DHS - Director's Office/Office Of Chief Counsel

Enabling Laws

Act 282 of 2014
A.C.A. §25-10-101
A.C.A. §25-10-102
A.C.A. §25-10-106
A.C.A. §25-10-108
A.C.A. §25-10-111
A.C.A. §25-10-113

History and Organization

The Department of Human Services operates under an integrated service delivery system provided by 11 divisions and other support offices. Each Division is under the direction, control and supervision of the Director of the Department of Human Services. The Director has the authority to transfer or assign duties or programs whether existing or new to offices, sections or units as deemed necessary for efficient and necessary operation of the department.

Act 1954 of 2005 merged the Department of Health into the Department of Human Services and renamed the agency the Department of Health and Human Services. In 2007, the 86th General Assembly enacted what became Act 384 and authorized the Governor to create two separate agencies within the Department. Governor Beebe signed Executive Order EO 07-05 on May 2, 2007 creating a separate Department of Health and a separate Department of Human Services with the change effective July 1, 2007.

Ark Code Ann.§ 25-10-102(b)(1)(A) delegated administrative authority for the Department to the Director. The Director is responsible for establishing Departmental policy to carry out Executive Directives, federal and state legislative mandates and coordination of services across Division lines when individuals and families are provided services by multiple programs. The Director is also responsible for receiving from each of the divisions/offices and submitting a Department budget for review and approval by the Governor and General Assembly. The state institutions and operation of institutions remain under the jurisdiction of the State Institutional Systems Board and the Board of Developmental Disabilities Services. Both Boards work in concert with the DHS Director on issues that impact services for which each is responsible.

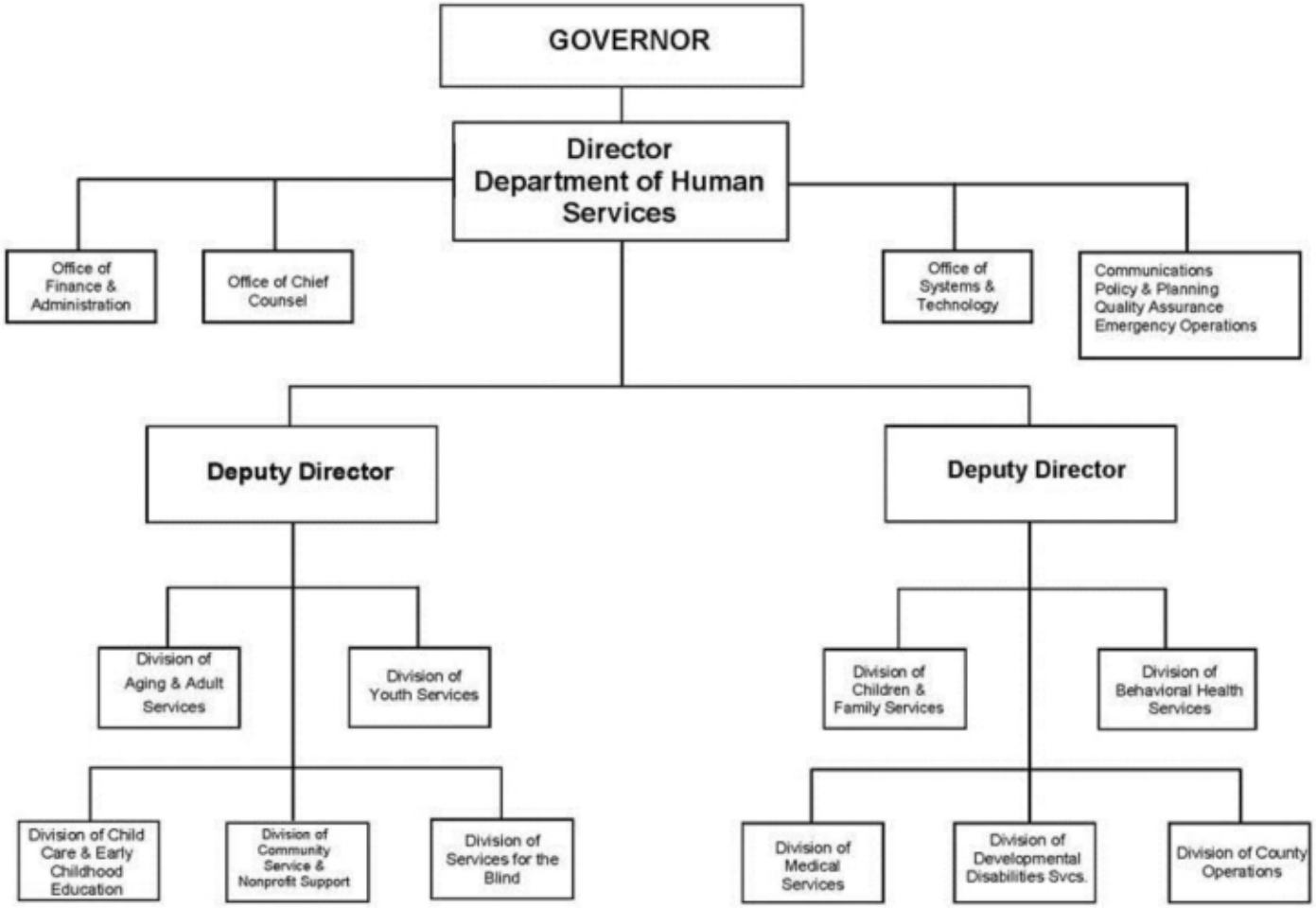
The Mission of the Department is "Together we improve the quality of all Arkansans by protecting the vulnerable, fostering independence, and promoting better health."

The Office of Chief Counsel provides legal and administrative hearing services to the various divisions and offices within the Department. Specific areas of responsibility within the Office of Chief Counsel include:

- General Counsel Section provides legal assistance on administrative hearings, litigation, delivery of services, program administration, personnel, civil rights, and overpayment collections.
- Child and Adult Protection Section provides legal support in all counties and provides assistance primarily in areas of child welfare and adult protective services. Attorneys also provide assistance in Family In Need of Services (FINS) cases when the children are placed in foster care, and in Division of Youth Services cases in transitioning youth from their facilities when they cannot return home.
- Appeals and Hearings administers the appeal process on adverse actions, which include those related to all categories of Medicaid, TANF, and Child Maltreatment.
- Office of Employee Relations/Office of Equal Opportunity is responsible for employee grievance/complaint processing and conducting mediations and fact-finding conferences related to grievances and complaints.
- DHS Policy unit is responsible for drafting, editing, and promulgating policies, rules, procedures, and forms for the entire agency, serving a workforce of more than 7,500 employees across the state. The unit ensures that all DHS policies and procedures are updated in order to meet Arkansas Code as well as federal mandates, and develops and writes new policies and procedures based on agency need.

Office of Quality Assurance includes the following:

- Audit Section conducts performance, compliance and some financial related audits, and consults on operational and program issues. It coordinates the development of audit requirements and guidelines and monitors program resolution.
- Fraud Investigations is responsible for investigating and referring for prosecution allegations of recipient fraud or Intentional Program Violation (IPV) in the public assistance programs administered by the Department of Human Services. These include Transitional Employment Assistance, Food Stamps, Medicaid, Child Care, and Special Nutrition. The unit also conducts investigations of suspected Food Stamp trafficking by both recipients and retailers, and/or program divisions with investigations involving service providers who contract with the agency to perform services for a defined recipient population. The Internal Affairs section of the unit conducts investigations involving allegations of internal misconduct.


GOVERNOR
Director
Department of Human
Services
Office of
Finance &
Administration
Office of Chief
Counsel
Office of
Systems &
Technology
Communications
Policy & Planning
Quality Assurance
Emergency Operations
Deputy Director
Deputy Director
Division of
Aging & Adult
Services
Division of
Youth Services
Division of
Children &
Family Services
Division of
Behavioral Health
Services
Division of Child
Care & Early
Childhood
Education
Division of
Community
Service &
Nonprofit Support
Division of
Services for the
Blind
Division of
Medical
Services
Division of
Developmental
Disabilities Svcs.
Division of County
Operations

Agency Commentary

The DHS Director's Office consists of 7 budgeted positions in SFY2015 and provides administrative direction to eleven (11) divisions and other support offices. Each Division is under the direction, control and supervision of the Director of the Department of Human Services. The Director has the authority to transfer or assign duties or programs whether existing or new to offices, sections or units as deemed necessary for efficient and necessary operation of the department.

Funding for this appropriation comes from a mix of sources that include General Revenue, Federal Funds and Other. Federal and Other funding is determined by the Department's Cost Allocation Plan.

The DHS Director's Office requests continuing Base Level for the new biennium.

The Office of Chief Counsel consists of 183 budgeted positions in FY2015 and provides legal, investigative, audit and administrative hearing services to the various Divisions and Offices within the Department of Human Services.

Funding for this appropriation comes from a mix of sources that include General Revenue, Federal Funds and Other. Federal and Other funding is determined by the Department's Cost Allocation Plan and from sources such as client fees, food stamp and overpayment collections.

In addition to Base Level, the Office of Chief Counsel requests an increase in unfunded appropriation for extra help ($50,029), fringe ($4,242) and unfunded appropriation for conference fee and travel ($25,000).

Findings	Recommendations
None	None

Findings Covering Programs Audited by Other External Auditors

U.S. Department of Agriculture

Finding Number:	**13-710-01**
State/Educational Agency(s):	**Arkansas Department of Human Services**
CFDA Number(s) and Program Title(s):	**10.553 - School Breakfast Program** **10.555 - National School Lunch Program** **10.559 - Summer Food Service Program for Children** **(Child Nutrition Cluster)**
Federal Award Number(s):	**2012IN109946; 2013IN109946**
Federal Award Year(s):	**2012 and 2013**
Compliance Requirement(s) Affected:	**Reporting**
Type of Finding:	**Noncompliance and Material Weakness**

Criteria:
In accordance with 7 CFR §§ 210.5(d)(1), 210.8(4) and 7 CFR §§ 225.8 (b), 225.9(d)(5), the FNS-10 Report of School Program Operations captures meals served under the National School Lunch Program (NSLP) and School Breakfast Program (SBP), as well as half-pints of milk served under the Special Milk Program for Children (SMP). A state agency administering the NSLP, SBP, and SMP compiles the data gathered on its subrecipients' claims for reimbursement into monthly reports to its FNS regional office. A final report containing only actual participation data is due 90 days after the close of the report data. Revisions to the data presented in a 90-day report (FNS-10) must be submitted by the last day of the quarter in which they are identified. However, the agency must immediately submit an amended report if, at any time following the submission of the 90-day report, identified changes to the data cause the agency's level of funding to change by more than (plus or minus) 0.5%. The state agency shall submit to FNS a final report on the Summer Food Service Program for Children (SFSPC) Operations (FNS-418) for each month no more than 90 days following the last day of the month covered by the report. This report documents the number of meals served under the SFSPC by sponsors under the state

Recommendation:
We recommend the Agency strengthen controls to ensure program summary reports are complete, accurate, and timely.

Views of Responsible Officials and Planned Corrective Action:

The Agency concurs with the findings for the USDA food programs and will continue to work to improve internal controls and documentation practices. The Agency will strengthen controls via activities designed to ensure compliance with program rules and regulations. The errors generating the current finding appear to have resulted from substantial turnover in the positions responsible for making the reconciliation adjustments. As a result, training for existing and future staff assigned this function has been strengthened and unit management will monitor the performance of these duties as well as review the final reports prior to submission to USDA.

Anticipated Completion Date: Complete

Contact Person:
Tonya Williams
Director
Arkansas Department of Human Services
Division of Child Care and Early Childhood Education
Donaghey Plaza South, Slot S140
Little Rock, AR 72203-1437
(501) 320-8953
tonya.williams@dhs.arkansas.gov

Findings

Recommendations

agency's oversight. States shall not receive Program funds, regardless of when it is determined that such adjustments need to be made, for any month for which the final report is not postmarked and/or submitted within this time limit, unless FNS grants an exception. Upward adjustments to a report shall not be made after 90 days from the month covered by the report unless authorized by FNS. Downward adjustments shall always be made without FNS authorization. Adjustments to a report shall be reported to FNS in accordance with procedures established by FNS.

