overpayment process and provide relevant training to staff. In addition, ALA staff recommend the Agency immediately develop procedures for notifying the Adoption Unit regarding termination of adoptive parent parental rights to ensure subsidy end date information is processed timely.

Views of Responsible Officials and Planned Corrective Action:
DHS concurs with this finding. The Division of Children and Family Services (DCFS) has reviewed and updated the internal control procedures to include overpayment processes. Additional training has been provided to the adoption staff responsible for reviewing overpayments. DCFS has also worked with the Office of Information Technology to create a new report to identify when the termination of parental rights has been entered in CHRIS for a dissolved adoption. The report will allow the adoption staff to complete the subsidy end date in CHRIS and review for any overpayment.

Anticipated Completion Date: April 30, 2021

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Finding Number:	**2020-014**
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):	**05-1905AR5021; 05-2005AR5021 (Children's Health Insurance Program)** **05-1905AR5MAP; 05-2005AR5MAP (Medicaid Cluster)**
Federal Award Year(s):	**2019 and 2020**
Compliance Requirement(s) Affected:	**Allowable Costs/Cost Principles**
Type of Finding:	**Noncompliance and Significant Deficiency**

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

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

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

Finally, 42 CFR § 457.628(a) states that the requirements for the Medicaid program under 42 CFR §§ 433.312 - 433.322 also apply to the Children's Health Insurance Program (CHIP).

Condition and Context:
ALA review of the Agency's process for reporting provider overpayments due to fraud resulted in the discovery of four overpayments, totaling $72,686, that were not reported on the CMS-64 as required. In addition, three of the four overpayments were never entered into the Agency's QuickBooks system, intended to be the Agency's monitoring mechanism for its receivables.

The Agency confirmed that it does not identify the program from which overpayments were originally paid (i.e., Medicaid or CHIP). Therefore, ALA was unable to determine that all reported overpayments, which were not recouped through ICN level adjustments in MMIS, were appropriately applied to the Medicaid program.

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
Medicaid - $72,686
CHIP - Unknown

Cause:
Individuals involved in the collecting and reporting of provider overpayments did not have an adequate understanding of the federal regulations governing the reporting of identified overpayments.

Finding Number:	**2020-014 (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):	**05-1905AR5021; 05-2005AR5021 (Children's Health Insurance Program)** **05-1905AR5MAP; 05-2005AR5MAP (Medicaid Cluster)**
Federal Award Year(s):	**2019 and 2020**
Compliance Requirement(s) Affected:	**Allowable Costs/Cost Principles**
Type of Finding:	**Noncompliance and Significant Deficiency**

Effect:
The Agency failed to report all identified overpayments and to report the overpayments timely. 42 CFR § 433.320(a)(4) states that if the federal share of an overpayment is not refunded, the state will be liable for interest on the amount equal to the federal share of the non-recovered, non-refunded overpayment amount. Interest during this period will be at the Current Value of Funds Rate and will accrue beginning on the day after the end of the one-year period following discovery until the last day of the quarter for which the CMS-64 is submitted, refunding the federal share of the overpayment.

Recommendation:
ALA staff recommend the Agency provide adequate training to ensure staff responsible for identifying and reporting provider overpayments fully understand the reporting requirements for overpayments that are identified by the Office of Medicaid Inspector General and the Medicaid Fraud Control Unit. ALA further recommends the Agency strengthen controls to ensure all identified overpayments are included on the appropriate CMS-64 and reported timely.

Views of Responsible Officials and Planned Corrective Action:
DHS concurs with this finding. The agency updated its procedures for processing Medicaid provider overpayments received from OMIG and MFCU on February 19, 2020. The payments noted in the findings were received from MFCU prior to the agency's implementation of corrective action.

The agency will attach funding codes to overpayments that can be identified as Medicaid or CHIP for reporting.

Anticipated Completion Date: June 30, 2021

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Finding Number:	**2020-015**
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):	**05-1905AR5021; 05-2005AR5021 (Children's Health Insurance Program)** **05-1905AR5MAP; 05-2005AR5MAP (Medicaid Cluster)**
Federal Award Year(s):	**2019 and 2020**
Compliance Requirement(s) Affected:	**Allowable Costs/Cost Principles – Managed Care Medical Loss Ratio (PASSE and Dental)**
Type of Finding:	**Material Weakness**

Repeat Finding:
Not applicable

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

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

- Establish and maintain effective internal control over the federal award that provides reasonable assurance that the non-federal entity is managing the federal award in compliance with federal statutes, regulations, and the terms and conditions of the award. These controls should 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 documented Medical Loss Ratio (MLR) internal controls for the Dental managed care program. After further inquiry to gain an understanding of the Agency's control processes, ALA was unable to identify any internal controls and could not perform MLR control testing on the Dental managed care program.

ALA was able to identify and test MLR controls for the Provider-Led Arkansas Shared Savings Entity (PASSE) managed care program. MLR reports are a requirement of each PASSE. These reports must be submitted to the Agency by April 30 and meet certain requirements outlined in the PASSE agreement as follows:

a) Total incurred claims.
b) Expenditures on quality improving activities.
c) Expenditures related to activities compliant with program integrity requirements.
d) Non-claims costs.
e) Premium revenue.
f) Taxes.
g) Licensing fees.
h) Regulatory fees.
i) Methodologies for allocation of expenditures.
j) Any credibility adjustment applied.
k) The calculated MLR.
l) Any remittance owed to the state, if applicable.

Finding Number:	**2020-015 (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):	**05-1905AR5021; 05-2005AR5021 (Children's Health Insurance Program)** **05-1905AR5MAP; 05-2005AR5MAP (Medicaid Cluster)**
Federal Award Year(s):	**2019 and 2020**
Compliance Requirement(s) Affected:	**Allowable Costs/Cost Principles – Managed Care Medical Loss Ratio (PASSE and Dental)**
Type of Finding:	**Material Weakness**

Condition and Context (Continued):

m) A comparison of the information reported with the audited financial report.

n) A description of the aggregation method used to calculate total incurred claims.

o) The number of member months.

Our testing revealed that adequate documentation was not provided to support that the required MLR reports were submitted timely and contained complete and accurate information. As a result, ALA was unable to determine if there was sufficient, appropriate evidence documenting that this control was operating effectively.

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
None

Cause:
The Agency did not adequately develop or document internal control procedures for its staff regarding MLR for the Dental managed care program. Adequate oversight was not in place regarding MLR for PASSE.

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

Recommendation:
ALA staff recommend the Agency develop and document internal controls regarding MLR for the Dental managed care program. In addition, ALA recommends the Agency strengthen the PASSE internal controls for MLR to ensure consistent operating effectiveness of the controls.

Views of Responsible Officials and Planned Corrective Action:
DHS concurs with this finding. The agency contracts with a vendor to perform an actuarial analysis of Medical Loss Ratio (MLR reports) for PASSE and Dental Managed Care. The vendor produces a report of this analysis. The agency will develop written controls addressing the actuarial review, submission, and completion of MLR reports for PASSE and Dental Managed Care.

Anticipated Completion Date: April 30, 2021

Finding Number:	**2020-015 (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**
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Federal Award Year(s):	**2019 and 2020**
Compliance Requirement(s) Affected:	**Allowable Costs/Cost Principles – Managed Care Medical Loss Ratio (PASSE and Dental)**
Type of Finding:	**Material Weakness**

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

Contact Person:

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Finding Number:	**2020-016**
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):	**05-1905AR5021; 05-2005AR5021 (Children's Health Insurance Program)** **05-1905AR5MAP; 05-2005AR5MAP (Medicaid Cluster)**
Federal Award Year(s):	**2019 and 2020**
Compliance Requirement(s) Affected:	**Allowable Costs/Cost Principles - Managed Care Medical Loss Ratio (PASSE and Dental)**
Type of Finding:	**Noncompliance and Material Weakness**

Repeat Finding:
Not applicable

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

Additionally, 42 CFR § 438.8(e)(4) defines the requirements regarding fraud prevention activities for the numerator of the MLR calculation.

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

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

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

Finding Number:	**2020-016 (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):	**05-1905AR5021; 05-2005AR5021 (Children's Health Insurance Program)** **05-1905AR5MAP; 05-2005AR5MAP (Medicaid Cluster)**
Federal Award Year(s):	**2019 and 2020**
Compliance Requirement(s) Affected:	**Allowable Costs/Cost Principles - Managed Care Medical Loss Ratio (PASSE and Dental)**
Type of Finding:	**Noncompliance and Material Weakness**

Condition and Context (Continued):

Dental Managed Care:

Two entities participate in the Dental managed care program, Delta Dental and Managed Care of North America (MCNA). ALA review of the MLR requirements regarding these entities revealed the following:

- No documentation was provided to substantiate that the MLR calculation for calendar year 2018 was performed by MCNA and provided to the Agency.
- Although fraud prevention expenses were included in the numerator of the MLR calculation for Delta Dental for both calendar years 2018 and 2019, there was no Agency review of the calculation; therefore, whether the amounts included were in accordance with the amounts allowed could not be determined.
- Although it is assumed that the MLR reported for a rating period was calculated by using data from that rating period, this could not be verified as there was no Agency review of the accuracy/appropriateness of the MLR calculations performed by Delta Dental and MCNA for calendar years 2018 and 2019.

