Program Integrity in State Medicaid and CHIP Programs

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This paper explores the issues related to Medicaid and CHIP dental program integrity. State Medicaid and CHIP Dental Program Managers, third-party administrators and others play a role in ensuring program integrity by developing and implementing policies, processes and tools that limit the overuse, underuse and misuse of services in the program for the purpose of safeguarding and improving the health and welfare of Medicaid and CHIP recipients.

In order for a Medicaid and/or CHIP program to be efficient and effective, all of the parties involved need to work together and understand program policies and processes and be aware of service utilization norms among patients and providers. The collection and utilization of data is essential to this effort. In both public and commercial dental insurance administration, states/companies are just beginning to embark on using more sophisticated data collection and analysis techniques. These techniques will not only allow the detection and prevention of fraud and abuse but also help all parties understand how practice patterns vary by providers and which patterns may lead to improved health outcomes.

BACKGROUND

It is the responsibility of all Medicaid and CHIP stakeholders (state and federal government policy makers and administrators, payers, providers, educators and patients) to ensure that the billions of dollars spent in the these programs are spent in the most efficient and effective way. The management of these dollars is a multi-pronged effort that should focus on preventing both the intentional mismanagement of program dollars as well as the intentional mismanagement of program dollars caused by a lack of knowledge and/or education around current or standard processes and practices. Clearly, fraud and abuse are a problem that must be dealt with but the use of data for management of utilization for quality purposes should also be considered as an essential component of any plan for program integrity.

Fraud is defined by the Centers for Medicare and Medicaid Services (CMS) to be the intentional deception or misrepresentation made by a person with knowledge that the deception could result in some unauthorized benefit to himself or some other person. This includes any act that constitutes fraud under applicable Federal of State law. Abuse is further defined by the Centers for Medicare and Medicaid Services (CMS) to be: Provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. This includes recipient practices that result in unnecessary cost to the Medicaid program.
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State Medicaid dental programs are responsible for detecting and preventing fraud, waste and abuse program-wide. State Program Integrity Units (PIUs) and State Medicaid Fraud Control Units (MFCUs) protect Medicaid Program dollars. Provider, member and vendor actions are monitored, investigated, and if necessary referred to law enforcement. CMS offers States technical assistance, guidance and oversight on an ongoing basis.

From a federal perspective, Medicaid program integrity was impacted in 2006 by the passage of the Deficit Reduction Act (DRA), which created the Medicaid Integrity Program (MIP) under Section 1936 of the Social Security Act. The MIP is a comprehensive federal strategy to prevent and reduce fraud, waste and abuse in the $447 billion per year Medicaid program.

METHODS OF IMPROVING PROGRAM INTEGRITY IN MEDICAID AND CHIP DENTAL PROGRAMS
With increasing focus on Medicaid and CHIP program integrity, dental programs must also be an area where the scope and breath of policies, processes and procedure around fraud and abuse are well defined. Periodic program review and subsequent program improvements are essential to an organized and effective program.

STATE MEDICAID DENTAL DIRECTOR OR PROGRAM MANAGER’S ROLE
A State Medicaid Dental Program Manager’s role around program integrity varies by state but usually includes one or some of the following functions:

- Oversight and monitoring of contractor/s
- Direct involvement in case review
- Policy and/or Program Integrity Plan revisions
- Dental provider education

Some degree of ongoing involvement by dental program managers in the identification of program integrity issues and trends fosters good communication between departments within the state. Whereas the sharing of timely and relevant information among PIUs, MFCUs and state agencies is essential, dental program managers can also be instrumental in creating linkages among parties involved in an investigation and lending critical program expertise when necessary. Dental program managers have a good understanding of dental claims databases, which are the most vital baseline component for gathering the essential data necessary to perform accurate and complete program monitoring.

Although a state Medicaid and CHIP program manager’s interaction with PIUs and MFCUs does vary from one state to the next, at a minimum, dental program managers should be aware of PIU and MFCU contacts and of their various procedures around investigating fraud and abuse. There is also an opportunity for state dental program directors and managers to interact with CMS regarding program integrity issues.

A comprehensive Medicaid Program Integrity Program should include:

- Written policies and procedures for a consistent, documented approach
- Training and retraining for employees
- Periodic review of the Program’s policies and procedures

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THE ROLE OF THE PAYER/ADMINISTRATOR

The integrity of state Medicaid and CHIP dental programs must be maintained through ongoing efforts to combat Medicaid provider fraud, waste and abuse, which diverts dollars that could otherwise be spent to safeguard the health and welfare of Medicaid recipients.

As an integral part of state policies focused on program integrity, program surveillance data and sophisticated data mining processes are key elements. Very often this role is filled by the third party payer/administrator and their employees and contractors who are responsible for ensuring an adequate system to collect and analyze data for overall quality and utilization, fraud, and abuse management.