Condition and Context:
The Agency's Special Nutrition Program (SNP) Unit failed to report revisions in its NSLP FNS-10 and SFSPC FNS-418 reports during fiscal year 2013. Of the four FNS 90-day reports tested (two FNS-10 and two FNS-418), three reports listed incorrect meal counts. Total NSLP lunches served on the February 2013 FNS-10 90-day report appear under reported by 2,053 or 2.18%; total SFSPC meals served on the June 2013 FNS-418 90-day report appear over reported by 5,114 or 0.4%; and total SFSPC meals served on the July 2012 FNS-418 90-day report for July 2012 appear under reported by 117 or 0.01%.

Questioned Costs:
None

Cause:
During fiscal year 2013, the Agency failed to report revisions to the FNS 90-day reports when meal counts were adjusted. The Agency has historically reported meals served in FNS-10 Reports of School Program Operations and FNS-418 SFSPC from meal summary reports obtained through its SNP System. The SNP Fiscal Support Analyst usually maintains a listing or log of adjusted reimbursement claims previously submitted in the Food Programs Reporting System (FPRS) as a reminder to revise FNS 90-day reports. Employment of the Fiscal Support Analyst was terminated in February 2013, and the position was not filled until August 5, 2013. It appears SNP controls for FNS 90-day reporting were not consistently followed, nor were revisions completed.

Effect:
Total NSLP lunches served on the February 2013 FNS-10 90-day report appear under reported by 2,053 or 2.18%; total SFSPC meals served on the June 2013 FNS-418 90-day report appear over reported by 5,114 or 0.4%; and total SFSPC meals served on the July 2012 FNS-418 90-day report for July 2012 appear under reported by 117 or 0.01%. This

Findings | Recommendations

information should have been reported immediately after the level of funding changed by more than 0.5% or submitted by the last day of the quarter in which the changes were identified.

U.S. Department of Agriculture (Continued)

Finding Number:	**13-710-02**
State/Educational Agency(s):	**Arkansas Department of Human Services**
CFDA Number(s) and Program Title(s):	**10.553 - School Breakfast Program** **10.555 - National School Lunch Program** **10.559 - Summer Food Service Program for Children** **(Child Nutrition Cluster)**
Federal Award Number(s):	**2012IN109946; 2013IN109946**
Federal Award Year(s):	**2012 and 2013**
Compliance Requirement(s) Affected:	**Subrecipient Monitoring**
Type of Finding:	**Noncompliance and Significant Deficiency**

Criteria:
In accordance with 7 CFR § 225.6, agencies administering the Child Nutrition Cluster Programs must provide sufficient and qualified consultative, technical, and managerial personnel to administer the Summer Food Service Program (SFSPC), monitor performance, and measure progress in achieving Program goals. In addition, state agencies administering the Child Nutrition Cluster Programs are required to perform specific monitoring procedures for the SFSPC in accordance with 7 CFR § 225.7: review every new sponsor at least once during the first year of operation; annually review a number of sponsors whose program reimbursements, in the aggregate, accounted for at least one-half of the total program meal reimbursements in the state in the prior year; annually review every sponsor that experienced significant operational problems in the prior year; review each sponsor at least once every three years; conduct reviews of at least 10% of each sponsor's sites, or one site, whichever number is greater, as part of each sponsor review; and conduct follow-up reviews of sponsors and sites as necessary. Each agency must develop and implement a monitoring system to ensure that sponsors, including site personnel, and the sponsor's food service management company, if applicable, immediately receive a copy of any review reports that indicate Program violations and could result in a Program disallowance.

Recommendation:
We recommend the Agency strengthen controls to ensure adequate review and training. In addition, we recommend the Agency establish and implement procedures to ensure all required documentation is maintained in sponsor files. The Agency should also provide adequate staffing and training.

Views of Responsible Officials and Planned Corrective Action:

The Agency concurs with the findings for the USDA food programs and will continue to work to improve internal controls and documentation practices. The Agency will strengthen controls via activities designed to ensure compliance with program monitoring. The errors generating the current finding appear to have resulted from substantial turnover in the positions responsible for sponsor monitoring and corrective action plan review, especially in light of the significant growth in the Summer Feeding Program. As a result, training for existing and future staff assigned this function was strengthened and unit management is monitoring the performance of these duties. In addition, several new positions have been identified and are currently in the state hiring process with the intent to strengthen the unit from a staffing perspective. The Agency is committed to the provision of adequate staff availability and training.

Anticipated Completion Date: Complete

Contact Person:
Tonya Williams
Director
Arkansas Department of Human Services
Division of Child Care and Early Childhood Education
Donaghey Plaza South, Slot S140
Little Rock, AR 72203-1437
(501) 320-8953
tonya.williams@dhs.arkansas.gov

Findings	Recommendations

Condition and Context:
The Division of Child Care and Early Childhood Education (DCCECE), Special Nutrition Program (SNP) Unit administers the Child Nutrition Cluster Programs at the Arkansas Department of Human Service (DHS), which includes monitoring of NSLP School Food Authority (SFA) and SFSPC sponsor activities. Compliance testing for SNP monitoring of five SFSPC sponsor reviews revealed the DHS DCCECE SNP management and personnel failed to properly monitor one SFSPC sponsor. SNP personnel requested the sponsor provide a corrective action plan (CAP) for program deficiencies, including some disallowed meals, during the sponsor's July 25, 2013, review. When the sponsor did not submit a CAP by the requested date of August 19, 2013, SNP personnel failed to contact the sponsor by the prescribed method. When meals are disallowed during a review, SNP policy is to conduct a follow-up review or other measures to verify corrective action has been taken. If the sponsor fails to fully and completely correct all deficiencies, the sponsor should be declared "seriously deficient" and action initiated to terminate SFSP operations.

Questioned Costs:
Unknown

Cause:
SNP's failure to properly monitor the referenced sponsor's review appears due to inadequate management review. This situation resulted from insufficient training of personnel performing entry of sponsor reviews in the SNP System and a SFSPC staffing shortage. The Agency utilizes the SNP System's coordinator, open review, and violation reports to monitor sponsor review activities. The coordinator report lists the sponsor's latest review and initial review dates; the open review report lists sponsor reviews that have not been closed and the number of days the review has been open; and the violation report lists each sponsor's review findings with the review status. The noted sponsor's July 25, 2013, review was listed in the open review report; however, review findings were not listed in the 2013 violation report. This appears to be due to SNP personnel not fully completing the entry of the review in the SNP System. The sponsor's previous review on July 5, 2011, was also listed in the open review report; however, approved corrective action for this review was noted in the sponsor's file. For audit purposes, when SNP System reports and electronic reviews cannot be relied upon for accuracy and completeness, the auditor must be able to review timely the requested sponsor reviews, which includes all supporting documentation, manual as well as electronic.

Findings | Recommendations

Effect:
The SNP System's SFSPC open review and violation reports appear incomplete and inaccurate; therefore, these reports cannot be relied upon to monitor sponsor reviews or resolution of findings. Inadequate documentation for sponsor reviews could jeopardize program services and Agency payments for meals.

U.S. Department of Health and Human Services

Finding Number:	**13-710-03**
State/Educational Agency(s):	**Arkansas Department of Human Services**
CFDA Number(s) and Program Title(s):	**93.558 - Temporary Assistance for Needy Families (TANF Cluster)**
Federal Award Number(s):	**G-1202ARTANF**
Federal Award Year(s):	**2012**
Compliance Requirement(s) Affected:	**Allowable Costs/Cost Principles; Eligibility**
Type of Finding:	**Noncompliance and Significant Deficiency**

Criteria:
For cash assistance costs to be allowable, they must be made to eligible clients, as outlined in Sections 3 and 11 of the State Plan for Title IV-A of the Social Security Act: Temporary Assistance for Needy Families (TANF). In addition, Section 2800 of the TEA Policy Manual governs sanctions related to client non-compliance. Also, Section 2213 of the TEA Policy Manual governs verification that children are living with the parent or other relative.

Condition and Context
To test the $16,101,134 in cash assistance disbursements to 13,951 clients, we randomly sampled $67,770 in cash assistance payments to 60 clients to determine allowable cost and eligibility for those clients. Our sample revealed three clients with overpayments, as summarized below:

- One client was paid a total of $1,488 over various supplemental payments,

Recommendation:
We recommend the Agency provide adequate training to staff responsible for determining client eligibility as well as strengthen the review process performed by supervisory staff to ensure federal program funds are utilized in accordance with federal regulations and the State Plan for TANF.

Views of Responsible Officials and Planned Corrective Action:

The Agency concurs with the findings and will provide additional training and monitoring of caseworker actions as well as improve communications with the Department of Workforce Services. The Agency will develop a Computer Based Training to TEA caseworkers regarding the calculation of supplemental payments. Additional supervisory monitoring will be done to ensure that when children receiving TEA benefits are placed in foster care the case will be closed. The Agency will continue working with the Department of Workforce Services to establish a more efficient line of communication to ensure that when an employment plan is updated the DCO caseworker is notified to reduce the grant.

Anticipated Completion Date: April 2014

Contact Person: Joni Jones, Director
Arkansas Department of Human Services
Division of County Operations
P.O. Box 1437, Mail Slot S301
Little Rock, AR 72203-1437
(501) 682-8375
joni.jones@dhs.arkansas.gov

Findings	Recommendations

some of which were calculated incorrectly, resulting in an overpayment of $860.

- One client was paid two monthly $162 payments for a child-only TEA case. The case should have been closed these two months due to the children being in foster care, resulting in an overpayment of $324.
- One client was paid $162 for four months for a child-only TEA case. The case should have been closed these four months due to the children no longer living in the household, resulting in an overpayment of $810.

Questioned Costs:
$1,994

Cause:
Lack of adequate training for staff who apply sanctions, lack of appropriate communication between case workers, and inadequate review by supervisory staff led to the clients being paid amounts to which they were not entitled.

Effect:
Failure to provide staff with adequate training and to properly review client eligibility placed

U.S. Department of Health and Human Services (Continued)

Finding Number:	**13-710-04**
State/Educational Agency(s):	**Arkansas Department of Human Services**
CFDA Number(s) and Program Title(s):	**93.575 - Child Care and Development Block Grant** **93.596 - Child Care Mandatory and Matching Funds of the Child Care and Development Fund (CCDF Cluster)**
Federal Award Number(s):	**G-1101ARCCDF; G-1201ARCCDF; G-1301ARCCDF**
Federal Award Year(s):	**2011, 2012, and 2013**
Compliance Requirement(s) Affected:	**Allowable Costs/Cost Principles**
Type of Finding:	**Noncompliance**

Recommendation:
We recommend the Agency continue to provide training for employees, implement policy changes, and increase monitoring to reduce overpayments to clients and providers.

Views of Responsible Officials and Planned Corrective Action:

The Agency concurs with the findings for the Child Care Development Fund program and will continue to work to improve internal controls and reduce fraud and overpayments. Possible provider overpayments or fraud continue to drop in comparison to prior years, a representation of the continuing efforts of the Division to control and or reduce such occurrences. In addition, historically, the Division has found that after completing this type of investigation, the actual proven instances of overpayments are often reduced from the preliminary amount. The Division will continue to upgrade and improve the automated control environment in the KIDCare system via program enhancement releases each year. Finally, the five clients noted by legislative audit are undergoing further examination, and as

Findings

Criteria:
The Arkansas Department of Human Services (DHS) is responsible for administering the State's Child Care and Development Fund (CCDF) "Child care" program. The Agency's responsibility includes determining eligibility for each applicant and documenting that eligibility criteria were met. The Agency outlines eligibility for the program in its State Plan.

Condition and Context:
Between October 1, 2012 and September 30, 2013, the Division of Child Care and Early Childhood Education identified 57 cases of client and provider overpayments totaling $59,663. The Agency identified an additional 53 cases of possible overpayments totaling $100,439 that are currently under investigation.

In addition to the above, we selected 95 clients for audit testing from the database of child care billings. This sample included the 46 clients receiving the highest benefits. As a result of this testing, we referred five clients to the Agency for further analysis due to information in the records that raised questions regarding eligibility and appropriateness of payments. The Agency already had open investigations on two of these cases.