PASSE:

- No documentation was provided to substantiate that the Agency received prior approval from CMS for the revised calendar year 2019 rates prior to implementing the revised rates in October 2019.
- No documentation was provided to substantiate that the Agency received prior approval from CMS for the revised calendar year 2020 rates prior to implementing the revised rates in June 2020.

Statistically Valid Sample:

Not applicable

Questioned Costs:

Unknown

Cause:

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

Effect:

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

Recommendation:

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

Finding Number:	**2020-016 (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):	**05-1905AR5021; 05-2005AR5021 (Children's Health Insurance Program)** **05-1905AR5MAP; 05-2005AR5MAP (Medicaid Cluster)**
Federal Award Year(s):	**2019 and 2020**
Compliance Requirement(s) Affected:	**Allowable Costs/Cost Principles - Managed Care Medical Loss Ratio (PASSE and Dental)**
Type of Finding:	**Noncompliance and Material Weakness**

Views of Responsible Officials and Planned Corrective Action:

DHS concurs with this finding. The agency contracts with a vendor to perform an actuarial analysis of Medical Loss Ratio (MLR reports) for PASSE and Dental Managed Care. The vendor produces a report of this analysis. The agency will develop written controls addressing the actuarial review, submission, and completion of MLR reports for PASSE and Dental Managed Care.

The agency timely submitted capitation rates to CMS pursuant to 42 CFR § 438.3 for calendar years 2019 and 2020. The agency will work with the CMS to avoid any future delays in rate approval.

Anticipated Completion Date: April 30, 2021

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Finding Number:	**2020-017**
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:	**US Department of Health and Human Services**
Federal Award Number(s):	**05-1905AR5021; 05-2005AR5021 (Children's Health Insurance Program)** **05-1905AR5MAP; 05-2005AR5MAP (Medicaid Cluster)**
Federal Award Year(s):	**2019 and 2020**
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 **2019-017**.

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

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

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

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

The Agency does not maintain documentation identifying the original source of revenues categorized as other non-federal. State general revenues used to meet match requirements are transferred to the paying funds once available. The Agency utilizes an outside accounting system, Lotus 1-2-3, to maintain and trace state general revenue and other non-federal funds available. Agency staff manually key information into this system daily; however, no reviews or controls are in place to ensure the accuracy of this information or the funding category balances.

ALA's prior-year testing revealed that accounting records maintained in the Lotus 1-2-3 system included one-sided adjustments to state general revenue and other non-federal funds, causing the ending balances of both funding categories to be inaccurate. Periodic reconciliations of fund balances in the Lotus 1-2-3 system were only performed "in total" and not by the funding source (i.e., federal, state, or other non-federal).

Finally, Agency procedures implemented to monitor the use of state general revenue and other non-federal funding sources are completed at the Division level instead of the federal program level (i.e., Medicaid, CHIP, etc.).

As a result, sufficient, appropriate evidence could not be provided for ALA to perform testing to determine if the State met the required match in accordance with federal regulations.

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
Unknown

Finding Number:	**2020-017 (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:	**US Department of Health and Human Services**
Federal Award Number(s):	**05-1905AR5021; 05-2005AR5021 (Children's Health Insurance Program)** **05-1905AR5MAP; 05-2005AR5MAP (Medicaid Cluster)**
Federal Award Year(s):	**2019 and 2020**
Compliance Requirement(s) Affected:	**Matching, Level of Effort, Earmarking**
Type of Finding:	**Material Noncompliance and Material Weakness**

Cause:
Internal controls and monitoring procedures regarding the identification of revenue sources used for matching are inadequate to effectively monitor state match requirements at the federal program level.

Effect:
Compliance with the matching compliance requirement cannot be determined.

Recommendation:
ALA recommends the Agency review and strengthen internal controls to allow the Agency to appropriately identify funding sources used to meet state match requirements.

Views of Responsible Officials and Planned Corrective Action:
DHS disputes in part and concurs in part with this finding. While the agency maintains documentation identifying funds classified as "other non-federal" in its fund control *ledgers, the funds and sources could be documented with greater specificity. The agency will update its process to* provider greater specificity in tracking "other non-federal" funds.

The agency is in the process of reviewing general ledger systems to replace Lotus 1-2-3. This system will contain enhanced controls to support maintaining and documenting the accuracy of fund balances.

While the agency is not able to provide the level of detail requested by ALA, we maintain that the current process meets the State match obligation and complies with GAAP and state and federal law.

Anticipated Completion Date: December 31, 2021

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Finding Number:	**2020-018**
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):	**05-1905AR5021; 05-2005AR5021**
Federal Award Year(s):	**2019 and 2020**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed – Managed Care (PASSE)**
Type of Finding:	**Material 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, individuals must have an independent assessment (IA) performed that designates them at the appropriate level of need to participate in the program.

The 1915(c) Home and Community-Based Services Waiver, applicable to the DD population, requires that an IA be performed at least every three years.

Section 1915(i) of the Social Security Act, applicable to the BH population, which provides states the option to offer home and community-based services through the state's plan, requires that an IA be performed at least every 12 months. In addition, 42 CFR § 441.720(b) states that for reassessments, the IA 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:
From a population of over 7,000 PASSE recipients, ALA selected a sample of 60 (classified as BH) to determine if the following attributes had been met:

- An open eligibility segment for the recipient during the dates of service.
- A valid IA on file in effect for the dates of service.
- Appropriate amount paid in accordance with the actuarially determined rates.

ALA's review revealed exceptions affecting payments for 29 recipients as detailed below:

The following 11 exceptions occurred because the Agency could not provide documentation supporting that an IA was updated or in effect for the payments made representing all dates of service. As a result, payments were made outside an approved/updated IA.

- Sample item 1: The IA expired on July 2, 2019, and payments for this recipient continued for dates of service through September 30, 2019. *Questioned costs totaled $8,187.*
- Sample item 3: The IA expired on May 31, 2019, and payments for this recipient continued for dates of service through December 31, 2019. *Questioned costs totaled $8,138.*
- Sample item 12: The IA expired on July 22, 2019, and payments for this recipient continued for dates of service through December 31, 2019. *Questioned costs totaled $6,431.*
- Sample item 14: The IA expired on April 19, 2019, and payments for this recipient continued for dates of service through August 31, 2019. *Questioned costs totaled $1,998.*
- Sample item 25: The IA expired on March 8, 2019, and payments for this recipient continued for dates of service through August 31, 2019. *Questioned costs totaled $2,798.*
- Sample item 26: The IA expired on March 29, 2019, and payments for this recipient continued for dates of service through August 31, 2019. *Questioned costs totaled $3,129.*

Finding Number:	**2020-018 (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):	**05-1905AR5021; 05-2005AR5021**
Federal Award Year(s):	**2019 and 2020**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed – Managed Care (PASSE)**
Type of Finding:	**Material Noncompliance and Material Weakness**

Condition and Context (Continued):

- Sample item 31: The IA expired on May 2, 2019, and payments for this recipient continued for dates of service through August 31, 2019. *Questioned costs totaled $2,996.*
- Sample item 38: The IA expired on April 22, 2019, and payments for this recipient continued for dates of service through June 4, 2019. *Questioned costs totaled $133.*
- Sample item 40: The IA for this recipient became effective on June 28, 2019, and a payment for this recipient was made representing dates of service that were prior to the effective date of the IA. *Questioned costs totaled $899.*
- Sample item 42: The IA expired on May 31, 2019, and payments for this recipient continued for dates of service through December 31, 2019. *Questioned costs totaled $8,138.*
- Sample item 49: The IA expired on November 20, 2019, and payments for this recipient continued for dates of service through December 31, 2019. *Questioned costs totaled $1,710.*

The following 18 exceptions occurred because an IA was not updated timely, resulting in payments made for dates of service outside an approved/updated IA.