Payers use their claims systems, data analytics and fraud prevention tools and applications to monitor and develop provider networks, manage plan design, cost, and outcomes and to identify individual providers or members who may be gaming the system. They also use these systems to evaluate and enhance claims processing edits and to manage overall program integrity.

Payers work closely with state and federal agencies such as state dental program directors and the CMS and/or the Office of Inspector General. They may take referrals regarding suspicious or fraudulent activity from these entities or from members or other providers and their staff and will work together to determine if there is in fact fraud and/or abuse and to determine the appropriate intervention or action.

Payers’ Claims payment systems most often have built in system edits that will deny duplicate services, services performed outside of time and/or frequency limitations, services that do not meet eligibility or age requirements, etc.

Payers may also have processes in place that help detect fraudulent activities such as:

- Billing for services that weren’t provided. This can be detected through data analysis of the number of expected visits and/or services within a day between providers.
- Unbundling of charges. This is a practice where the provider separates the components of a procedure, billing them separately rather than using the appropriate code describing the total procedure. This practice usually results in a higher reimbursement.
- Services or upcoding of services. This is a practice where the provider bills for a service at a level higher than the one performed. One example of this is billing for a partial or full bony extraction rather than a simple extraction.

More mature and sophisticated systems can support fact based management and decision-making. Data is critical to managing Program Integrity, according to the National Healthcare Ant-Fraud Association. Companies like P&R Dental Strategies, Inc., a national dental cost containment consulting firm, have adopted “best practices” from the medical insurance marketplace. In the medical and commercial markets, the analytic tools incorporated in their data warehouse and dental data analytic applications provide users with depth and flexibility, enabling them to view both pre-formatted and customized reports specific to their needs. The program reporting available from these tools include some of the traditional fraud and abuse reporting mentioned above as well as more sophisticated analysis that can profile practice patterns and provide outcomes analysis compared to peers. These tools could and should be expanded for quality improvement purposes.

The purpose of all of the tools currently in place is to identify behaviors that are out of the norm, of questionable medical necessity or fraudulent. Once identified, payers begin to delve deeper into the data to determine the exact issue. This may be done by additional data review, focused review of particular providers and procedures and/or by conducting records audits, in-office audits and, in some cases, in-mouth reviews of patients. Once complete, the appropriate intervention can be implemented. This may include provider education and behavior modification, peer review to suggest different or additional recommendations and changes, financial recovery,
removal of the provider from the network and finally, recommendation back to the appropriate agencies for removal of licensure or for criminal prosecution.

ISSUES AND CONCLUSIONS
Although there are systems in place that aim to improve program integrity, all of the partners in the system clearly have additional work to do. This effort should be an ongoing evaluation process aimed at continuous process and quality improvement. Due to the levels of bureaucracy, a lack of clarity around the roles of federal and state agency and the state-to-state differences in plan design, funding and management, Medicaid may not be a system of care and financing that is as efficient as it could be. According to Steven Malanga of the Manhattan Institute, “At $300 billion, Medicaid is one of our federal government’s biggest programs—one it shares with the states, which administer it. Unfortunately, Medicaid often also seems like one of our most-abused programs, the subject of an estimated $30 billion in waste and fraud each year by recipients, health-care providers and outright scam artists who target the program.”

It should be noted that not all waste in the system is due to fraud and abuse and that most providers are not acting with the intent to manipulate or take advantage of the system. In fact, those that do game the system place a financial burden on all participating providers since the money spent on fraud and abuse could be spent to increase reimbursement and/or pay for additional necessary services.

It also should be noted that there is data available that may help all of us to make decisions about what is quality care in dentistry—what services provided to whom and at what time produce the best outcomes at the best possible price. Again, the problem lies in that states have varying abilities to get at this data. States can and should require their vendors and contractors to meet certain standards around the ability to collect and analyze data for these purposes.

Data is the key to managing the problems that plague dental Medicaid. Not just data, but clean, comprehensive, nationwide data and state of the art data warehousing and analytic tools. There are no losers in establishing a powerful national Medicaid data warehouse and protocols for the use of data analytics that exist today to support fact based management and decision-making.

Medicaid data is currently fragmented and in some states considered of questionable quality by the highest levels in state Medicaid management. If the data in its current state is not accurate, how can it be used to make timely, fact-based decisions? There is a need for a nationwide system using existing technology to establish state of the art controls and best practices. State Medicaid departments, dental providers and the patients they serve are those that will benefit from the establishment of nationwide clean Medicaid data. State Medicaid directors, payers and other key stakeholders are in key positions to be able to share their data, collaborate in conducting studies, and support establishment of best practices from state to state. It is only with a collaborative approach that we can be proactive and better manage Medicaid plans, increase Medicaid program integrity, reduce unnecessary benefit costs and ultimately improve quality and service outcomes.
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