Questioned Cost:
Unknown

Cause:
Factors contributing to these issues included the following: (a) case heads and/or clients failing to report changes in client eligibility criteria that affected eligibility status, (b) clients willfully misrepresenting their eligibility data, and (c) providers billing for services not provided.

Effect:
Benefits could have been provided to ineligible clients and providers.

U.S. Department of Health and Human Services (Continued)

Finding Number:	**13-710-05**
State/Educational Agency(s):	**Arkansas Department of Human Services**
CFDA Number(s) and Program Title(s):	**93.658 - Foster Care_Title IV-E**

Recommendations

noted two cases had already been referred to the DHS investigations unit for further review.

Anticipated Completion Date: June 2014

Contact Person:
Tonya Williams
Director
Arkansas Department of Human Services
Division of Child Care and Early Childhood Education
Donaghey Plaza South, Slot S140
Little Rock, AR 72203-1437
(501) 320-8953
tonya.williams@dhs.arkansas.gov

Recommendation:
We ***again*** recommend the Agency complete the necessary programming revisions between the CHRIS and Kidcare systems to ensure child care payments are made on behalf of eligible foster children.

Findings

Federal Award Number(s): **1201AR1401; 1301AR1401**
Federal Award Year(s): **2012 and 2013**
Compliance Requirement(s) Affected: **Activities Allowed or Unallowed; Allowable Costs/Cost Principles**
Type of Finding: **Noncompliance and Significant Deficiency**

Criteria:
For an activity or cost to be considered allowable, it must meet the general criteria outlined in 2 CFR § 225 and the program regulations set forth in 42 USC § 672 and 45 CFR § 1356.

Condition and Context:
We reviewed child care payments on behalf of 60 foster children. Each child's eligibility status was verified using the Agency's Children's Reporting and Information System (CHRIS). Our review revealed the following:

- Fifteen children were determined by the State to be eligible but not claimable due to placement. The foster child as well as the foster family home must meet all eligibility criteria to receive Title IV-E funds. If the foster family home does not meet all criteria, the result is non-claimable status. Questioned costs for these instances of noncompliance totaled $4,044.

- One child was determined by the State to be eligible but not claimable due to the child's receipt of Supplemental Security Income (SSI) benefits. Questioned costs for this instance of noncompliance totaled $107.
- Two children were determined by the State to be ineligible to receive Title IV-E child care benefits. These children had exited care at the time of the payment. Questioned costs for these instances of noncompliance totaled $417.

Similar instances of noncompliance were also reported in the 2009 - 2012 State of Arkansas Single Audit reports.

Questioned Costs:
$4,568

Cause:

Recommendations

Views of Responsible Officials and Planned Corrective Action:

The Division of Children and Family Services (DCFS) has reviewed the finding by Legislative Audit detailed above and is in agreement with the finding. DCFS and the Division of Child Care and Early Childhood Education (DCC/ECE) have engaged in requirements gathering activities in preparation for a software development start date in the second quarter of 2014. The revision necessary to address the control issues noted in this finding is planned to be in production in the third quarter of 2014.

Anticipated Completion Date: Third quarter, 2014

Contact Person:
Cecile Blucker
Director
Arkansas Department of Human Services
Division of Children and Family Services
P.O. Box 1437 / Slot S-560
Little Rock, AR 72203-1437
(501) 682-8770
cecile.blucker@dhs.arkansas.gov

Findings	Recommendations

Payments for child care for non-claimable and ineligible foster children continue to be processed because the Agency has not completed the necessary programming revisions between the CHRIS and Kidcare systems. As a result, incompatibility continues between the systems.

Effect:
Payments for child care continue to be made for non-claimable and ineligible foster children. Incomplete programming revisions continue to place assets at risk and may jeopardize the Agency's ability to provide program funding to claimable and eligible foster children.

U.S. Department of Health and Human Services (Continued)

Finding Number:	**13-710-06**
State/Educational Agency(s):	**Arkansas Department of Human Services**
CFDA Number(s) and Program Title(s):	**93.658 - Foster Care_Title IV-E**
Federal Award Number(s):	**1201AR1401; 1301AR1401**
Federal Award Year(s):	**2012 and 2013**
Compliance Requirement(s) Affected:	**Cash Management**
Type of Finding:	**Noncompliance and Significant Deficiency**

Criteria:
In accordance with 31 CFR § 205.33, a state must minimize the time between the drawdown of federal funds from the federal awarding agency and their disbursement for federal program purposes. The timing and amount of funds transfers must be as close as administratively feasible to a state's actual cash outlay for direct program costs and the proportionate share of any allowable indirect costs.

Condition and Context:
We reviewed federal draws recorded in the Payment Management System (PMS) to determine if draws were adequately supported, were made for actual program expenditures, and met the immediate cash needs of the program. Our review included comparing the program draws recorded in PMS to program expenditures recorded in the Arkansas Administrative Statewide Information System (AASIS) and reported on the

Recommendation:
We recommend the Agency establish and implement procedures to ensure new staff are adequately trained. In addition, existing procedures for supervisory review should be strengthened to ensure cash management requirements are being met.

Views of Responsible Officials and Planned Corrective Action:

The Division of Administrative Services (DAS) has reviewed the finding by Legislative Audit detailed above and is in agreement with the finding. The overdrawn federal funds are currently being repaid by reducing federal draws. DAS has made a change to the management of this unit and expect improvement in accountability. A new reconciliation process for this grant award has been implemented. The new personnel directly responsible for this grant along with their direct supervisors have received additional training on the grant administrator responsibilities.

Anticipated Completion Date: March, 2014

Contact Person:
Karen Fricke
Director
Arkansas Department of Human Services
Division of Administrative Services
P.O. Box 1437, Slot W401
Little Rock, AR 72203-1437
(501) 682-5448

Findings | Recommendations

program's quarterly financial reports. Our review revealed that federal draws exceeded actual program expenditures by $1,325,145.

Questioned Costs:
$1,325,145

Cause:
Because of a change in personnel and lack of adequate training for the new staff responsible for ensuring compliance with cash management criteria, the Agency failed to prepare a reconciliation between federal draws and actual expenditures for three of the four quarters of fiscal year 2013.

Effect:
The Agency's federal draws exceeded actual program expenditures by $1,325,145.

U.S. Department of Health and Human Services (Continued)

Finding Number:	**13-710-07**
State/Educational Agency(s):	**Arkansas Department of Human Services**
CFDA Number(s) and Program Title(s):	**93.767 - Children's Health Insurance Program**
Federal Award Number(s):	**05-1105AR5021; 05-1205AR5021**
Federal Award Year(s):	**2012 and 2013**
Compliance Requirement(s) Affected:	**Cash Management**
Type of Finding:	**Noncompliance and Significant Deficiency**

Criteria:
As noted in OMB Circular A-133, § 300(b), the auditee shall maintain internal control over federal programs that provides reasonable assurance that the auditee is managing federal awards in compliance with laws, regulations, and provisions of contracts or grant agreements that could have a material effect on each of its federal programs. This includes establishing proper internal controls to ensure the accuracy of federal draws.

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 authorized states to cover parents under the Children's Health Insurance Program (CHIP) at an enhanced Federal Medical Assistance Percentage (FMAP) of 79.12% until September 30,

karen.fricke@dhs.arkansas.gov

Recommendation:
We recommend the Agency review and strengthen internal controls to ensure federal draws are properly calculated and drawn from the appropriate federal grant.

Views of Responsible Officials and Planned Corrective Action:

The Division of Administrative Services (DAS) has reviewed the finding by Legislative Audit detailed above and is in agreement with the finding. These errors resulted from new personnel in the Medicaid reporting section missing a few required updates to a complicated worksheet that is only modified annually. The overdrawn federal funds were repaid by reducing federal draws. DAS has implemented a new review process to ensure correct rates and formulas are in place at the start of each federal fiscal year.

Anticipated Completion Date: Complete

Contact Person:
Karen Fricke
Director
Arkansas Department of Human Services
Division of Administrative Services
P.O. Box 1437, Slot W401

Findings

2012. Beginning October 1, 2012, the FMAP was reduced to 70.17%.

Condition and Context:
During our review of the Medicaid Cluster, we discovered a formula error within an Agency worksheet that resulted in a draw of federal funds from CHIP for Medicaid expenditures. Questioned costs totaled $14,392.

We also discovered another error involving CHIP during our review. As previously stated, the FMAP was reduced as of October 1, 2012, for states covering parents under CHIP. The Agency failed to reduce the FMAP as of October 1, 2012, and, as a result, requested and received excess federal funds totaling $29,613.

Questioned Costs:
$44,005

Cause:
The Agency failed to make necessary adjustments to the worksheet used to calculate the weekly federal draws for Medicaid and CHIP. In addition, adequate supervisory oversight was not provided to ensure the accuracy of these worksheets.

Effect:
The Agency incorrectly requested and received federal funds from CHIP for Medicaid expenditures.

U.S. Department of Health and Human Services (Continued)

Finding Number:	**13-710-08**
State/Educational Agency(s):	**Arkansas Department of Human Services**
CFDA Number(s) and Program Title(s):	**93.778 - Medical Assistance Program (Medicaid Cluster)**
Federal Award Number(s):	**05-1205AR5ADM; 05-1305AR5ADM**
Federal Award Year(s):	**2012 and 2013**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed - Administration and Training**
Type of Finding:	**Noncompliance and Significant Deficiency**

Recommendations

Recommendation:
We recommend the Agency strengthen monitoring controls to ensure certifications are completed timely as required.

Views of Responsible Officials and Planned Corrective Action:

The Agency concurs with the finding regarding employee certifications and will work to appropriately train managers and supervisors on the use of available system generated information designed to aid in ascertaining if all applicable employees have completed their certification on a timely basis.

Anticipated Completion Date: May 2014

Little Rock, AR 72203-1437
(501) 682-5448
karen.fricke@dhs.arkansas.gov

Findings

Criteria:
2 CFR § 225, Appendix B.8.h (3), states that, "where employees are expected to work solely on a single federal award or cost objective, charges for their salaries and wages will be supported by periodic certifications that the employees worked solely on that program for the period covered by the certification. These certifications will be prepared at least semi-annually and will be signed by the employee or supervisory official having firsthand knowledge of the work performed by the employee."

The Agency uses an automated system via email to notify employees requiring certification. Employee responses are required within 30 days. Divisional CFOs are responsible for ensuring all certifications are completed timely.

Condition and Context:
We selected 25 employees for our review to determine if the Agency was in compliance with the certification requirement. We obtained and reviewed the Direct Employee Certification report for these employees to verify that (1) the coding listed on the report matched the coding listed on the Arkansas Administrative Statewide Information System (AASIS) position control report, (2) the certification was completed within 30 days, and (3) the certification disposition was appropriate.

Our review revealed that two employees did not complete their certifications timely. One of these employees received a request for certification in February and August 2013; neither was received timely. Our testing in this compliance area had not revealed exceptions in prior years, so we expanded our testing to determine if the exceptions were isolated.

An additional sample of 25 employees was selected. Our review revealed an additional four employees who did not complete their certifications timely. Additionally, one employee was not certified for the six-month period beginning November 1, 2012 to May 1, 2013. The employee had terminated employment in January 2013, which was prior to the certification period end date, and was rehired for the same position on March 18, 2013, which was also prior to the original certification end date. According to the Agency, this unusual situation was not recognized by the system as a certification pending.

Questioned Cost:
None

Recommendations

Contact Person:

Mark Story, Assistant Director
Arkansas Department of Human Services
Division of Medical Services
P.O. Box 1437
Little Rock, AR 72203-1437
(501) 320-8955
Mark.Story@dhs.arkansas.gov

Findings | Recommendations

Cause:
The Agency failed to properly monitor timely completion of employee certifications.

Effect:
Required certifications were not completed timely.

U.S. Department of Health and Human Services (Continued)

Finding Number:	**13-710-09**
State/Educational Agency(s):	**Arkansas Department of Human Services**
CFDA Number(s) and Program Title(s):	**93.778 - Medical Assistance Program (Medicaid Cluster)**
Federal Award Number(s):	**05-1205AR5MAP; 05-1305AR5MAP**
Federal Award Year(s):	**2012 and 2013**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed - Claims Payments**
Type of Finding:	**Noncompliance and Material Weakness**

Criteria:
In accordance with Arkansas Medicaid Provider Manual Section II - Rehabilitative Services for Persons with Mental Illness (RSPMI) sections 218.000 and 218.100, for each beneficiary entering the RSPMI Program, the treatment team must develop an individualized master treatment plan. The master treatment plan must be completed by a mental health professional, approved by a psychiatrist or physician, and reviewed by the treatment team at least every 90 calendar days.