- Sample item 2: The IA expired on August 12, 2019, and was not updated until November 12, 2019. Payments for this recipient continued for dates of service from August 13, 2019 through November 11, 2019. *Questioned costs totaled $9,093.*
- Sample item 4: The IA expired on September 4, 2019, and was not updated until January 2, 2020. Payments for this recipient continued for dates of service from September 5, 2019 through January 1, 2020. *Questioned costs totaled $5,009.*
- Sample item 7: The IA expired on June 21, 2019, and was not updated until August 22, 2019. Payments for this recipient continued for dates of service from June 22, 2019 through August 21, 2019. *Questioned costs totaled $1,845.*
- Sample item 9: The IA expired on August 9, 2019, and was not updated until January 13, 2020. Payments for this recipient continued for dates of service from August 10, 2019 through January 12, 2020. *Questioned costs totaled $5,851.*
- Sample item 11: The IA expired on May 29, 2019, and was not updated until August 23, 2019. Payments for this recipient continued for dates of service from May 30, 2019 through August 22, 2019. *Questioned costs totaled $2,707.*
- Sample item 13: The IA expired on March 15, 2019, and was not updated until July 10, 2019. Payments for this recipient continued for dates of service from March 16, 2019 through July 9, 2019. *Questioned costs totaled $1,289.*
- Sample item 17: The IA expired on June 19, 2019, and was not updated until July 11, 2019. Payments for this recipient continued for dates of service from June 20, 2019 through July 10, 2019. *Questioned costs totaled $643.*
- Sample item 21: The IA expired on August 5, 2019, and was not updated until October 17, 2019. Payments for this recipient continued for dates of service from August 6, 2019 through October 16, 2019. *Questioned costs totaled $1,837.*
- Sample item 24: The IA expired on March 21, 2019, and was not updated until August 28, 2019. Payments for this recipient continued for dates of service from March 22, 2019 through August 27, 2019. *Questioned costs totaled $2,678.*

Finding Number:	**2020-018 (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):	**05-1905AR5021; 05-2005AR5021**
Federal Award Year(s):	**2019 and 2020**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed – Managed Care (PASSE)**
Type of Finding:	**Material Noncompliance and Material Weakness**

Condition and Context (Continued):

- Sample item 29: The IA expired on May 24, 2019, and was not updated until July 3, 2019. Payments for this recipient continued for dates of service from May 25, 2019 through July 2, 2019. *Questioned costs totaled $1,058.*
- Sample item 36: The IA expired on August 23, 2019, and was not updated until August 30, 2019. Payments for this recipient continued for dates of service from August 24, 2019 through August 29, 2019. *Questioned costs totaled $193.*
- Sample item 39: The IA expired on May 15, 2019, and was not updated until July 12, 2019. Payments for this recipient continued for dates of service from May 16, 2019 through July 11, 2019. *Questioned costs totaled $1,253.*
- Sample item 44: The IA expired on June 13, 2019, and was not updated until November 25, 2019. Payments for this recipient continued for dates of service from June 14, 2019 through November 24, 2019. *Questioned costs totaled $6,048.*
- Sample item 55: The IA expired on June 6, 2019, and was not updated until July 8, 2019. Payments for this recipient continued for dates of service from June 7, 2019 through July 7, 2019. *Questioned costs totaled $1,025.*
- Sample item 56: The IA expired on July 25, 2019, and was not updated until October 9, 2019. Payments for this recipient continued for dates of service from July 26, 2019 through October 8, 2019. *Questioned costs totaled $2,377.*
- Sample item 57: The IA expired on July 12, 2019, and was not updated until July 22, 2019. Payments for this recipient continued for dates of service from July 13, 2019 through July 21, 2019. *Questioned costs totaled $290.*
- Sample item 59: The IA expired on April 25, 2019, and was not updated until July 18, 2019. Payments for this recipient continued for dates of service from April 26, 2019 through July 17, 2019. *Questioned costs totaled $3,966.*
- Sample item 60: The IA expired on April 30, 2019, and was not updated until September 17, 2019. Payments for this recipient continued for dates of service from May 1, 2019 through September 16, 2019. *Questioned costs totaled $2,996.*

Questioned Costs:
$94,715

Cause:
The full-risk PASSE program began in March 2019. Rather than being performed evenly throughout the year, the majority of the BH assessments were performed by the Agency's contractor, Optum, in large groupings during calendar year 2018. To more evenly distribute the assessment workload throughout the year, the Agency and its contractor spread the assessments out over the full 12 months. Due to the timing of this process, there were still instances of late BH assessments noted during fiscal year 2020.

Effect:
Gaps were revealed in the performance of the required independent assessments for the BH population. As a result, payments were made outside the approved/updated dates of service for numerous recipients.

Finding Number:	**2020-018 (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):	**05-1905AR5021; 05-2005AR5021**
Federal Award Year(s):	**2019 and 2020**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed – Managed Care (PASSE)**
Type of Finding:	**Material Noncompliance and Material Weakness**

Recommendation:
ALA staff recommend the Agency review and strengthen its independent assessment procedures to ensure they are completed timely and in accordance with federal regulations.

Views of Responsible Officials and Planned Corrective Action:
DHS concurs with the finding. As of January 1, 2020, the agency has updated its independent assessment process to ensure timely completion of reassessments. The scheduling process for assessments begins 60 days from the due date of assessment and beneficiaries may call to schedule an assessment up to six months prior to the assessment due date. Members that are not assessed prior to their reassessment date will be removed from the PASSE. (Note: Members are not being removed from the PASSE for lack of reassessment during the COVID-19 federal public health emergency)

Anticipated Completion Date: Complete

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Finding Number:	**2020-019**
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):	**05-1905AR5021; 05-2005AR5021**
Federal Award Year(s):	**2019 and 2020**
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 **2019-006**.

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 40 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 11 of the provider files as follows:

Moderate-risk category:

- Sample item 23: The Agency failed to perform the additional screening requirement (site visit). *Questioned costs totaled $1,978.*
- Sample item 29: The provider's revalidation was due by February 19, 2020, but was not performed until April 13, 2020. In addition, a site visit was never performed supporting the 2015 revalidation. (Subsequent site visits were suspended on March 4, 2020, due to the COVID-19 pandemic.) *Questioned costs totaled $5,155.*
- Sample item 30: The Agency failed to perform the additional screening requirement (site visit). *Questioned costs totaled $523.*
- Sample item 33: The provider's revalidation was due by June 25, 2016, but was not performed until June 6, 2019. *Questioned costs totaled $1,120.*

Finding Number:	**2020-019 (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):	**05-1905AR5021; 05-2005AR5021**
Federal Award Year(s):	**2019 and 2020**
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):

- Sample item 36: The provider's revalidation was due by September 25, 2016, but was not performed until May 7, 2019. *Questioned costs totaled $280.*

Limited-risk category:

- Sample item 9: The provider's revalidation was due by September 25, 2016, but was never performed. According to the Agency, the provider was to be terminated, but due to the COVID-19 pandemic, no providers have been terminated. *Questioned costs totaled $126.*
- Sample item 24: The provider's revalidation was due by April 30, 2017, but was not performed until May 3, 2019. *Questioned costs totaled $480.*
- Sample item 25: The provider's revalidation was due by September 25, 2016, but was not performed until August 29, 2019. In addition, there was not an application on file that covered the entire enrollment period. *Questioned costs totaled $2,206.*
- Sample item 26: The provider's revalidation was due by September 25, 2016, but was not performed until August 29, 2019. In addition, there was not an application on file that covered the entire enrollment period. *Questioned costs totaled $5,607.*
- Sample item 34: The provider's revalidation was due by June 21, 2017, but was not performed until October 25, 2019. *Questioned costs totaled $570.*
- Sample item 38: The Agency did not provide documentation of the provider's certification that covered the entire enrollment period. *Questioned costs totaled $2,665.*

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
$20,710

Cause:
The Agency had asserted that, effective May 31, 2019, it established and implemented new procedures to improve the following areas of provider enrollment: maintenance of provider enrollment application documents, provider revalidation, site visits, and fingerprint background requirements. However, due to timing of the implementation of the new procedures, deficiencies continued to exist during fiscal year 2020.

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

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

Finding Number:	**2020-019 (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):	**05-1905AR5021; 05-2005AR5021**
Federal Award Year(s):	**2019 and 2020**
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:

DHS concurs with this finding. Effective May 31, 2019, DMS established and implemented new procedures to improve the following areas of provider enrollment: maintenance of provider enrollment application documents, provider revalidation, site visits, and fingerprint background requirements. The DHS Office of Payment Integrity and Internal Audit also conducts regular provider eligibility compliance reviews and reports its findings to DMS.

Eight of the eleven deficient provider files relate to non-compliance with revalidation requirements pre-dating May 31, 2019. The deficiencies noted that occurred prior to May 31, 2019 will be corrected upon revalidation for the provider.

Two of the eleven deficient providers revalidated after the established revalidation deadline in SFY2020. These providers submitted applications for revalidation which were not able to be processed by the revalidation deadline due to incomplete information on the application. The providers were not terminated as they submitted the missing information at the request of the agency.

One of the eleven deficient providers did not have the required proof of grant award required for eligibility. The agency sends an automatic notification when a provider's grant award on file expires. If the updated award is not received within 60 days of the expiration date the provider is terminated. This provider was not terminated as the expiration of award occurred during the federal COVID-19 public health emergency.

Anticipated Completion Date: Complete

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Finding Number:	**2020-020**
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):	**05-1905AR5021; 05-2005AR5021**
Federal Award Year(s):	**2019 and 2020**
Compliance Requirement(s) Affected:	**Special Tests and Provisions – Provider Eligibility (Managed Care Organizations)**
Type of Finding:	**Material Noncompliance and Material Weakness**

Repeat Finding:
A similar issue was reported in prior-year finding **2019-007**.

