ENSURING PROGRAM INTEGRITY IN ARKANSAS MEDICAID

Preventing fraud is a top priority at the Arkansas Department of Human Services. There are several key ways that program integrity is protected within Medicaid, including both the internal and external procedures and units detailed below.

Utilization Management

This process includes reviews of prior authorization requests for medical necessity and retrospective reviews for medical necessity and appropriate billing. These reviews are conducted both internally and by two separate Quality Improvement Organizations (AFMC and Acentra).

DHS Office of Payment Integrity

This internal office conducts reviews of financial transactions after payment, including claims and contracts payouts. This team looks for inappropriate billing as well as areas where DHS could improve internal processes.

Office of Medicaid Inspector General (OMIG)

This external office housed at the Office of Inspector General looks for patterns of waste, abuse, or fraud in Medicaid claims. OMIG may make credible allegations of fraud, and any criminal fraud is turned over to the state Attorney General's office.

Attorney General's Medicaid Fraud Control Unit (MFCU)

This external unit investigates and prosecutes criminal fraud cases, as well as some civil fraud cases. MFCU also looks into allegations of nursing home abuse and neglect.