RSPMI section 226.200 indicates that the provider must develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which Medicaid reimbursement is sought. At minimum, this includes the following:

- The specific services rendered (must be individualized; duplicated notes are not allowed).
- The relationship of the services provided to the treatment regimen described in the master treatment plan.

Recommendation:
We recommend the Agency establish and implement procedures to ensure all required RSPMI documentation is maintained in the beneficiary files.

Views of Responsible Officials and Planned Corrective Action:

The Agency concurs with the findings for these Rehabilitative Services for Persons with Mental Illness (RSPMI) categories and will continue to work to improve internal controls and documentation practices in the RSPMI program. The Agency will strengthen controls via activities designed to ensure compliance with program rules and regulations and medical necessity. These controls will include contracting for services, specifically; inspection of care, desk reviews, and retrospective reviews for services provided through RSPMI program. In addition, the Division of Medical Services reviewed its RSPMI Inspection of Care Policy throughout 2012 and promulgated a revision to include new guidelines for review of services. These revisions became effective December 1, 2013, providers were notified, and the resulting review tool was implemented January 1, 2014 of the current year. The Division of Medical Services will continue to analyze and review outlier providers via desk review and refer such provider sites, as warranted, to the Office of Medicaid Inspector General for investigation of suspected waste and abuse of RSPMI funding.

Anticipated Completion Date: September 2014

Contact Person:
Mark Story
Assistant Director
Arkansas Department of Human Services
Division of Medical Services
P.O. Box 1437
Little Rock, AR 72203-1437

Findings | Recommendations

- The date and actual time the services were rendered.
- The name and credentials of the individual who provided the services.
- The setting in which the services were provided.
- Updates describing the beneficiary's progress or lack thereof.
- Both daily notes and a weekly summary if receiving Rehabilitative Day Services (Weekly summary was not required for services dates prior to 12/1/12).

Condition and Context:
We selected 60 beneficiary files for review to determine if the provider maintained documentation as required by the specific sections of the RSPMI manual stated above. Our review revealed the following:

- 17 beneficiary files did not contain adequate supporting documentation to determine that an individualized Master Treatment Plan was completed and reviewed at least every 90 calendar days.
- 28 beneficiary files lacked some form of documentation to support services billed.

Questioned Costs:
$43,062

Cause:
The Agency failed to ensure all required RSPMI documentation was maintained.

Effect:
Inadequate documentation for services provided could jeopardize beneficiary care and Agency payments made for the care.

\U.S. Department of Health and Human Services (Continued)

Finding Number: **13-710-10**
State/Educational Agency(s): **Arkansas Department of Human Services**
CFDA Number(s) and Program Title(s): **93.778 - Medical Assistance Program (Medicaid Cluster)**

(501) 320-8955
Mark.Story@dhs.arkansas.gov

Recommendation:
We recommend the Agency establish and implement procedures to ensure all required documentation is maintained in beneficiary case files.

Views of Responsible Officials and Planned Corrective Action:

Findings

Federal Award Number(s): **05-1205AR5MAP; 05-1305AR5MAP**
Federal Award Year(s): **2012 and 2013**
Compliance Requirement(s) Affected: **Activities Allowed or Unallowed - Home and Community-Based Services**
Type of Finding: **Material Noncompliance and Material Weakness**

Criteria:
A state may obtain a waiver of statutory requirements to provide an array of home and community-based services that may permit an individual to avoid institutionalization (42 CFR §§ 441.300 - 441.310). The U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) issued a special fraud alert concerning home health care. Problems noted include cost report frauds, billing for excessive services or services not rendered, and use of unlicensed staff. The full alert was published in the Federal Register on August 10, 1995, and is available online in the Special Fraud Alerts section of the HHS OIG home page.

Currently, Arkansas has five Section 1915(c) Home and Community-Based Services waivers for Medicaid:

1. Elder Choices.
2. Alternative Community Services (ACS).
3. Alternatives for Adults with Physical Disabilities (APD).
4. Living Choices Assisted Living.
5. Autism.

Our review included the Living Choices Assisted Living program. In addition, we selected the Prosthetics program, which does not operate under a waiver but is defined and regulated by 42 CFR § 440.120.

We also considered qualitative factors, such as management oversight and the Medicaid Program's high profile and public interest, that could have a significant impact on the integrity of the program.

Arkansas Provider Manuals for Living Choices Assisted Living and the Prosthetics programs (as well as the Medicare/Medicaid Crossover Only Provider Manual for crossover claims) dictate the information that must be documented and maintained in provider files to

Recommendations

The Agency agrees with the control and access to documentation portions of the finding for the Living Choices Assisted Living program. After a limited review of the providers tested by Legislative Audit, DHS has been able to obtain the documentation listed as unavailable for review or missing completely from a sample of the exceptions noted. Therefore, DHS is not in agreement with the amount noted as questioned costs. As a part of the determination of an appropriate corrective action plan DHS will, in conjunction with the Office of Quality Assurance, perform a secondary review of all of the cases tested in the finding in an effort to ascertain why any of the documents requested were not immediately available to Legislative Audit as well as to document all those not in existence. In our tests thus far the records have been available but appear to have been scattered throughout areas responsible for the care of individuals residing in these assisted living facilities, for instance the case notes would likely be maintained in the nurse's area and not with the financial records. In addition, it should be noted that all of these providers are paid on a per diem basis and that the services they perform are designed to be at the direction of the individual under care. In short, the information gleaned from the secondary review will inform DHS as to the specific nature of improvements needed in the controls surrounding this program as well as the most effective road map for use in future audits or reviews, allowing better and timelier access to the documentation needed by Legislative Audit in their future engagements. Additionally, the Division of Aging and Adult Services (DAAS) will issue a Provider Information Memorandum clarifying those documentation requirements and will continue to conduct provider workshops with continued emphasis on documentation requirements.

The Agency agrees with the finding regarding the Prosthetics program and will strengthen the controls surrounding documentation of the required information in order to properly substantiate the "audit trail" noted by legislative audit.

Anticipated Completion Date: June 2014

Contact Person:
Mark Story
Assistant Director
Arkansas Department of Human Services
Division of Medical Services
P.O. Box 1437
Little Rock, AR 72203-1437
(501) 320-8955
Mark.Story@dhs.arkansas.gov

Findings | Recommendations

support the services billed.

Condition and Context:
We selected 60 provider files for review from the Living Choices Assisted Living program to determine if required documentation was being maintained in accordance with Provider Manual sections 202.100 and 202.110. The manual states that the provider must maintain sufficient written documentation in the beneficiary's case file supporting billing for services rendered. At minimum, this includes the following:

- The beneficiary's attending or primary care physician's name, office address, telephone number, and after-hours contact information.
- A copy of the beneficiary's plan of care.
- Written instructions to the facility's attendant care staff.
- Documentation of limited nursing services performed by the provider's nursing staff in accordance with the beneficiary's plan of care. Records must include:
  - Nursing service(s) performed.
  - Date and time of day nursing services are performed.
  - Progress or other notes regarding the resident's health status.
  - The signature or initials and the title of the person performing the services.
- Documentation of periodic nursing evaluations performed by the assisted living facility nursing staff in accordance with the beneficiary's plan of care.
- Quarterly Monitoring Forms (AAS-9506) completed every 90 days (effective 1/1/13).
- Records of attendant care services.
  - Documentation of attendant care services performed.
  - The signature or initials of the person performing the services as well as the date services were performed.

Our review of the Living Choices Assisted Living program revealed that 56 case files lacked some form of documentation to support the services billed. Questioned costs totaled $855,085.

We also selected 60 provider files for review from the Prosthetics program to determine if

Findings

Recommendations

required documentation was being maintained.

The documentation required for the Prosthetics program is contained in the Prosthetics Provider Manual section 203.100, which states that Prosthetics providers must maintain sufficient documentation to support each service billed. At minimum, this includes the following:

- An audit trail between the prosthetics provider, the beneficiary, the beneficiary's primary care physician, and the Division of Medical Services.
- When applicable, documentation including the request for and approval of prior authorization and/or the request for and approval of extension of benefits for services provided.
- The prescription for prosthetics services, signed and dated by the beneficiary's primary care physician.
- The prosthetics provider's signed and dated:
  - Certification that used equipment is reconditioned, is in good working order, and has no defects in workmanship or material.
  - The beneficiary's consent to receive services.
  - Notification of termination of prosthetics services.
  - Documentation to reflect that necessary training and orientation have been provided to the beneficiary and any other applicable persons.

For crossover claims only, the Medicare/Medicaid Crossover Only Provider Manual sections 215.300 and 142.300 indicate that providers must maintain:

- Complete and accurate original records that fully disclose the nature and extent of goods, services, or both provided to and for eligible beneficiaries. The delivery of all goods and services billed to Medicaid must be documented in the beneficiary's medical record. Beneficiary records must support the levels of service billed to Medicaid.

Additionally, a beneficiary must be dually eligible for both Medicaid and Medicare.

Our review of the Prosthetics program revealed that six case files lacked some form of documentation to support the services billed. Three of the case files were Prosthetics program files and had questioned costs totaling $3,504. The other three case files were Medicare/Medicaid Crossover Only files with questioned costs totaling $1,846.

Findings | Recommendations

Questioned Costs:
$860,435

Cause:
The Agency failed to ensure that all required documentation was maintained.

Effect:

Inadequate documentation for services provided could jeopardize beneficiary care and Agency payments made for the care.

U.S. Department of Health and Human Services (Continued)

Finding Number:	**13-710-11**
State/Educational Agency(s):	**Arkansas Department of Human Services**
CFDA Number(s) and Program Title(s):	**93.778 - Medical Assistance Program (Medicaid Cluster)**
Federal Award Number(s):	**05-1205AR5MAP; 05-1305AR5MAP**
Federal Award Year(s):	**2012 and 2013**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed - Home and Community-Based Services**
Type of Finding:	**Material Noncompliance and Material Weakness**

Criteria:
Follow-up procedures for prior-year finding 12-710-05 from the 2012 Statewide Single Audit revealed continued noncompliance and inadequate internal controls for three Home and Community-Based Services programs. In 2012, we reviewed the following programs:

- Assisted Living Services
- ElderChoices
- Personal Care Services

Specific criteria for these programs are located on the following page.

Recommendation:
We ***again*** recommend the Agency establish and implement procedures to ensure all required documentation is maintained in beneficiary case files.

Views of Responsible Officials and Planned Corrective Action:

The Agency agrees with the control and documentation portions of the finding for the Living Choices Assisted Living program but is not in agreement regarding the questioned costs. After consultation with our federal partners at the Centers for Medicare and Medicaid Services (CMS) and the provision of prior year finding documentation by DHS and review of that documentation by CMS, both agencies agree that the documentation issues are not significant enough to lead to recoverable questioned costs. The agencies agree that program required services were performed and that the core requirements of the program were met. However, DHS recognizes that internal control and proper documentation are important and both DDS and DAAS have corrective action plans detailed below designed to improve the control environment and result in better documentation for federal claims.

Assisted Living Services management agrees that internal controls are very important, and would point out that large transformative changes to the HCBS waiver service delivery system are under way. This shift includes the transition of services now in the waiver to the Community First Choice Option, and development of an electronic medical records system that will streamline the agency's ability to closely monitor compliance with administrative and documentation requirements. In addition, ongoing training will be provided to home

Findings	Recommendations

As part of its response to the 2012 finding, the Agency stated it disagreed with the finding because its review indicated that services were delivered in accordance with the plans of care, and accordingly, the payments were not improper.