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 (PASSE) managed care program. ALA review revealed deficiencies with 19 of the provider files as follows:

High-risk category:

- Sample item 38: The Agency did not perform the additional screening requirements (site visit and fingerprint background check) or provide documentation of the provider's certification that covered the entire enrollment period. *Ineligible costs totaled $65,070.*

Moderate-risk category:

- Sample item 18: The Agency did not perform the additional screening requirement (site visit) or provide documentation of the provider's certification that covered the entire enrollment period. *Ineligible costs totaled $183.*

Finding Number:	**2020-020 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services**
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Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-1905AR5021; 05-2005AR5021**
Federal Award Year(s):	**2019 and 2020**
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):

- Sample item 19: The Agency did not perform the additional screening requirement (site visit). *Ineligible costs totaled $80.*
- Sample item 20: The Agency did not perform the additional screening requirement (site visit). *Ineligible costs totaled $2,352.*
- Sample item 21: The Agency did not perform the additional screening requirement (site visit). *Ineligible costs totaled $309.*
- Sample item 23: The Agency did not perform the additional screening requirement (site visit) or provide documentation of the provider's certification that covered the entire enrollment period. *Ineligible costs totaled $3,568.*
- Sample item 30: The provider's revalidation was due by December 12, 2019, but was not performed until February 4, 2020. In addition, the Agency did not perform the additional screening requirement (site visit) for the 2014 re-enrollment. *Ineligible costs totaled $18,466.*
- Sample item 39: The provider's revalidation was due by September 25, 2016, but was not performed until October 31, 2019. *Ineligible costs totaled $1,598.*

Limited-risk category:

- Sample item 2: The provider's revalidation was due by September 25, 2016, but was not performed until May 22, 2019. In addition, the Agency could not provide the required W-9 that covered the entire enrollment period. *Ineligible costs totaled $153.*
- Sample item 3: The provider's revalidation was due by September 25, 2016, but was not performed until July 26, 2019. *Ineligible costs totaled $213.*
- Sample item 4: The provider's revalidation was due by September 17, 2017, but was not performed until August 2, 2019. *Ineligible costs totaled $58.*
- Sample item 7: No documentation was provided for this testing item. *Ineligible costs totaled $304.*
- Sample item 8: The provider's revalidation was due by September 25, 2016, but was not performed until July 8, 2019. *Ineligible costs totaled $65.*
- Sample item 12: The provider's revalidation was due by September 25, 2016, but was not performed until March 4, 2020. *Ineligible costs totaled $330.**
- Sample item 22: The provider's revalidation was due by September 25, 2016, but was not performed until August 22, 2019. In addition, the Agency could not provide documentation of the provider's certification that covered the entire enrollment period. *Ineligible costs totaled $1,082.*
- Sample item 24: The provider's revalidation was due by September 25, 2016, but was not performed until June 19, 2019. *Ineligible costs totaled $60.*
- Sample item 27: The provider's revalidation was due by May 22, 2017, but was not performed until August 16, 2019. *Ineligible costs totaled $50.*
- Sample item 31: The provider's revalidation was due by September 25, 2019, but was not performed until December 11, 2019. *Ineligible costs totaled $31.*
- Sample item 34: The provider's revalidation was due by September 25, 2016, but was not performed until August 14, 2019. *Ineligible costs totaled $1,808.**

Finding Number:	**2020-020 (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):	**05-1905AR5021; 05-2005AR5021**
Federal Award Year(s):	**2019 and 2020**
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):
Dental Managed Care* payments for the deficiencies noted above totaled $2,138. PASSE payments totaled $93,642.

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

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

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
Unknown

Cause:
The Agency had asserted that, effective May 31, 2019, it established and implemented new procedures to improve the following areas of provider enrollment: maintenance of provider enrollment application documents, provider revalidation, site visits, and fingerprint background requirements. However, due to timing of the implementation of the new procedures, deficiencies continued to exist during fiscal year 2020.

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

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

Views of Responsible Officials and Planned Corrective Action:
DHS concurs with this 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. Fifteen of the nineteen deficient provider files relate to non-compliance with revalidation requirements pre-dating May 31, 2019. The deficiencies noted that occurred prior to May 31, 2019 will be corrected upon revalidation for the provider. The DHS Office of Payment Integrity and Internal Audit also conducts regular provider eligibility compliance reviews and reports its findings to DMS.

Two of the nineteen deficient providers revalidated after the established revalidation deadline in SFY2020. These providers submitted applications for revalidation which were not able to be processed by the revalidation deadline due to incomplete information on the application. The providers were not terminated as they submitted the missing information at the request of the agency.

Two of the nineteen deficient providers did not have the required proof of certification on file. The agency sends an automatic notification when a provider's certification on file expires. If the certification is not received within 60 days of the expiration date the provider is terminated. One provider submitted the requested certification during SFY20. The other provider has not submitted the requested certification but was not terminated due to the federal COVID-19 public health emergency.

Finding Number:	**2020-020 (Continued)**
State/Educational Agency(s):	**Arkansas Department of Human Services**
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Federal Awarding Agency:	**U.S. Department of Health and Human Services**
Federal Award Number(s):	**05-1905AR5021; 05-2005AR5021**
Federal Award Year(s):	**2019 and 2020**
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: Complete

Contact Person:

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Finding Number:	**2020-021**
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):	**05-1905AR5MAP; 05-2005AR5MAP**
Federal Award Year(s):	**2019 and 2020**
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 **2019-011**.

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 the Arkansas Department of Human Services (DHS) Registered Nurses (RNs) as the basis for calculating the number of attendant care hours that are reasonably and medically necessary. In addition, an Individual Service Budget (ISB) sets the maximum dollar amount for all waiver services received by an individual. Services must be provided according to the beneficiary's PCSP, with reimbursement limited to the amount and frequency authorized on the PCSP.

Condition and Context:
ALA staff reviewed data for 40 beneficiaries to determine if a valid PCSP was in effect for all dates of service for which claims were paid and if attendant care services were provided in accordance with the beneficiary's PCSP and did not exceed the frequency or the maximum amount allowed. This review revealed the following deficiencies regarding 28 beneficiaries:

- Sample item 2: Claims were paid without a valid PCSP for dates of service beginning May 27, 2019 through October 25, 2019. *Questioned costs totaled $3,053.*
- Sample item 3: Claims were paid without a valid PCSP for dates of service beginning June 17, 2019 through January 21, 2020. *Questioned costs totaled $6,187.*
- Sample item 6: Claims were paid without a valid PCSP for dates of service beginning June 4, 2019 through February 13, 2020. *Questioned costs totaled $1,373.*
- Sample item 7: Claims were paid without a valid PCSP for dates of service beginning June 1, 2019 through May 30, 2020. *Questioned costs totaled $19,274* but were only calculated through March 17, 2020, *to ensure adherence to the guidance contained in the note below*.
- Sample item 9: Claims were paid without a valid PCSP for dates of service beginning May 27, 2019 through August 22, 2019. *Questioned costs totaled $1,840.*
- Sample item 10: Claims were paid without a valid PCSP for dates of service beginning June 4, 2019 through May 29, 2020. *Questioned costs totaled $11,857* but were only calculated through March 17, 2020, *to ensure adherence to the guidance contained in the note below*.
- Sample item 11: Claims were paid without a valid PCSP for dates of service beginning June 17, 2019 through October 18, 2019. *Questioned costs totaled $4,828.*
- Sample item 13: Claims were paid without a valid PCSP for dates of service beginning April 3, 2019 through April 28, 2020. *Questioned costs totaled $14,444* but were only calculated through March 17, 2020, *to ensure adherence to the guidance contained in the note below*.

Finding Number:	**2020-021 (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):	**05-1905AR5MAP; 05-2005AR5MAP**
Federal Award Year(s):	**2019 and 2020**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed – Home and Community-Based Services (ARChoices Waiver)**
Type of Finding:	**Noncompliance and Material Weakness**

Condition and Context (Continued):