However, the payments are considered improper as defined by the Improper Payments Information Act of 2002, as amended by Pub. L. No. 111-204; the Improper Payments Elimination and Recovery Act, Executive Order 13520 on reducing improper payments; and the June 18, 2010, Presidential memorandum to enhance payment accuracy. The term "improper payment" refers to the following:

- Any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements.
- Incorrect amounts, which include overpayments or underpayments made to eligible recipients (including inappropriate denials of payment or service, any payment that does not account for credit for applicable discounts, payments that are for the incorrect amount, and duplicate payments).
- Any payment made to an ineligible recipient or for an ineligible good or service or payments for goods or services not received (except for such payments where authorized by law).
- **Any payment that an agency cannot determine was appropriate because of insufficient or lack of documentation.**

In addition, the Agency also stated it conducted follow-up audits for the 15 Assisted Living Services beneficiary case files we reviewed and believes documentation was sufficient to support the billing submitted by the providers.

We noted in one of these case files that, after several attempts and requests, we were unable to locate and receive files from the provider. Questioned costs for that case file totaled $102,205. This is one of the files the Agency stated it reviewed and found sufficient documentation to support the billing.

On June 11, 2013, the provider of those services was referred to the Medicaid Fraud Control Unit for investigation.

The Agency also stated it disagreed with the finding because "DLA's interpretation of policy is the provider should have an actual start and stop time for each service performed during the day."

and community based service providers at the corporate level as well as at the direct care level to make sure that the DDS program standards are met. Management will also continue to review all current documentation requirements to ensure that they are related to and in furtherance of state and federal statutory and regulatory requirements for targeted case management for the ACS Waiver program and ensure that requirements are closely aligned with the goals of delivering higher quality services more efficiently in a manner that will result in better outcomes for those individuals served through the program. Finally, ACS Waiver Staff and DDS Certification and Licensure staff will conduct monitoring visits to home and community based service providers to ensure compliance with DDS program standards

Since the 2012 Statewide Single Audit, DAAS completed the following actions related to the ElderChoices and Personal Care Services programs. In conjunction with the Division of Medical Services, DAAS conducted ElderChoices workshops where documentation requirements were specifically reviewed and emphasized. In conjunction with the Division of Medical Services and Program Integrity, DAAS conducted ElderChoices Webinars specifically targeted to clarification on documentation requirements. DAAS also issued a Provider Information Memorandum specifically stating documentation requirements as outlined in Medicaid Policy. Finally, DAAS Quality Assurance began conducting desk audits of providers. If desk audits identified documentation problems, DAAS Quality Assurance advised providers of the problems as well as documentation requirements per Medicaid Policy.

Anticipated Completion Date: Complete

Contact Person:
Mark Story
Assistant Director
Arkansas Department of Human Services
Division of Medical Services
P.O. Box 1437
Little Rock, AR 72203-1437
(501) 320-8955
Mark.Story@dhs.arkansas.gov

Findings

DLA's position is that documentation of the date and actual time service(s) are rendered **is a requirement** because it is clearly stated as such in the provider manuals established by the Agency. This specific criterion is located on the following page.
We also considered qualitative factors such as management oversight and the Medicaid Program's high profile and public interest, which could have a significant impact on the integrity of the program.

Condition and Context:
Our purpose in reviewing these programs was to determine if adequate supporting documentation was being maintained in beneficiary case files as required by Arkansas Provider Manuals. The manuals dictate the information that must be documented and maintained in these files to support the services billed.

The manuals dictate the following information be maintained in the files:

Assisted Living Services (section 202.100)

- A copy of the beneficiary's person-centered service plan.
- The specific services rendered.
- The date and actual time the services were rendered.
- The name and title of the individual who provided the service.
- Updates describing the beneficiary's progress or lack thereof. Updates should be maintained on a daily basis or at each contact with or on behalf of the beneficiary. Progress notes must be signed and dated by the provider of the service.

ElderChoices (section 214.000)

- A copy of the participant's plan of care.
- A brief description of the specific service(s) provided.
- The signature and title of the individual rendering the service(s).
- The date and actual time the service(s) was rendered.

Personal Care Services (section 220.110(D))

- The date of service.

Recommendations

Findings

Recommendations

- The routines performed on that date of service.
- The time of day the aide begins the beneficiary's services.
- The time of day the aide ends a beneficiary's services.
- Notes regarding the beneficiary's condition as instructed by the service supervisor.
- Task performance difficulties.
- The justification for any emergency unscheduled tasks and documentation of the prior-approval or post-approval of the unscheduled tasks.
- The justification for not performing any scheduled service plan required tasks.
- Any other observations the aide believes are of note or should be reported to the supervisor.

Our follow-up procedures included reviewing 31 beneficiary files to determine if required documentation was being maintained to support services billed. Seven were selected from the Assisted Living Services program, and 12 each were selected from the ElderChoices and Personal Care Services programs.

Our review revealed the following:

Assisted Living Services

- Five case files lacked some form of documentation to support the services billed. Questioned costs totaled $58,768.

ElderChoices

- Five case files lacked some form of documentation to support the services billed. Questioned costs totaled $28,479.

Personal Care Services

- Seven case files lacked some form of documentation to support the services billed. Questioned costs totaled $16,622.

Questioned Costs:
$103,869

Cause:
The Agency failed to ensure that all required documentation was maintained.

Findings | Recommendations

Effect:

Inadequate documentation for services provided could jeopardize beneficiary care and Agency payments made for the care.

U.S. Department of Health and Human Services (Continued)

Finding Number:	**13-710-12**
State/Educational Agency(s):	**Arkansas Department of Human Services**
CFDA Number(s) and Program Title(s):	**93.778 - Medical Assistance Program (Medicaid Cluster)**
Federal Award Number(s):	**05-1205AR5MAP; 05-1305AR5MAP**
Federal Award Year(s):	**2012 and 2013**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed - Home and Community-Based Services**
Type of Finding:	**Material Weakness**

Criteria:
The U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) issued a special fraud alert concerning home health care. Problems noted include cost report frauds, billing for excessive services or services not rendered, and use of unlicensed staff. The full alert was published in the Federal Register on August 10, 1995 and is available on the HHS OIG home page in the Special Fraud Alerts section.

As these programs are especially risky, the Agency asserted that internal controls that relate specifically to Home and Community-Based (HCB) Waiver Programs were in place during fiscal year 2013. First, the Agency's Division of Medical Services Quality Assurance (DMS QA) staff performed a review to determine if services billed were in agreement with the services allowed according to the recipient's plan of care. Second, effective January 1, 2013, DMS QA began performing home visits to ensure that services were actually being provided for claims submitted. Finally, the financial accountability section (I-1) of the various HCB waivers requires independent audits of providers meeting established thresholds. Independent audits are required to be submitted to and reviewed by the DHS Office of Chief Council audit staff for compliance.

Recommendation:
We recommend the Agency strengthen controls to ensure adequate documentation is maintained to provide evidence of reviews performed. In addition, the Agency should establish procedures to ensure independent audits are reviewed in accordance with existing guidelines.

Views of Responsible Officials and Planned Corrective Action:

The Agency concurs with the finding regarding documentation of review procedures performed as well as issues concerning proper review of independent audits of providers. DMS will establish additional controls related to expected and reasonable documentation of review procedures performed for all reviews, regardless of whether issues are noted in the engagements. In addition, DMS will work with the DHS Office of Quality Assurance to ensure timely and proper review of provider audits in accordance with Agency policy.

Anticipated Completion Date: June 2014

Contact Person:
Mark Story
Assistant Director
Arkansas Department of Human Services
Division of Medical Services
P.O. Box 1437
Little Rock, AR 72203-1437
(501) 320-8955
Mark.Story@dhs.arkansas.gov

Findings

Recommendations

Condition and Context:
In order to determine if adequate controls were in place specific to the HCB Waiver Programs, we conducted three separate control tests.

Our first test included obtaining a listing of all reviews performed by DMS QA whereby services billed were compared to services allowed per the plans of care. We selected 60 items from this listing to determine if supporting documentation was adequate to substantiate that the reviews had been performed. Our review revealed that 19 items did not have adequate supporting documentation of a review being performed by DMS QA. DMS QA indicated that unless an issue was noted as a result of its review, no documentation of the review would be available.

Our second test included obtaining a listing of all home visits made by DMS QA whereby services were actually being provided for claims submitted. We selected 60 items from this listing to determine if supporting documentation was adequate to substantiate that the home visit had been made. Our review revealed that 49 items did not have adequate supporting documentation of a home visit. DMS QA indicated that unless an issue was noted as a result of the home visit, no documentation of the review would be available.

Our third test involved verification that all independent audits for providers meeting the criteria previously mentioned were being received and reviewed by DHS Office of Chief Council. Our discussion with the Agency revealed that no procedures were in place to review independent audits of providers, as required per the financial accountability sections of the HCB waivers.

Questioned Costs:
None

Cause:
Although the Agency has designed internal control procedures to specifically address risks associated with Home and Community-Based Programs, deficiencies exist that render controls ineffective.

Effect:
Inadequate controls could jeopardize beneficiary care and Agency payments made for the care.

Findings

U.S. Department of Health and Human Services (Continued)

Finding Number:	**13-710-13**
State/Educational Agency(s):	**Arkansas Department of Human Services**
CFDA Number(s) and Program Title(s):	**93.778 - Medical Assistance Program (Medicaid Cluster)**
Federal Award Number(s):	**05-1205AR5MAP; 05-1305AR5MAP**
Federal Award Year(s):	**2012 and 2013**
Compliance Requirement(s) Affected:	**Activities Allowed or Unallowed - Targeted Case Management**
Type of Finding:	**Noncompliance and Significant Deficiency**

Criteria:
Follow-up procedures for prior-year finding 12-710-09 from the 2012 Statewide Single Audit revealed continued noncompliance and inadequate internal controls regarding case management services for the Alternative Community Services (ACS) Waiver program.

As part of its response to the 2012 finding, the Agency stated it disagreed with the finding because "the most common finding alleges that providers failed to record specific service delivery times. There is, however, no reason to collect such information because payments hinge on the delivery of services in accordance with care plans. It makes no difference whether a particular service was delivered at 2:00 p.m. or 3:00 p.m."

Our position is that documentation of the date and actual time service(s) are rendered **is a requirement** because it is clearly stated as such in the provider manuals established by the Agency. This specific criterion is located below.

We also considered qualitative factors such as management oversight and the Medicaid Program's high profile and public interest, which could have a significant impact on the integrity of the program.

Condition and Context:
Our purpose in reviewing this program was to determine if adequate supporting documentation was being maintained in beneficiary case files as required by Section II of the Arkansas Medicaid Provider Manual for the ACS Waiver section 202.100. The manual

Recommendations

Recommendation:
We ***again*** recommend the Agency establish and implement procedures to ensure all required documentation is maintained in the beneficiary files.

Views of Responsible Officials and Planned Corrective Action:

The Agency agrees with the finding. The audit revealed some concerns in the area of adequate documentation by service providers, therefore the Agency will improve controls, training and documentation procedures in the following manner. ACS Waiver Staff and DDS Certification and Licensure staff will conduct monitoring visits to home and community based service providers to ensure compliance with DDS program standards. Ongoing Training will be provided to home and community based service providers at the corporate level as well as at the direct care level to make sure that the DDS program standards are met. Management agrees that internal controls are very important, and would point out that large transformative changes to the HCBS waiver service delivery system are under way. This shift includes the transition of services now in the waiver to the Community First Choice Option, and development of an electronic medical records system that will streamline the agency's ability to closely monitor compliance with administrative and documentation requirements. Management will continue to review all current documentation requirements to ensure that they are related to and in furtherance of state and federal statutory and regulatory requirements for targeted case management for the ACS Waiver program and ensure that requirements are closely aligned with the goals of delivering higher quality services more efficiently in a manner that will result in better outcomes for those individuals served through the program.

Anticipated Completion Date: April 2014

Contact Person:
Mark Story
Assistant Director
Arkansas Department of Human Services
Division of Medical Services
P.O. Box 1437
Little Rock, AR 72203-1437
(501) 320-8955
Mark.Story@dhs.arkansas.gov

Findings	Recommendations

dictates the information that must be documented and maintained in files to support the services billed as follows:

- A copy of the beneficiary's person-centered service plan.
- The specific services rendered.
- The date and actual time the services were rendered.
- The name and title of the individual who provided the services.
- Updates describing the beneficiary's progress or lack thereof. Updates should be maintained on a daily basis or at each contact with or on behalf of the beneficiary. Progress notes must be signed and dated by the provider of the service.

In addition, case management services are available at three levels of support as defined by ACS Waiver
sections 230.211 - 230.213:

- Pervasive - Minimum of one face-to-face visit AND one other contact with the beneficiary or legal representative each month. At least one visit must be made annually at the beneficiary's place of residence.
- Extensive - Minimum of one face-to-face visit with the beneficiary or legal representative each month. At least one visit must be made annually at the beneficiary's place of residence.
- Limited - Minimum of one face-to-face visit with the beneficiary or legal representative each quarter and a minimum of one contact monthly for the months when a face-to-face visit is not made. At least one visit must be made annually at the beneficiary's place of residence.

Our follow-up procedures included reviewing 15 beneficiary files to determine if required documentation was being maintained by the provider (case manager) to support services billed. Our review revealed the following:

- Eight beneficiary files did not contain adequate supporting documentation for services billed.
- Three beneficiary files did not contain adequate supporting documentation to determine case management services had been provided.
- Seven beneficiary files did not contain adequate supporting documentation to determine if the level of support had been met by case managers.

Findings | Recommendations

Questioned Costs:
$9,181

Cause:
The Agency failed to ensure all required documentation was maintained.

Effect:
Inadequate documentation for services provided could jeopardize beneficiary care and Agency payments made for the care.

U.S. Department of Health and Human Services (Continued)

Finding Number:	**13-710-14**
State/Educational Agency(s):	**Arkansas Department of Human Services**
CFDA Number(s) and Program Title(s):	**93.778 - Medical Assistance Program (Medicaid Cluster)**
Federal Award Number(s):	**05-1205AR5ADM; 05-1305AR5ADM**
Federal Award Year(s):	**2012 and 2013**
Compliance Requirement(s) Affected:	**Allowable Costs/Cost Principles - Rebates for Drug Purchases**
Type of Finding:	**Noncompliance and Significant Deficiency**

Criteria:
Section 1927 of the Social Security Act allows states to receive rebates for drug purchases. No later than 60 days after the end of the quarter, the State Medicaid Agency (i.e., the Arkansas Department of Human Services [DHS]) must provide drug utilization data (invoices) to the manufacturers. Within 30 days of receipt of the invoices from DHS, the manufacturers are required to pay the rebate or provide DHS with written notice of disputed items not paid because of discrepancies found.

Condition and Context:
We selected 60 National Drug Codes (NDC) from the quarter ended December 31, 2012, to determine if the Agency generated invoices timely and if the manufacturers submitted rebate

Recommendation:
We recommend the Agency establish and implement procedures to ensure all rebates for drug purchases are pursued for collection.

Views of Responsible Officials and Planned Corrective Action:

The Agency concurs with the finding regarding policies and procedures to pursue collection of outstanding rebate balances. DMS will establish procedures to pursue collection of rebate balances. DMS will also establish stronger reporting and tracking capability in an effort to develop more effective analytical tools for decision making surrounding these outstanding balances.

Anticipated Completion Date: September 2014

Contact Person:
Mark Story
Assistant Director
Arkansas Department of Human Services
Division of Medical Services
P.O. Box 1437
Little Rock, AR 72203-1437
(501) 320-8955
Mark.Story@dhs.arkansas.gov

Findings | Recommendations

payments timely. Our review revealed that all invoices were generated timely. However, rebate payments representing 30 of the NDC reviewed were not received timely. In addition, rebate payments for two of the NDC had yet to be received as of December 23, 2013, and the Agency could not provide adequate evidence documenting that the outstanding rebate balances were being actively pursued for collection.

Questioned Costs:
None

Cause:
There is no way to determine the cause for the untimely payments from the manufacturers as this is beyond Agency control. However, the Agency does not have adequate procedures in place to pursue collection of outstanding rebate balances.

Effect:
The Agency is not receiving all rebates for drug purchases timely. In addition, documentation is inadequate to support that outstanding rebate balances are being actively pursued.

U.S. Department of Health and Human Services (Continued)

Finding Number:	**13-710-15**
State/Educational Agency(s):	**Arkansas Department of Human Services**
CFDA Number(s) and Program Title(s):	**93.778 - Medical Assistance Program (Medicaid Cluster)**
Federal Award Number(s):	**05-1205AR5ADM; 05-1305AR5ADM**
Federal Award Year(s):	**2013 and 2012**
Compliance Requirement(s) Affected:	**Allowable Costs/Cost Principles - Rebates for Drug Purchases**
Type of Finding:	**Significant Deficiency**

Criteria:
In accordance with Ark. Code Ann. § 19-2-305 (a) - (b)(1), "A state agency shall diligently and actively pursue the collection of their accounts and notes receivable. Diligently and actively pursuing the collection of these accounts may include, but is not limited to: contacting

Recommendation:
We recommend the Agency establish and implement procedures to ensure all rebates for drug purchases are pursued for collection. In addition, the Agency should establish and implement procedures to identify and refer uncollectable balances to the proper authorities for abatement.

Views of Responsible Officials and Planned Corrective Action:

The Agency concurs with the finding and agrees with the lack of written policies regarding rebate balances. DMS will develop written policies regarding uncollectable balances and abatement consistent with Arkansas code and Federal regulations.

Anticipated Completion Date: September 2014

Contact Person: Mark Story
Assistant Director
Arkansas Department of Human Services

Findings	Recommendations

debtor by phone or letter within a reasonable time after an account is deemed delinquent."

Additionally, written policies should be in place outlining procedures to both identify and write-off uncollectible balances. Ark. Code Ann. § 19-2-306 (a) states, "If after the state agency has pursued collection of the debt owed it as set out in this subchapter and the debt or partial debt is decreed to be uncollectible, then the debt shall be referred to the Chief Fiscal Officer of the State for abatement."

Condition and Context:
During our review to determine compliance with rebates for drug purchases, we discovered the Agency was not actively pursuing outstanding balances, as noted in finding **13-710-14**. As a result, we inquired about formal written policies and procedures for the following:

- Pursuit of outstanding accounts receivable balances regarding rebates for drug purchases.
- Identification of outstanding accounts receivable balances regarding rebates for drug purchases that are not collectable and should be referred to the proper authorities for abatement.

Agency personnel stated that there are no written policies and procedures for these areas.

Questioned Costs:
None

Cause:
The Agency failed to develop written policies and procedures to actively pursue outstanding accounts receivable balances regarding rebates for drug purchases or to identify and refer uncollectable balances to the proper authorities for abatement.

Effect:
As of June 30, 2013, the outstanding accounts receivable balance for rebates for drug purchases was $56 million, $5 million of which is over one year old.

Division of Medical Services
P.O. Box 1437
Little Rock, AR 72203-1437
(501) 320-8955
Mark.Story@dhs.arkansas.gov

U.S. Department of Health and Human Services (Continued)

Finding Number: **13-710-16**

Recommendation:
We recommend the Agency continue providing adequate communication and training to

Findings

State/Educational Agency(s): **Arkansas Department of Human Services**
CFDA Number(s) and Program Title(s): **93.778 - Medical Assistance Program (Medicaid Cluster)**
Federal Award Number(s): **05-1205AR5MAP; 05-1305AR5MAP**
Federal Award Year(s): **2012 and 2013**
Compliance Requirement(s) Affected: **Eligibility**
Type of Finding: **Noncompliance and Material Weakness**

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. For certain categories of Medicaid eligibility (e.g., TEA Medicaid), the MS manual refers to policies outlined in the TEA Cash Assistance and Financial Assistance manuals that apply to the specific Medicaid category. However, these manuals are considered reference manuals for the MS manual, not Medicaid manuals. The MS manual is specific to Medicaid eligibility policies and procedures and is in addition to the approved State Plan required in 42 CFR § 430.10.

42 CFR § 435.913 Case Documentation states, "The Agency must include in each application record facts to support the Agency's decision on his application."

Condition and Context:
We reviewed 120 Medicaid recipient files to ensure adequate documentation was provided to support the Agency's determination of eligibility. Sixty files were for aid categories determined to be spend downs. The other 60 represented all other aid categories. Our review revealed the following:

- In one recipient file representing paid claims for State Aid category 27 (AFDC Spend Down), documentation revealed medical bills were inadequate to spend the recipients' income down to the point of eligibility or that the medical bills used were not verified to ensure that amounts were still outstanding, were applicable to the recipient in question, and were not being addressed through a payment plan. The Agency's failure to follow program requirements regarding the use of medical bills to spend down income resulted in known questioned costs totaling $1,668.
- In one recipient file representing paid claims for State Aid category 47

Recommendations

appropriate personnel to ensure compliance with all program requirements as defined in the MS manual.

Views of Responsible Officials and Planned Corrective Action:

The Agency concurs with the findings for these Spend Down categories. We are very pleased that there were no findings for the remaining Medicaid categories for the second consecutive year. The Agency will continue our existing program integrity efforts as marked improvement has occurred since the previous years' findings for two of the very complex Spend Down categories.

Anticipated Completion Date: Complete

Contact Person:
Joni Jones
Director
Arkansas Department of Human Services
Division of County Operations
P.O. Box 1437, Mail Slot S301
Little Rock, AR 72203-1437
(501) 682-8375
joni.jones@dhs.arkansas.gov

Findings

Recommendations

limits were either exceeded or not verified; Social Security enumeration was not satisfied; medical bills were inadequate to spend the recipients' income down to the point of eligibility; or the medical bills used were not verified to ensure that amounts were still outstanding, were applicable to the recipient in question, and were not being addressed through a payment plan. As a result of the Agency's failure to follow program requirements regarding resource limitations or verifications and medical bills used to spend down income, known questioned costs were determined to be $371. As a result of our testing in 2013, additional known questioned costs for fiscal year 2012 were discovered totaling $22,435.

- In one recipient file representing paid claims for State Aid category 47 (Disabled Spend Down), documentation revealed that the approved resource limits were either exceeded or not verified. As a result of the Agency's failure to follow program requirements for resource limitations or verification, known questioned costs were determined to be $9,558.

In addition to the three compliance and internal control deficiencies summarized above, an additional 47 internal control deficiencies were noted. Deficiencies included missing signed applications as well as various eligibility attributes, including those related to Social Security enumeration, citizenship, assignment of rights, categorical relatedness, medical necessity, appropriateness of care, and resources, that were either not initially considered or adequately documented when eligibility was determined. Additionally, there were also cases of missing spend down computations documenting a recipient's unmet liability as well as the medical bills that were used to spend down the recipient's income, improper spend down computations, and several instances of inadequate documentation supporting the medical bills used to spend down the income. However, the Agency was able to address these specific deficiencies, and the recipient's eligibility was not affected.

Questioned Costs:
$11,597 (2013)

$22,435 (2012)

Cause:
Although the Agency has designed internal control procedures to review recipient files to ensure adequate documentation is provided to support the Agency's determination of

Findings | Recommendations

eligibility, certain areas still require continued communication to and training of the appropriate Agency personnel.

Effect:

Payments to providers were made on behalf of ineligible recipients.

U.S. Department of Health and Human Services (Continued)

Finding Number:	**13-710-17**
State/Educational Agency(s):	**Arkansas Department of Human Services**
CFDA Number(s) and Program Title(s):	**93.778 - Medical Assistance Program (Medicaid Cluster)**
Federal Award Number(s):	**05-1205AR5MAP; 05-1305AR5MAP**
Federal Award Year(s):	**2012 and 2013**
Compliance Requirement(s) Affected:	**Eligibility**
Type of Finding:	**Material Weakness**

Criteria:
As noted in OMB Circular A-133, § 300(b), the auditee shall maintain internal control over federal programs that provides reasonable assurance that the auditee is managing federal awards in compliance with laws, regulations, and provisions of contracts or grant agreements that could have a material effect on each of its federal programs.

Medicaid eligibility is determined by Program Eligibility Specialists (PES) located in the various county offices throughout the State. It is essential that the number of trained and knowledgeable PES is adequate to perform eligibility determinations. All activity concerning eligibility is documented by the PES in the Arkansas Network System for Welfare Eligibility and Reporting (ANSWER) and is subject to supervisory review. All new PES are subject to a 100% review, at minimum, during their first month of employment and a 75% review, at minimum, during their second month. Reviews are conducted as needed at the beginning of the third month.