- Sample item 14: Claims were paid without a valid PCSP for dates of service beginning February 6, 2019 through June 5, 2020. *Questioned costs totaled $7,097* but were only calculated through March 17, 2020, *to ensure adherence to the guidance contained in the note below*.
- Sample item 15: Claims were paid without a valid PCSP for dates of service beginning October 22, 2019 through January 24, 2020. *Questioned costs totaled $268.*
- Sample item 16: Claims were paid without a valid PCSP for dates of service beginning June 18, 2019 through November 4, 2019. *Questioned costs totaled $1,119.*
- Sample item 19: Claims were paid without a valid PCSP for dates of service beginning June 17, 2019 through October 25, 2019. *Questioned costs totaled $4,338.*
- Sample item 21: Claims were paid without a valid PCSP for dates of service beginning June 17, 2019 through September 9, 2019. *Questioned costs totaled $2,350.*
- Sample item 22: Claims were paid without a valid PCSP for dates of service beginning June 10, 2019 through August 17, 2019. *Questioned costs totaled $2,153.*
- Sample item 23: Claims were paid without a valid PCSP for dates of service beginning October 15, 2018 through June 12, 2020. *Questioned costs totaled $7,106* but were only calculated through March 17, 2020, *to ensure adherence to the guidance contained in the note below*.
- Sample item 24: Claims were paid without a valid PCSP for dates of service beginning June 17, 2019 through January 2, 2020. *Questioned costs totaled $11,581.*
- Sample item 26: Claims were paid without a valid PCSP for dates of service beginning June 17, 2019 through February 7, 2020. *Questioned costs totaled $13,090.*
- Sample item 27: Claims were paid without a valid PCSP for dates of service beginning May 1, 2019 through November 25, 2019. *Questioned costs totaled $12,678.*
- Sample item 28: Claims were paid without a valid PCSP for dates of service beginning May 1, 2019 through October 25, 2019. *Questioned costs totaled $5,957.*
- Sample item 29: Claims were paid without a valid PCSP for dates of service beginning June 10, 2019 through June 12, 2020. *Questioned costs totaled $9,221* but were only calculated through March 17, 2020, *to ensure adherence to the guidance contained in the note below*.
- Sample item 30: Claims were paid without a valid PCSP for dates of service beginning August 9, 2019 through October 4, 2019. *Questioned costs totaled $1,252.*
- Sample item 31: Claims were paid without a valid PCSP for dates of service beginning April 19, 2019 through October 28, 2019. *Questioned costs totaled $6,090.*
- Sample item 32: Claims were paid without a valid PCSP for dates of service beginning October 16, 2019 through March 11, 2020. *Questioned costs totaled $3,412.*
- Sample item 33: Claims were paid without a valid PCSP for dates of service beginning January 28, 2020 through February 28, 2020. *Questioned costs totaled $506.*
- Sample item 34: Claims were paid without a valid PCSP for dates of service beginning June 16, 2019 through June 13, 2020. *Questioned costs totaled $14,222* but were only calculated through March 17, 2020, *to ensure adherence to the guidance contained in the note below*.

Finding Number:	**2020-021 (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):	**05-1905AR5MAP; 05-2005AR5MAP**
Federal Award Year(s):	**2019 and 2020**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed – Home and Community-Based Services (ARChoices Waiver)**
Type of Finding:	**Noncompliance and Material Weakness**

Condition and Context (Continued):

- Sample item 37: Claims were paid without a valid PCSP for dates of service beginning June 1, 2019 through September 8, 2019. *Questioned costs totaled $908.*
- Sample item 38: Claims were paid without a valid PCSP for dates of service beginning June 17, 2019 through June 12, 2020. *Questioned costs totaled $16,577* but were only calculated through March 17, 2020, *to ensure adherence to the guidance contained in the note below*.
- Sample item 39: Claims were paid without a valid PCSP for dates of service beginning June 16, 2019 through February 17, 2020. *Questioned costs totaled $14,563.*

NOTE: In accordance with the Families First Coronavirus Response Act (FFCRA), states must provide continuous coverage, through the end of the month in which the emergency period ends, to all Medicaid beneficiaries who were enrolled in Medicaid on or after March 18, 2020, regardless of any changes in circumstances or redeterminations at scheduled renewals that otherwise would result in termination.

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
$197,344

Cause:
The Agency failed to ensure that attendant care hour claims for ARChoices wavier beneficiaries were adequately supported by current and valid agreements (PCSP, RUG score, or ARIA assessment).

Effect:
Amounts paid were in excess of amounts authorized.

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

Views of Responsible Officials and Planned Corrective Action:
DHS concurs with the finding. On July 20, 2020, the agency implemented a workflow management system and strategy to track and report re-evaluation activities that will ensure timely completion of Person-Centered Service Plans for ARChoices beneficiaries.

Anticipated Completion Date: Complete

Finding Number:	**2020-021 (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):	**05-1905AR5MAP; 05-2005AR5MAP**
Federal Award Year(s):	**2019 and 2020**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed – Home and Community-Based Services (ARChoices Waiver)**
Type of Finding:	**Noncompliance and Material Weakness**

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

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Finding Number:	**2020-022**
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; 05-2005AR5MAP**
Federal Award Year(s):	**2019 and 2020**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed – Managed Care (PASSE)**
Type of Finding:	**Noncompliance and Material Weakness**

Repeat Finding:
A similar issue was reported in prior-year finding **2019-012**.

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, individuals must have an independent assessment performed that designates them at the appropriate level of need to participate in the program.

The 1915(c) Home and Community-Based Services Waiver, applicable to the DD population, requires that an IA be performed at least every three years.

Section 1915(i) of the Social Security Act, applicable to the BH population, provides states the option to offer home and community-based services through the state's plan and requires that an IA be performed at least every 12 months. In addition, 42 CFR § 441.720(b) states that, for reassessments, the IA 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 (50 BH recipients and 10 DD recipients) to determine if the following attributes had been met:

- An open eligibility segment for the recipient during the dates of service.
- A valid IA on file in effect for the dates of service.
- Appropriate amount paid in accordance with the actuarially determined rates.

Our review revealed exceptions affecting payments for 22 BH recipients as detailed below:

The following six exceptions occurred because the Agency could not provide documentation supporting that an IA was updated or in effect for the payments made representing all dates of service. As a result, payments were made outside an approved/updated IA as required.

- Sample item 6: The IA expired on May 9, 2019, and payments for this recipient continued for dates of service through August 31, 2019. *Questioned costs totaled $1,973.*
- Sample item 19: The IA expired on May 14, 2019, and payments for this recipient continued for dates of service through August 31, 2019. *Questioned costs totaled $1,973.*
- Sample item 25: The IA expired on April 18, 2019, and payments for this recipient continued for dates of service through August 31, 2019. *Questioned costs totaled $1,973.*
- Sample item 36: The IA expired on October 11, 2019, and payments for this recipient continued for dates of service through December 31, 2019. *Questioned costs totaled $2,852.*
- Sample item 45: The IA expired on December 9, 2019, and payments for this recipient continued for dates of service through December 31, 2019. *Questioned costs totaled $1,863.*
- Sample item 52: The IA expired on June 11, 2019, and payments for this recipient continued for dates of service through December 31, 2019. *Questioned costs totaled $5,793.*

Finding Number:	**2020-022 (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; 05-2005AR5MAP**
Federal Award Year(s):	**2019 and 2020**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed – Managed Care (PASSE)**
Type of Finding:	**Noncompliance and Material Weakness**

Condition and Context (Continued):
The following 16 exceptions occurred because an IA was not updated timely, resulting in payments made for dates of service outside an approved/updated IA.

- Sample item 1: The IA expired on December 19, 2019, and was not updated until February 19, 2020. Payments for this recipient continued for dates of service from December 20, 2019 through February 18, 2020. *Questioned costs totaled $417.*
- Sample item 8: The IA expired on February 26, 2019, and was not updated until May 11, 2020. Payments for this recipient continued for dates of service from February 27, 2019 through May 10, 2020. *Questioned costs, totaling $9,037*, were calculated beginning February 27, 2019 through March 17, 2020, *to ensure adherence to the guidance contained in the note below*.
- Sample item 10: The IA expired on June 10, 2019, and was not updated until June 1, 2020. Payments for this recipient continued for dates of service from June 11, 2019 through May 31, 2020. *Questioned costs, totaling $18,882*, were calculated beginning June 11, 2019 through March 17, 2020, *to ensure adherence to the guidance contained in the note below*.
- Sample item 14: The IA expired on September 17, 2019, and was not updated until December 6, 2019. Payments for this recipient continued for dates of service from September 18, 2019 through December 5, 2019. *Questioned costs totaled $6,524.*
- Sample item 15: The IA expired on August 1, 2019, and was not updated until September 23, 2019. Payments for this recipient continued for dates of service from August 2, 2019 through September 22, 2019. *Questioned costs totaled $8,129.*
- Sample item 22: The IA expired on October 17, 2019, and was not updated until October 30, 2019. Payments for this recipient continued for dates of service from October 18, 2019 through October 29, 2019. *Questioned costs totaled $1,124.*
- Sample item 31: The IA expired on June 3, 2019, and was not updated until July 2, 2019. Payments for this recipient continued for dates of service from June 4, 2019 through July 1, 2019. *Questioned costs totaled $4,211.*
- Sample item 35: The IA expired on June 14, 2019, and was not updated until September 20, 2019. Payments for this recipient continued for dates of service from June 15, 2019 through September 19, 2019. *Questioned costs totaled $1,620.*
- Sample item 40: The IA expired on March 28, 2019, and was not updated until June 21, 2019. Payments for this recipient continued for dates of service from March 29, 2019 through June 20, 2019. *Questioned costs totaled $470.*
- Sample item 44: The IA expired on May 24, 2019, and was not updated until August 22, 2019. Payments for this recipient continued for dates of service from May 25, 2019 through August 21, 2019. *Questioned costs totaled $5,265.*
- Sample item 46: The IA expired on September 4, 2019, and was not updated until November 26, 2019. Payments for this recipient continued for dates of service from September 5, 2019 through November 25, 2019. *Questioned costs totaled $2,587.*
- Sample item 50: The IA expired on August 29, 2019, and was not updated until November 18, 2019. Payments for this recipient continued for dates of service from August 30, 2019 through November 17, 2019. *Questioned costs totaled $9,636.*

Finding Number:	**2020-022 (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; 05-2005AR5MAP**
Federal Award Year(s):	**2019 and 2020**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed – Managed Care (PASSE)**
Type of Finding:	**Noncompliance and Material Weakness**

Condition and Context (Continued):

- Sample item 54: The IA expired on June 25, 2019, and was not updated until July 29, 2019. Payments for this recipient continued for dates of service from June 26, 2019 through July 28, 2019. *Questioned costs totaled $753.*
- Sample item 55: The IA expired on July 22, 2019, and was not updated until February 13, 2020. Payments for this recipient continued for dates of service from July 23, 2019 through February 12, 2020. *Questioned costs totaled $18,613.*
- Sample item 58: The IA expired on October 23, 2019, and was not updated until December 23, 2019. Payments for this recipient continued for dates of service from October 24, 2019 through December 22, 2019. *Questioned costs totaled $3,553.*
- Sample item 60: The IA expired on October 11, 2019, and was not updated until December 3, 2019. Payments for this recipient continued for dates of service from October 12, 2019 through December 2, 2019. *Questioned costs totaled $1,712.*

NOTE: In accordance with the Families First Coronavirus Response Act (FFCRA), states must provide continuous coverage, through the end of the month in which the emergency period ends, to all Medicaid beneficiaries who were enrolled in Medicaid on or after March 18, 2020, regardless of any changes in circumstances or redeterminations at scheduled renewals that otherwise would result in termination.

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
$108,960

Cause:
The full-risk PASSE program began in March 2019. Rather than being performed evenly throughout the year, the majority of the BH assessments were performed by the Agency's contractor, Optum, in large groupings during calendar year 2018. To more evenly distribute the assessment workload throughout the year, the Agency and its contractor spread the assessments out over the full 12 months. Due to the timing of this process, there were still instances of late BH assessments noted during fiscal year 2020.

Effect:
Gaps were revealed in the performance of the required independent assessments for the BH population. As a result, payments were made outside the approved/updated dates of service for numerous recipients.

Recommendation:
ALA staff recommend the Agency review and strengthen its independent assessment procedures to ensure they are completed timely and in accordance with federal regulations.

Finding Number:	**2020-022 (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; 05-2005AR5MAP**
Federal Award Year(s):	**2019 and 2020**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed – Managed Care (PASSE)**
Type of Finding:	**Noncompliance and Material Weakness**

Views of Responsible Officials and Planned Corrective Action:

DHS concurs with this finding. As of January 1, 2020, the agency has updated its independent assessment process to ensure timely completion of reassessments. The scheduling process for assessments begins 60 days from the due date of assessment and beneficiaries may call to schedule an assessment up to six months prior to the assessment due date. Members that are not assessed prior to their reassessment date will be removed from the PASSE. (Note: Members are not being removed from the PASSE for lack of reassessment during the COVID-19 federal public health emergency)

Anticipated Completion Date: Complete

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Finding Number:	**2020-023**
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; 05-2005ARMAP**
Federal Award Year(s):	**2018, 2019, and 2020**
Compliance Requirement(s) Affected:	**Eligibility**
Type of Finding:	**Noncompliance and Significant Deficiency**

Repeat Finding:
A similar issue was reported in prior-year finding **2019-016**.

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 § 435.914 that states, "The Agency must include in each applicant's case 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, and in that case, the initial determination should be made within 90 days. Also, 42 CFR § 435.916 requires that eligibility redeterminations be performed at least once every 12 months.

States are required, per Section 1940 of the Social Security Act (42 USC 139w), to have a mechanism in place to verify assets by accessing information held by financial institutions. This information is to be used to determine or renew Medicaid eligibility for aged, blind, and disabled Medicaid applicants or recipients when an asset test is required.

Condition and Context:
ALA staff reviewed 19 traditional Medicaid recipient files in the ANSWER system and 41 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 108 claims totaling $47,578, did not contain a DCO-704 signed by a registered nurse verifying medical necessity, affecting 80 claims. *Questioned costs totaled $25,478.*

  The annual reevaluation was also not completed timely. The 2020 reevaluation, due in August 2019, was not completed until November 8, 2019. (Aid to the Aged) (Non-MAGI/ANSWER)
- One client file, with 46 claims totaling $131, was for an individual who was deceased at the time of the claims and, therefore, not eligible, affecting all 46 claims. *Questioned costs totaled $98.*

  In addition, 33 claims paid in 2019 and 2018 were also affected. Questioned costs totaled $89 and $20, respectively. (Aid to the Aged) (Non-MAGI/ANSWER)
- One client file, with 62 claims totaling $1,029, did not contain disability verification, affecting 2 claims. *Questioned costs totaled less than $1.*

  In addition, 13 claims paid in 2019 were also affected. Questioned costs totaled $565. (Disabled Tax Equity and Fiscal Responsibility Act [TEFRA] Child) (Non-MAGI/ANSWER)
- One client file, with 117 claims totaling $14,940, did not contain a DCO-704 signed by a registered nurse verifying medical necessity, affecting 58 claims. *Questioned costs totaled $5,481.* (Aid to the Aged) (Non-MAGI/ANSWER)
- One client file, with 19 claims totaling $32,962, did not contain adequate documentation supporting the income and resources criteria, affecting 3 claims. *Questioned costs totaled $12,090.*

  The initial eligibility determination was also not completed timely. The application was received on September 26, 2019, but not approved until April 29, 2020, exceeding the 45-day limit. (Aid to the Aged) (Non-MAGI/ANSWER)

Finding Number:	**2020-023 (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; 05-2005ARMAP**
Federal Award Year(s):	**2018, 2019, and 2020**
Compliance Requirement(s) Affected:	**Eligibility**
Type of Finding:	**Noncompliance and Significant Deficiency**

Condition and Context (Continued):

- One client file, with 341 claims totaling $19,289, did not contain a DCO-704 signed by a registered nurse verifying medical necessity, affecting 55 claims. *Questioned costs totaled $2,837.* (Disabled Tax Equity and Fiscal Responsibility Act [TEFRA] Child) (Non-MAGI/ANSWER)
- One client file, with 15 claims totaling $1,679, did not contain documentation proving income eligibility, affecting all 15 claims. *Questioned costs totaled $1,561.*

  The annual reevaluation was also not completed timely. The 2020 reevaluation, due in September 2019 was not completed until December 17, 2019. (Adult Expansion) (MAGI/CURAM)

Deficiencies related to eligible recipients with late initial determinations (no questioned costs):

- One client file did not have a timely eligibility determination. The application was received on July 5, 2019, but was not approved until September 19, 2019, exceeding the 45-day limit. (Aid to the Aged) (Non-MAGI/ANSWER)
- One client file did not have a timely eligibility determination. The application was received on November 5, 2019, but was not approved until February 18, 2020, exceeding the 90-day limit. (Aid to the Disabled) (Non-MAGI/ANSWER)

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

- One client file did not have a timely reevaluation, as it was due in January 2020 but was not completed until February 12, 2020. The claims paid for dates of services between when the reevaluation was due and the day before it was performed totaled $5,492 in state fiscal year 2020. (Aid to the Aged) (Non-MAGI/ANSWER)
- One client file did not have a timely reevaluation, as it was due in July 2019 but was not completed until October 11, 2019. The claims paid for dates of services between when the reevaluation was due and the day before it was performed totaled $15,768 in state fiscal year 2020. (Aid to the Aged) (Non-MAGI/ANSWER)
- One client file did not have a timely reevaluation, as it was due in October 2019 but was not completed until November 13, 2019. The claims paid for dates of services between when the reevaluation was due and the day before it was performed totaled $5,955 in state fiscal year 2020. (Aid to the Aged) (Non-MAGI/ANSWER)
- One client file did not have a timely reevaluation, as it was due in June 2019 but was not completed until July 19, 2019. The claims paid for dates of services between when the reevaluation was due and the day before it was performed totaled $2,243 in state fiscal year 2020. (Aid to the Aged) (Non-MAGI/ANSWER)

Additionally, for 1 of 19 traditional Medicaid determinations reviewed, there was no evidence in the file to show that the Asset Verification System was utilized during the eligibility determination.

Statistically Valid Sample:
Not a statistically valid sample

Finding Number:	**2020-023 (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; 05-2005ARMAP**
Federal Award Year(s):	**2018, 2019, and 2020**
Compliance Requirement(s) Affected:	**Eligibility**
Type of Finding:	**Noncompliance and Significant Deficiency**

Questioned Costs:
State fiscal year 2020 - $47,546
State fiscal year 2019 - $654
State fiscal year 2018 - $20

Cause:
The Agency had previously asserted that the root cause of the deficiencies resulted from the Division of Aging, Adult, and Behavioral Health Services and the Agency's contractor, Optum, being unable to complete the reassessments timely. Although the Agency asserted that a new business process was being developed to ensure timely eligibility determinations, deficiencies continued to exist during fiscal year 2020.

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 with 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 this finding. These deficiencies were a result of staff's non-compliance with agency eligibility processes and policy. Staff will receive training focused on correcting the noted deficiencies and compliance with policy will be monitored.