Condition and Context:
We reviewed the Agency's supervisory review process for 10 newly-hired PES. Our review revealed eligibility actions of three PES were not documented as reviewed by a supervisor

Recommendation:
We recommend the Agency strengthen existing controls to ensure supervisory reviews are performed as required for newly hired PES.

Views of Responsible Officials and Planned Corrective Action:

One of these new employees was in New Worker training from March 18, 2013 to April 5, 2013. Trainees are required to conduct re-evaluations while in training with oversight by the trainer. The two cases cited by Legislative Audit for this employee were appropriately reviewed by the trainer. The other two employees work for the Access Arkansas Processing Center doing more specialized work. After numerous case reviews that indicated a 98 - 100% accuracy rate, the supervisor determined a complete review of their work was no longer necessary. As a corrective action measure, for cases worked during training, the review will now be documented by the trainer. Targeted second party reviews will continue to be conducted for staff in county offices.

Anticipated Completion Date: Complete

Contact Person:
Joni Jones
Director
Arkansas Department of Human Services
Division of County Operations
P.O. Box 1437, Mail Slot S301
Little Rock, AR 72203-1437
(501) 682-8375
joni.jones@dhs.arkansas.gov

Findings | Recommendations

during their first month of employment. In addition, eligibility actions for one PES was not documented as reviewed during the first or second month of employment.

Questioned Costs:
None

Cause:
Although the Agency has designed internal control procedures to ensure the accuracy of eligibility determinations by newly hired PES, the control is not operating as designed.

Effect:
Payments on behalf of ineligible recipients could have been processed.

U.S. Department of Health and Human Services (Continued)

Finding Number:	**13-710-18**
State/Educational Agency(s):	**Arkansas Department of Human Services**
CFDA Number(s) and Program Title(s):	**93.778 - Medical Assistance Program (Medicaid Cluster)**
Federal Award Number(s):	**05-1205AR5MAP; 05-1305AR5MAP**
Federal Award Year(s):	**2012 and 2013**
Compliance Requirement(s) Affected:	**Eligibility**
Type of Finding:	**Noncompliance and Significant Deficiency**

Criteria:
The Agency must operate a Medicaid Eligibility Quality Control (MEQC) program in accordance with 42 CFR
§ 431.810 - 431.822. The Agency's MEQC developed the Medicaid Miller Income Trust and Spouse Allowance (MIT-SA) pilot project for federal fiscal year 2013. The pilot project included Long Term Care (LTC) reviews with a focus on cases involving Miller Income Trusts and Community Spouse Monthly Income Allowance (CSMIA).

In addition to the pilot project, MEQC developed an in-house project that involved reviewing cases with claims exceeding $50,000 and determined to be in a high-risk category.

All errors found by MEQC would be presented at a weekly error committee meeting, and the committee would notify the county office of the errors. County offices would then have 10

Recommendation:
We recommend the Agency strengthen existing in-house project procedures to ensure errors and overpayments are processed timely.

Views of Responsible Officials and Planned Corrective Action:

The client's bank statement for the month of August 2013 was required In order to complete the overpayment. This statement was not printed by the bank until September 19, 2013 and was not provided by the client until October 7, 2013. The DCO-199 was completed upon receiving the requested information. Management staff in this office has been directed to more closely monitor the timely submission of documents required to complete overpayments within the 30 day time frame required by policy and to document the reason for delays.

Anticipated Completion Date: Complete

Contact Person:
Joni Jones
Director
Arkansas Department of Human Services
Division of County Operations
P.O. Box 1437, Mail Slot S301
Little Rock, AR 72203-1437
(501) 682-8375

Findings

days to appeal error decisions. If no appeal was submitted, the county offices would be responsible for correcting the errors and submitting an error response form, DCO-29, to MEQC within 30 days. If an error resulted in an overpayment, overpayment form DHS-199 would be submitted to the Overpayment Unit within 30 days. If fraud was suspected, the case would be referred to the Fraud Unit within 30 days.

Condition and Context:
We performed a test to determine compliance with project procedures. We selected 60 cases that had been reviewed by MEQC. MEQC discovered errors in five of the cases and found the remaining 55 cases to be without errors.

Our review revealed a breakdown in procedures for one case in which MEQC found an error. The recipient in this case was determined ineligible by MEQC. MEQC issued a memorandum to the County Office Administrator of Jefferson County, dated August 1, 2013, outlining the corrective action to be taken, including completion of a DCO-29 within 30 days. If an overpayment occurs , the DHS-199 must be submitted to the overpayment unit within 30 days. The DCO-29, dated August 13, 2013, was completed timely by the county office. However, the DHS-199 was not completed until October 4, 2013, subsequent to the case being selected for testing by DLA.

Questioned Costs:
$8,505 (2013)

$4,253 (2014)

Cause:
The county office failed to complete and submit the DHS-199 timely, as required.

Effect:
An overpayment totaling $12,758, identified by the Agency's MEQC, was not submitted to the overpayment unit within 30 days, as required.

U.S. Department of Health and Human Services (Continued)

Finding Number: **13-710-19**
State/Educational Agency(s): **Arkansas Department of Human Services**

Recommendations

joni.jones@dhs.arkansas.gov

Recommendation:
We recommend the Agency strengthen existing controls to ensure claims suspended by MMIS are properly processed. In addition, the Agency should review record retention policies with staff to ensure adequate supporting documentation is maintained.

Findings

CFDA Number(s) and Program Title(s): **93.778 - Medical Assistance Program (Medicaid Cluster)**
Federal Award Number(s): **05-1205AR5MAP; 05-1305AR5MAP**
Federal Award Year(s): **2012 and 2013**
Compliance Requirement(s) Affected: **Period of Availability of Federal Funds**
Type of Finding: **Significant Deficiency**

Criteria:
As noted in OMB Circular A-133, § 300(b), the auditee shall maintain internal control over federal programs that provides reasonable assurance that the auditee is managing federal awards in compliance with laws, regulations, and provisions of contracts or grant agreements that could have a material effect on each of its federal programs. In addition, 42 CFR § 447.45 defines timely submission of claims for processing and section 302.100 of the Provider Manual specifically addresses timely claims processing for Medicare/Medicaid Crossover claims.

Condition and Context:
We selected claims paid during a five-week period to determine if edits in the MMIS system properly suspend claims that are not submitted timely.

Our review revealed that six claims properly suspended by MMIS were manually overridden or "forced" by an HP resolution clerk and paid in error.

In addition, the Agency was unable to provide supporting documentation authorizing the approval for seven claims properly suspended but subsequently approved for processing. The Agency stated HP does not maintain authorizations past six months.

Questioned Costs:
$1,386

Note: The Agency recouped questioned costs of $1,378 on September 19, 2013, and $8 on January 16, 2014.

Cause:
HP claims resolution staff failed to follow the claims resolution directions set forth in the manual and failed to maintain adequate supporting documentation.

Effect:

Recommendations

Views of Responsible Officials and Planned Corrective Action:

The Agency agrees with the finding. The errors resulted from turnover in personnel by the MMIS operator. All new personnel have now received additional training and a recurrence of these errors is not expected. It should be reinforced that all of the questioned costs were recouped prior to the issuance of the audit report.

Anticipated Completion Date: Complete

Contact Person:
Mark Story
Assistant Director
Arkansas Department of Human Services
Division of Medical Services
P.O. Box 1437
Little Rock, AR 72203-1437
(501) 320-8955
Mark.Story@dhs.arkansas.gov

Findings	Recommendations

Claims were paid in error, and adequate documentation was not maintained for all claims suspended and subsequently processed for payment.

U.S. Department of Health and Human Services (Continued)

Finding Number:	**13-710-20**
State/Educational Agency(s):	**Arkansas Department of Human Services**
CFDA Number(s) and Program Title(s):	**93.778 - Medical Assistance Program (Medicaid Cluster)**
Federal Award Number(s):	**05-1205AR5MAP; 05-1305AR5MAP**
Federal Award Year(s):	**2012 and 2013**
Compliance Requirement(s) Affected:	**Special Tests and Provisions - Provider Eligibility**
Type of Finding:	**Noncompliance and Significant Deficiency**

Criteria:
In accordance with section I, part 141.000 of the Provider Manual, any provider of health services must be enrolled in the Arkansas Medicaid Program before Medicaid will cover any services provided to Arkansas Medicaid beneficiaries.
The manual indicates that the following documentation must be submitted to complete the enrollment process:

1) Signed application.
2) Internal Revenue Service (IRS) Form W-9.
3) Medicaid provider contract.
4) Primary Care Physician (PCP) agreement, if applicable.
5) Early Periodic Screening, Diagnosis, and Treatment (EPSDT) agreement, if applicable.
6) Change in ownership control or conviction of crime.
7) Disclosure of significant business transactions.

In addition, section II may contain supplemental, specific participation requirements for providers, which may include the following:

1) Specific license or certification required based on provider type and specialty.

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

Views of Responsible Officials and Planned Corrective Action:

The agency agrees with the findings and will work to continue improving quality assurance processes as they relate to provider enrollment requirements and record keeping. Quarterly, DMS staff review test enrollment files to ensure they meet federal and state requirements. New internal requirements have been implemented that require that the documents in question be present when scanning and saving enrollment files. In addition, new policies adopted to conform to the Affordable Care Act (ACA) require that all provider types re-enroll/revalidate their enrollment every five (5) years. This will assist in ascertaining whether changes that may have occurred with the enrollee have been appropriately updated; leading to an increase in the scrutiny and accuracy of files and records.

Anticipated Completion Date: Complete

Contact Person:
Mark Story
Assistant Director
Arkansas Department of Human Services
Division of Medical Services
P.O. Box 1437
Little Rock, AR 72203-1437
(501) 320-8955
Mark.Story@dhs.arkansas.gov

Findings | Recommendations

2) Participation in the Medicare program, if applicable.

Condition and Context:
We reviewed enrollment and other supplemental information as applicable for 60 active providers to determine if required documentation was completed and maintained. Our review revealed two instances of noncompliance as follows:

- Two provider files did not contain a signed application during the fiscal year under review. In addition, one of these provider files did not contain a signed Medicaid provider contract or IRS Form W-9. This documentation is required for the provider to be considered "enrolled" and eligible for reimbursement for services provided to Medicaid beneficiaries. As a result, claims paid during fiscal year 2013 totaling $114,340 were considered questioned costs.
- One provider file did not contain a Division of Behavioral Health Services (DBHS) certification. Prior to the end of fieldwork, the Agency addressed this specific deficiency, and the provider's eligibility was not affected.

Questioned Costs:
$114,340

Cause:
Although the Agency has designed internal control procedures to ensure providers are submitting all required documentation and the documentation is maintained, certain areas still require continued communication to the appropriate personnel.

Effect:
Claims payments to ineligible providers were processed.

Performance Audit Findings

DEPARTMENT OF HUMAN SERVICES

Findings and Conclusions:

Review of Arkansas Medicaid Program School Services and Reimbursements
Arkansas Department of Human Services (DHS)
Review Period: July 1, 2012 - June 30, 2013
Report Issued: June 6, 2014

Findings and Conclusions:

- DHS did not monitor participating school districts to ensure compliance with requirements for sampling methodology and recordkeeping for Medicaid-reimbursable activities as required by provisions of the Arkansas Medicaid Administrative Claiming (ARMAC) program.
- School districts tested by DLA did not maintain adequate documentation to support reimbursement requests.
- Participating school districts tested by DLA were not in compliance with the "free care" principle because they did not seek reimbursement from private insurance for covered students.

Recommendations:

- DHS should ensure participating school districts are in compliance with provisions of the ARMAC program.
- DHS should review school districts' ARMAC program claims for reimbursement on a systematic and routine basis.
- DHS should review school district records for compliance with the "free care" principle.

State Contracts Over $50,000 Awarded To Minority Owned Businesses Fiscal Year 2014

None

Employment Summary

	Male	Female	Total	%
White Employees	1008	3420	4428	60 %
Black Employees	510	2365	2875	39 %
Other Racial Minorities	24	74	98	1 %
Total Minorities			2,973	40 %
Total Employees			7,401	100 %

Publications

A.C.A. 25-1-201 et seq.