Anticipated Completion Date: April 30, 2021

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Finding Number:	**2020-024**
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):	**05-1905AR5ADM; 05-2005AR5ADM**
Federal Award Year(s):	**2019 and 2020**
Compliance Requirement(s) Affected:	**Reporting**
Type of Finding:	**Noncompliance and Significant Deficiency**

Repeat Finding:
A similar issue was reported in prior-year finding **2019-018**.

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. Amounts reported on the CMS-64 must be an accurate and complete accounting of actual expenditures.

Condition and Context:
ALA staff performed testing of expenditures reported on the CMS-64 for the quarters ended December 31, 2019, and March 31, 2020, to confirm accuracy and completeness with the expenditures recorded in the Agency's financial management system. ALA review revealed the following errors:

- From the December 31, 2019, CMS-64 report, six line items totaling $67,693,380 and representing 92% of administrative expenditures were selected. ALA identified uncorrected errors on four items, resulting in an **overstatement** of the federal portion of expenditures totaling $357,875.
- From the March 31, 2020, CMS-64 report, seven line items totaling $98,034,106 and representing 92% of administrative expenditures were selected. ALA identified uncorrected errors on 3 items, resulting in an **overstatement** of the federal portion of expenditures totaling $137,546.

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
$495,421

Cause:
The Agency implemented new procedures for calculating amounts to be reported on the quarterly CMS-64 expenditure reports. When designing this process, the Agency failed to adequately review and verify the accuracy of formulas used to determine the expenditure amounts for each report line. Additionally, the Agency failed to adequately review report calculations for accuracy prior to submitting the quarterly reports.

Effect:
Agency failed to properly report expenditures on the CMS-64 quarterly reports, resulting in the Agency claiming excess federal funds.

Recommendation:
ALA staff recommend the Agency review the Excel workbooks used to assist in completing the CMS-64 reports and verify the accuracy and necessity of formulas used to allocate expenditures to the appropriate report lines. ALA further recommends the Agency correct identified errors by entering prior period adjustments on subsequent CMS-64 reports.

Views of Responsible Officials and Planned Corrective Action:
DHS concurs with this finding. The agency has corrected the errors to the formulas used to allocate expenditures on the CMS-64 and will correct the identified errors by making prior period adjustments on the upcoming quarterly submission of the CMS-64. There will be no impact to federal financial participation with these adjustments.

Finding Number:	**2020-024 (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):	**05-1905AR5ADM; 05-2005AR5ADM**
Federal Award Year(s):	**2019 and 2020**
Compliance Requirement(s) Affected:	**Reporting**
Type of Finding:	**Noncompliance and Significant Deficiency**

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

Anticipated Completion Date: April 30, 2021

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Finding Number:	**2020-025**
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; 05-2005AR5MAP**
Federal Award Year(s):	**2015, 2016, 2017, 2018, 2019 and 2020**
Compliance Requirement(s) Affected:	**Special Tests and Provisions – Capitation Payments Paid Subsequent to Recipient Death**
Type of Finding:	**Noncompliance and Significant Deficiency**

Repeat Finding:
A similar issue was reported in prior-year finding **2019-19**.

Criteria:
It is the State's responsibility to ensure that capitation payments 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, the Arkansas Department of Human Services (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 listing of deceased individuals, which ALA used to identify individuals who had capitation payments paid or adjusted in state fiscal year 2020 with dates of service after their date of death.

ALA staff review of 40 recipients with capitation payments for dates of service subsequent to the date of death revealed the following:

- Twenty-nine recipients had capitation payments paid representing dates of service after their date of death. These payments had not been recouped as of fieldwork date November 16, 2020. *Questioned costs totaled $7,239.*
- For seven recipients, MMIS did not have a date of death recorded, or the date of death was not correct as of fieldwork date December 2, 2020.
- For eight recipients, capitation payments were paid more than six months past the date of death and ranged from 9 to 63 months.

As a result of testing performed, a system issue with the Arkansas's Network System for Welfare, Eligibility and Reporting (ANSWER) was revealed. The ANSWER system automatically opened a non-SSI eligibility segment for one recipient after the SSI eligibility segment for that recipient was closed due to the recipient's death. As a result, capitation payments began again for that recipient at the beginning of the next calendar year, months after the recipient's death.

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
State fiscal year 2020 - $698
State fiscal year 2019 - $6,311
State fiscal year 2018 - $154
State fiscal year 2017 - $31
State fiscal year 2016 - $36
State fiscal year 2015 - $9

Finding Number:	**2020-025 (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; 05-2005AR5MAP**
Federal Award Year(s):	**2015, 2016, 2017, 2018, 2019 and 2020**
Compliance Requirement(s) Affected:	**Special Tests and Provisions – Capitation Payments Paid Subsequent to Recipient Death**
Type of Finding:	**Noncompliance and Significant Deficiency**

Cause:
The Agency is not receiving timely notification of recipient deaths. Additional delays involve the time required to confirm the date of death after receiving notification. An automatic retrospective review is completed in MMIS to identify payments for recoupment that were made subsequent to the date of death. However, if an eligibility segment is closed for another reason prior to receiving notification of date of death and the date of death is not updated in MMIS, the payments will not be recouped. Although the Agency has indicated that it is reviewing all date of death discrepancies between the eligibility systems and MMIS, these deficiencies continued to exist during fiscal year 2020.

Effect:
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 capitation payments for dates of service subsequent to the date of death are not paid.

Views of Responsible Officials and Planned Corrective Action:
DHS concurs with the finding. The deficiencies noted can be attributed to the following factors:

- The incorrect date of death was received from the Social Security Administration
- The agency did not receive the date of death file prior to case closure
- The ANSWER system automatically opened an eligibility segment in error

The agency's new integrated eligibility system (ARIES) will prevent many system errors with dates of death related to the transfer of information between multiple eligibility systems. The entire Medicaid population for the state will be operational in ARIES by April 12, 2021.

It was also identified that claims were paid subsequent to a recipient's death when MMIS contained a date of death. 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 and reconciliation is completed in the MMIS to identify claims for recoupment that were paid subsequent to date of death. All deficiencies identified are NET and PCCM capitation payments. The retrospective review and reconciliation for NET is completed on annual basis in January and the agency is in the process of activating the review and reconciliation for PCCM. The PCCM review and reconciliation will be completed annually in June.

Anticipated Completion Date: June 30, 2021

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Finding Number:	**2020-026**
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; 05-2005AR5MAP**
Federal Award Year(s):	**2019 and 2020**
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 **2019-006**.

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 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 40 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 24 of the provider files as follows:

High-risk category:

- Sample item 34: The Agency failed to perform the additional screening requirements (site visit or finger print background check). *Questioned costs totaled $31,205.*
- Sample item 35: The Agency failed to perform the additional screening requirements (site visit or finger print background check). In addition, the Agency did not provide documentation of the provider's certification that covered the entire enrollment period. *Questioned costs totaled $13,321.*
- Sample item 36: The provider's revalidation was due by October 30, 2019, but was not performed until December 12, 2019. In addition, the Agency did not perform the additional screening requirements (site visit or finger print background check). *Questioned costs totaled $66,177.*

Finding Number:	**2020-026 (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; 05-2005AR5MAP**
Federal Award Year(s):	**2019 and 2020**
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):

- Sample item 39: The Agency failed to perform the additional screening requirements (site visit or finger print background check). *Questioned costs totaled $132,732.*
- Sample item 40: The provider's revalidation was due by March 23, 2020, but was not performed until July 29, 2020. In addition, the Agency did not perform the additional screening requirements (site visit or finger print background check). *Questioned costs totaled $620,884.*

Moderate-risk category:

- Sample item 19: The Agency failed to perform the additional screening requirement (site visit). In addition, the Agency did not provide documentation of the provider's certification that covered the entire enrollment period. *Questioned costs totaled $7,399.*
- Sample item 20: The Agency failed to perform the additional screening requirement (site visit). In addition, the Agency did not provide documentation of the provider's certification that covered the entire enrollment period. *Questioned costs totaled $4,405.*
- Sample item 21: The Agency failed to perform the additional screening requirement (site visit). *Questioned costs totaled $1,825.*
- Sample item 22: The Agency failed to perform the additional screening requirement (site visit). *Questioned costs totaled $9,999.*
- Sample item 28: The Agency failed to perform the additional screening requirement (site visit). In addition, the Agency did not provide documentation of the provider's professional license that covered the entire enrollment period. *Questioned costs totaled $550,058.*
- Sample item 29: The Agency failed to perform the additional screening requirement (site visit). *Questioned costs totaled $3,394.*
- Sample item 31: The provider's revalidation was due by March 8, 2018, but was not performed until August 20, 2019. In addition, the Agency was unable to provide the Lexis Nexis reports associated with the provider's initial 2013 enrollment. *Questioned costs totaled $1,543.*
- Sample item 38: The provider's revalidation was due by July 15, 2019, but was never performed. In addition, the Agency did not perform the additional screening requirement (site visit). *Questioned costs totaled $590.*

Limited-risk category:

- Sample item 2: The provider's revalidation was due by April 21, 2020, but was not performed until October 19, 2020. *Questioned costs totaled $70.*
- Sample item 8: The provider's revalidation was due by September 25, 2016, but was not performed until August 17, 2019. *Questioned costs totaled $128,381.*
- Sample item 9: The provider's revalidation was due by September 25, 2016, but was not performed until July 20, 2019. *Questioned costs totaled $9,540.*
- Sample item 10: The provider's revalidation was due by September 25, 2016, but was not performed until September 5, 2019. *Questioned costs totaled $152.*

Finding Number:	**2020-026 (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; 05-2005AR5MAP**
Federal Award Year(s):	**2019 and 2020**
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):

- Sample item 12: The provider's revalidation was due by September 25, 2016, but was not performed until February 18, 2020. In addition, the provider did not have a contract on file covering the entire enrollment period. *Questioned costs totaled $167,374.*
- Sample item 13: The provider's revalidation was due by September 25, 2016, but was not performed until January 29, 2020. *Questioned costs totaled $251,559.*
- Sample item 16: The provider's revalidation was due by September 10, 2018, but was not performed until January 10, 2019. *Questioned costs totaled $27,302.*
- Sample item 24: The provider's revalidation was due by September 25, 2016, but was not performed until May 2, 2019. *Questioned costs totaled $6.*
- Sample item 25: The provider's revalidation was due by September 25, 2016, but was not performed until May 3, 2019. In addition, the Agency failed to provide the required W9 associated with the 2019 revalidation. *Questioned costs totaled $50,946.*
- Sample item 27: The provider's revalidation was due by September 25, 2016, but was not performed until January 28, 2020. *Questioned costs totaled $393,991.*
- Sample item 33: The provider's revalidation was due by September 25, 2016, but was not performed until September 25, 2019. In addition, the Agency failed to provide the required W9 associated with the 1990 enrollment and disclosures associated with the 2019 revalidation. *Questioned costs totaled $4,545.*

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
$2,477,398

Cause:
The Agency had asserted that, effective May 31, 2019, it established and implemented new procedures to improve the following areas of provider enrollment: maintenance of provider enrollment application documents, provider revalidation, site visits, and fingerprint background requirements. However, due to timing of the implementation of the new procedures, deficiencies continued to exist during fiscal year 2020.

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

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

Finding Number:	**2020-026 (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; 05-2005AR5MAP**
Federal Award Year(s):	**2019 and 2020**
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:

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

Five of the twenty-four deficient providers did not have the required proof of certification or licensure. The agency sends an automatic notification when a provider's licensure or certification on file expires. If the licensure or certification is not received within 60 days of the expiration date the provider is terminated. One provider submitted the requested certification during SFY20. The other providers have not submitted the requested proof license or certification but were not terminated due to the COVID-19 federal public health emergency.

Three of the twenty-four deficient providers revalidated after the established revalidation deadline in SFY2020. These providers submitted applications for revalidation which were not able to be processed by the revalidation deadline due to incomplete information on the application. The providers were not terminated as they submitted the missing information at the request of the agency.

One of twenty-four deficient providers failed to complete revalidation requirements in SFY2020. The provider submitted an incomplete application and did not respond to requests for additional information requested by DHS. DHS has not terminated the provider due to the suspension of terminations during the COVID-19 federal public health emergency.

Anticipated Completion Date: Complete

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Finding Number:	**2020-027**
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; 05-2005AR5MAP**
Federal Award Year(s):	**2019 and 2020**
Compliance Requirement(s) Affected:	**Special Tests and Provisions – Provider Eligibility (Managed Care Organizations)**
Type of Finding:	**Material Noncompliance and Material Weakness**

Repeat Finding:
A similar issue was reported in prior-year finding **2019-007**.

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 submitted the following forms:

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

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

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

Condition and Context:
To determine if Managed Care Network providers met all necessary criteria to participate in the Medicaid program, ALA staff selected 40 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 Shared Savings Entity (PASSE), managed care program. ALA review revealed deficiencies with 10 of the provider files as follows:

Moderate-risk category:

- Sample item 20: The provider's revalidation was due by September 25, 2016, but was not performed until February 7, 2018. In addition, the Agency did not perform the additional screening requirement (site visit) or provide documentation of the provider's certification that covered the entire enrollment period. *Ineligible costs totaled $200.*
- Sample item 21: The provider's revalidation was due by May 20, 2020, but was never performed. In addition, the Agency did not perform the additional screening requirement (site visit) or provide documentation of the provider's certification that covered the entire enrollment period. *Ineligible costs totaled $6.*

Finding Number:	**2020-027 (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; 05-2005AR5MAP**
Federal Award Year(s):	**2019 and 2020**
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):

- Sample item 22: The Agency did not provide documentation of the provider's certification that covered the entire enrollment period. *Ineligible costs totaled $4,415.*
- Sample item 26: The Agency did not perform the additional screening requirement (site visit). *Ineligible costs totaled $70.*
- Sample item 30: The provider's revalidation was due by May 30, 2020, but was never performed. In addition, the Agency did not could not provide documentation supporting that the additional screening requirement (site visit) was performed supporting the 2015 revalidation. *Ineligible costs totaled $415,082.*
- Sample item 38: The provider's revalidation was due by September 25, 2016, but was not performed until September 13, 2019. *Ineligible costs totaled $18,172.*

Limited-risk category:

- Sample item 6: The provider's revalidation was due by September 25, 2016, but was never performed. Due to the COVID-19 pandemic, no providers have been terminated. *Ineligible costs totaled $252.*
- Sample item 7: The provider's revalidation was due by September 25, 2016, but was not performed until January 13, 2020. *Ineligible costs totaled $6,123.*
- Sample item 14: The provider's revalidation was due by September 25, 2016, but was not performed until October 7, 2019. *Ineligible costs totaled $3,798.**
- Sample item 27: The Agency did not provide documentation of the provider's professional license that covered the entire enrollment period. *Ineligible costs totaled $609.*

Dental Managed Care* payments for the deficiencies noted above totaled $3,798. PASSE payments totaled $444,929.

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

Questioned Costs:
Unknown

Finding Number:	**2020-027 (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; 05-2005AR5MAP**
Federal Award Year(s):	**2019 and 2020**
Compliance Requirement(s) Affected:	**Special Tests and Provisions – Provider Eligibility (Managed Care Organizations)**
Type of Finding:	**Material Noncompliance and Material Weakness**

Cause:
The Agency had asserted that, effective May 31, 2019, it established and implemented new procedures to improve the following areas of provider enrollment: maintenance of provider enrollment application documents, provider revalidation, site visits, and fingerprint background requirements. However, due to timing of the implementation of the new procedures, deficiencies continued to exist during fiscal year 2020.

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

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

Views of Responsible Officials and Planned Corrective Action:
DHS concurs with this 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. Five of the ten deficient provider files relate to non-compliance with revalidation requirements pre-dating May 31, 2019. The deficiencies noted that occurred prior to May 31, 2019 will be corrected upon revalidation for the provider. The DHS Office of Payment Integrity and Internal Audit also conducts regular provider eligibility compliance reviews.

Two of the ten deficient providers failed to complete revalidation requirements in SFY2020. The providers submitted an incomplete application and did not respond to requests for additional information requested by DHS. DHS has not terminated the providers due to the suspension of terminations during the COVID-19 federal public health emergency.

Three of the ten deficient providers did not have the required proof of certification or licensure. The agency sends an automatic notification when a provider's licensure or certification on file expires. If the licensure or certification is not received within 60 days of the expiration date the provider is terminated. One provider submitted the requested certification during SFY20. The other providers have not submitted the requested proof license or certification but were not terminated due to the COVID-19 federal public health emergency.

Anticipated Completion Date: Complete

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Finding Number:	**2020-028**
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; 05-2005AR5MAP**
Federal Award Year(s):	**2019 and 2020**
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:
A similar issue was reported in prior-year finding **2019-021**.

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 qualified review (EQR) is performed for each MCO or PAHP.

In addition, 42 CFR § 438.364 states that the EQR results 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 Managed Care of North America (MCNA). An EQR is required for both entities and was due by April 30, 2020.

The Provider-Led Arkansas Shared Savings Entity (PASSE) transitioned to a full-risk MCO effective March 1, 2019. Three entities participate in the PASSE program: AR Total Care, Empower, and Summit. An EQR is required for all three entities and was due by April 30, 2020.

ALA inquiry and request for the annual reports revealed that a contract to perform the EQRs was not put into place until July 1, 2020. The first EQRs are expected to be provided by April 30, 2021.

Statistically Valid Sample:
Not a statistically valid sample

Questioned Costs:
None

Cause:
The Agency has experienced staff turnover and did not implement steps to procure a contract for the EQRs timely.

Effect:
The contract to perform the EQRs was not implemented timely, and the EQRs were not performed as required.

Recommendation:
ALA staff recommend the Agency develop procedures to aid in ensuring compliance with the program, including those related to external quality reviews.

Views of Responsible Officials and Planned Corrective Action:
DHS concurs with the finding. The contract start date for the vendor performing external quality reviews was July 1, 2020 and the vendor is required to submit reports to the agency by April 30, 2021.

Finding Number:	**2020-028 (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; 05-2005AR5MAP**
Federal Award Year(s):	**2019 and 2020**
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: Completed

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