Name	Statutory Authorization	Required for		# of Copies	Reason(s) for Continued Publication and Distribution	Unbound Black & White Copies Produced During the Last Two Years	Cost of Unbound Copies Produced During the Last Two Years
		Governor	General Assembly				
None	N/A	N	N	0	N/A	0	0.00

Agency Position Usage Report

FY2012 - 2013						FY2013 - 2014						FY2014 - 2015					
Authorized in Act	Budgeted			Unbudgeted	% of Authorized Unused	Authorized in Act	Budgeted			Unbudgeted	% of Authorized Unused	Authorized in Act	Budgeted			Unbudgeted	% of Authorized Unused
	Filled	Unfilled	Total	Total			Filled	Unfilled	Total	Total			Filled	Unfilled	Total	Total	
174	169	4	173	1	2.87 %	173	178	13	191	-18	-2.89 %	190	173	17	190	0	8.95 %

Authorized in Act may differ from Authorized reflected on the Appropriation Summary due to Reallocation of Resources (Act 282 of 2014 section 17(d)), Miscellaneous Federal Grant (A.C.A. 19-7-501 et seq.) and POOL positions (A.C.A. 21-5-225(b)(1)).

Department Appropriation Summary

Appropriation	Historical Data						Agency Request and Executive Recommendation											
	2013-2014		2014-2015		2014-2015		2015-2016						2016-2017					
	Actual	Pos	Budget	Pos	Authorized	Pos	Base Level	Pos	Agency	Pos	Executive	Pos	Base Level	Pos	Agency	Pos	Executive	Pos
896 Director's Office	969,922	7	1,148,180	7	1,178,090	7	1,155,982	7	1,155,982	7	1,155,982	7	1,156,548	7	1,156,548	7	1,156,548	7
896 Office of Chief Counsel	11,846,878	180	12,285,298	183	12,594,769	183	12,410,492	183	12,489,763	183	12,489,763	183	12,415,583	183	12,494,854	183	12,494,854	183
Total	12,816,800	187	13,433,478	190	13,772,859	190	13,566,474	190	13,645,745	190	13,645,745	190	13,572,131	190	13,651,402	190	13,651,402	190
Funding Sources		%		%				%		%		%		%		%		%
General Revenue 4000010	4,800,769	37.5	4,802,557	35.8			4,850,234	35.8	4,850,234	35.8	4,850,234	35.8	4,852,254	35.8	4,852,254	35.8	4,852,254	35.8
Federal Revenue 4000020	5,675,916	44.3	5,388,044	40.1			5,442,524	40.1	5,442,524	40.1	5,442,524	40.1	5,444,764	40.1	5,444,764	40.1	5,444,764	40.1
Various Program Support 4000730	2,340,115	18.3	3,242,877	24.1			3,273,716	24.1	3,273,716	24.1	3,273,716	24.1	3,275,113	24.1	3,275,113	24.1	3,275,113	24.1
Total Funds	12,816,800	100.0	13,433,478	100.0			13,566,474	100.0	13,566,474	100.0	13,566,474	100.0	13,572,131	100.0	13,572,131	100.0	13,572,131	100.0
Excess Appropriation/(Funding)	0		0				0		79,271		79,271		0		79,271		79,271	
Grand Total	12,816,800		13,433,478				13,566,474		13,645,745		13,645,745		13,572,131		13,651,402		13,651,402	

Analysis of Budget Request

Appropriation: 896 - DHS–Admin Paying Account

Funding Sources: PWP - Administration Paying

Arkansas Code Annotated §25-10-106 delegated administrative authority for the entire Department of Human Services to the Office of the Director. According to Arkansas Code Annotated §25-10-102, the Department operates under an integrated service delivery system provided by eleven divisions, in addition to the Director's Office that includes the Office of Chief Counsel. Both the Director and Chief Counsel operate from the same appropriation but are given separate paying funds. The DHS Director is responsible for establishing departmental policy to carry out executive directives, federal and state legislative mandates and coordination of services across Division lines when individuals and families are provided services by multiple programs. Arkansas Code Annotated §20-76-201 delineates the powers and duties of the Department of Human Services.

The Arkansas Department of Human Services (DHS) is the largest state agency with more than 7,200 employees working in all 75 counties. Every county has at least one local office where citizens can apply for any of the services the Department offers. Some counties, depending on their size, have more than one office. DHS employees come into direct contact with thousands of people daily and offer the "safety net" Arkansas families turn to when they are facing difficult times. DHS takes care of Arkansans of all ages ranging from infants to senior citizens.

DHS is involved in virtually every facet of life in the state. DHS staff oversees the regulation of nursing home and childcare facilities. DHS is also responsible for finding adoptive families for foster children, protecting abused and neglected children, funding the home-delivery of meals for the elderly and operating the juvenile justice system. DHS oversees services to blind Arkansans and helps develop volunteer programs, which have a profound impact at the community level. The Department also protects elderly Arkansans from abuse and neglect and operates human development centers across the state, which serves the developmentally disabled. DHS also provides mental health services through its system of community mental health care centers.

The Mission of the Department is "Together we improve the quality of life of all Arkansans by protecting the vulnerable, fostering independence, and promoting better health."

The Office of Chief Counsel consists of various sections which provide extensive legal, investigative, audit and hearing services to the Department of Human Services' (DHS) Divisions. The sections and their areas of responsibility are as follows:

- General Counsel Section provides legal assistance on administrative hearings, litigation, delivery of services, program administration, personnel, civil rights, and overpayment collections.
- Child and Adult Protection Section provides legal support in all counties and provides assistance primarily in areas of child welfare and adult protective services. Attorneys also provide assistance in Family In Need of Services (FINS) cases when the children are placed in foster care, and in Division of Youth Services cases in transitioning youth from their facilities when they cannot return home.

Appeals and Hearings administers the appeal process on adverse actions, which include those related to all categories of Medicaid, TANF, and Child Maltreatment.

- Office of Employee Relations/Office of Equal Opportunity is responsible for employee grievance/complaint processing and conducting mediations and fact-finding conferences related to grievances and complaints.
- DHS Policy unit is responsible for drafting, editing, and promulgating policies, rules, procedures, and forms for the entire agency, serving a workforce of more than 7,500 employees across the state. The unit ensures that all DHS policies and procedures are updated in order to meet Arkansas Code as well as federal mandates, and develops and writes new policies and procedures based on agency need.

Office of Quality Assurance includes the following:

- Audit Section conducts performance, compliance and some financial related audits, and consults on operational and program issues. It coordinates the development of audit requirements and guidelines and monitors program resolution.
- Fraud Investigations is responsible for investigating and referring for prosecution allegations of recipient fraud or Intentional Program Violation (IPV) in the public assistance programs administered by the Department of Human Services. These include Transitional Employment Assistance, Food Stamps, Medicaid, Child Care, and Special Nutrition. The unit also conducts investigations of suspected Food Stamp trafficking by both recipients and retailers, and/or program divisions with investigations involving service providers who contract with the agency to perform services for a defined recipient population. The Internal Affairs section of the unit conducts investigations involving allegations of internal misconduct.

The Director's Office/Office of Chief Counsel (OCC) is funded from a mix of sources that include general revenue (DAS - Department of Human Services Administration Fund Account), federal, and other funds. Federal and other funding is determined by the Department's cost allocation plan. Other funding which is indicated as various program support can also include sources such as federal awards, fees, Fraud/Courts overpayment receipts and maximization of federal claiming. These other funds are considered to be non-federal and technically can be expended for any program or service within the Department.

Base Level Regular Salaries and Personal Services Matching include the continuation of the previously authorized 2015 1% Cost of Living Adjustment and Career Service Payments for eligible employees. Personal Services Matching also includes a $10 increase in the monthly contribution for State employee's health insurance for a total State match per budgeted employee of $420 per month. Base Level salaries and matching do not include appropriation for Merit Pay Increases. The Base Level salary of unclassified positions reflects the FY15 line item maximum plus the previously authorized 2015 1% Cost of Living Adjustment. The Base Level request for Regular Salaries includes board member stipend payments.

The Agency Base Level request for this appropriation is $13,566,474 in FY2016 and $13,572,131 in FY2017 with general revenue of $4,850,234 in FY2016 and $4,852,254 in FY2017 and 190 budgeted base level positions.

The Agency Change Level requests for this appropriation total $79,271 each year of the biennium with no new general revenue, and reflect the following:

- Extra Help and Personal Services Matching of $54,271 in support of 10 litigation attorneys as legal services specialist/paralegal.
- Conference Fees & Travel of $25,000 to support continuing education training for attorneys and auditors which is required for licensure.

The Executive Recommendation provides for the Agency Request.

Appropriation Summary

Appropriation: 896 - DHS–Admin Paying Account
Funding Sources: PWP - Administration Paying

		Historical Data			Agency Request and Executive Recommendation					
		2013-2014	2014-2015	2014-2015	2015-2016			2016-2017		
Commitment Item		Actual	Budget	Authorized	Base Level	Agency	Executive	Base Level	Agency	Executive
Regular Salaries	5010000	8,524,694	8,877,174	9,151,417	8,965,803	8,965,803	8,965,803	8,969,803	8,969,803	8,969,803
#Positions		**187**	**190**	**190**	**190**	**190**	**190**	**190**	**190**	**190**
Extra Help	5010001	40,906	177,770	177,770	177,770	227,799	227,799	177,770	227,799	227,799
#Extra Help		**3**	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**
Personal Services Matching	5010003	2,941,907	3,008,061	3,073,199	3,052,428	3,056,670	3,056,670	3,054,085	3,058,327	3,058,327
Operating Expenses	5020002	1,264,748	1,338,701	1,338,701	1,338,701	1,338,701	1,338,701	1,338,701	1,338,701	1,338,701
Conference & Travel Expenses	5050009	757	8,472	8,472	8,472	33,472	33,472	8,472	33,472	33,472
Professional Fees	5060010	910	11,000	11,000	11,000	11,000	11,000	11,000	11,000	11,000
Data Processing	5090012	0	0	0	0	0	0	0	0	0
Capital Outlay	5120011	34,411	0	0	0	0	0	0	0	0
Data Processing Services	5900044	8,467	12,300	12,300	12,300	12,300	12,300	12,300	12,300	12,300
Total		12,816,800	13,433,478	13,772,859	13,566,474	13,645,745	13,645,745	13,572,131	13,651,402	13,651,402
Funding Sources										
General Revenue	4000010	4,800,769	4,802,557		4,850,234	4,850,234	4,850,234	4,852,254	4,852,254	4,852,254
Federal Revenue	4000020	5,675,916	5,388,044		5,442,524	5,442,524	5,442,524	5,444,764	5,444,764	5,444,764
Various Program Support	4000730	2,340,115	3,242,877		3,273,716	3,273,716	3,273,716	3,275,113	3,275,113	3,275,113
Total Funding		12,816,800	13,433,478		13,566,474	13,566,474	13,566,474	13,572,131	13,572,131	13,572,131
Excess Appropriation/(Funding)		0	0		0	79,271	79,271	0	79,271	79,271
Grand Total		12,816,800	13,433,478		13,566,474	13,645,745	13,645,745	13,572,131	13,651,402	13,651,402

Change Level by Appropriation

Appropriation: 896 - DHS–Admin Paying Account
Funding Sources: PWP - Administration Paying

Agency Request

Change Level		2015-2016	Pos	Cumulative	% of BL	2016-2017	Pos	Cumulative	% of BL
BL	**Base Level**	**12,410,492**	**183**	**12,410,492**	**100.0**	**12,415,583**	**183**	**12,415,583**	**100.0**
C05	Unfunded Appropriation	79,271	0	12,489,763	100.6	79,271	0	12,494,854	100.6

Executive Recommendation

Change Level		2015-2016	Pos	Cumulative	% of BL	2016-2017	Pos	Cumulative	% of BL
BL	**Base Level**	**12,410,492**	**183**	**12,410,492**	**100.0**	**12,415,583**	**183**	**12,415,583**	**100.0**
C05	Unfunded Appropriation	79,271	0	12,489,763	100.6	79,271	0	12,494,854	100.6

Justification	
C05	Request for unfunded extra help and associated fringe appropriation in the amount of 54,271 for support to 10 litigation attorneys as legal services specialist/paralegal. Request for unfunded conference fee and training appropriation in the amount of 25,000 to support CLE and CPE for attorneys and auditors continuing education required for licensure.