



The Government's Medicaid Fraud Tools: Good Reasons to Stay out of Trouble and Strategies to Preempt Trouble

Medicaid is the largest health benefit program in the U.S. Hence, it is not surprising that some provisions in the U.S. Congress approved **Deficit Reduction Act (DRA)** of 2005 were aimed at preventing Medicaid fraud and abuse.

The AAPD, of course, supports efforts to weed out Medicaid abuse, but also cautions against ill-informed or misguided investigations that may discourage dental provider participation in the program. Given the historically low payment rates in many states, providers do not need extra reasons to "walk away" from the program.

Section 6032 of the DRA provides financial incentives for states to enact laws dealing with false or fraudulent claims. States are eligible for a 10 percent increase in their share of Medicaid fraud recoveries if they pass a state version of the federal False Claims Act (FCA)¹, which must:

- Establish liability to the state for false or fraudulent claims described in the federal FCA related to Medicaid;
- Contain provisions that are at least as effective in rewarding and facilitating whistleblower actions for false or fraudulent claims as those in the federal FCA;
- Allow whistleblowers to file actions under seal with a 60 day review period by the State Attorney General²
- Have a civil penalty no less than that authorized by the federal FCA.

States had until Jan. 1, 2007, to enact such a law, unless state legislation is required for a state plan amendment under DRA authority. In that case, states have until the first day of the first quarter following their next legislative session after Feb. 8, 2006. The U.S. Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) will determine if a state FCA complies with these provisions.

Section 6033 of the DRA makes compliance programs and education about the Federal and state FCA laws mandatory for entities that receive or pay \$5 million or more in Medicaid funds annually. States are required to enact provisions by Jan. 1, 2007 to require such entities to:

- Establish written policies for all employees and contractors or agents about false claims laws;
- Include, as part of their written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing waste, fraud, and abuse;
- Include discussions of these federal and state laws, anti-fraud policies of the entity, and whistleblower protection rights, in their employee handbooks.

Providers not complying with these provisions risk losing all of their Medicaid funding. As noted in a recent article in *Health Lawyer News*:

"Entities will have to balance the details contained in their policies, procedures, educational materials, and employee handbooks against the risk of unjustifiably creating whistleblowers in their ranks."

While pediatric dental offices are unlikely to have Medicaid receipts that reach the statutory threshold, many pediatric dentists have privileges at hospitals or clinics that will be subject to the section 6033 education requirements.

Section 6035 of the DRA established a new Medicaid Integrity Program, funded at \$50 million in fiscal years 2007 and 2008 and \$75 million in subsequent fiscal years. DHHS must develop a five-year plan for combating Medicaid waste, fraud and abuse. Each year, DHHS must report to Congress the use and effectiveness of such funding. The law also increased the CMS (Centers for Medicare

and Medicaid Services) staffing devoted to protecting Medicaid program integrity by 100 full-time equivalent employees. Also the OIG received \$25 million in additional annual funding and must make an annual report to Congress regarding its use of this funding and the effectiveness of its efforts. Finally, this section increased funding for the "Medicare-Medicaid Data Match" program, which uses computer algorithms to look for payment anomalies.

Despite the good intentions of these laws, experts predict health care providers will see more investigations and enforcement actions, more whistleblower cases, and will need to devote more resources toward compliance. While all existing data and experience indicate that dental fraud in Medicaid is extremely low, one high profile case can increase scrutiny, as well as influence public perception of dentists' honesty and ethics.

Given this environment, what strategies can be pursued?³ In recent years, many AAPD member advocates have already worked diligently to address pro-active strategies. However, there must be on-going education of state Medicaid officials and other policymakers such as the state attorney general's office. These individuals need to know the following:

- Pediatric dentists play a critical role in the Medicaid program and there will be a negative impact on access to care if honest providers are unduly harassed.
- Pediatric dentists provide comprehensive care; hence, the state can expect valuable services, such as stainless steel crowns for primary molars and the use of space maintainers. A pediatric dental practice looks a lot different, with a much improved outcome for a child's oral health, rather than a "clean and screen" type of Medicaid provider service. This is a good opportunity to explain how children should be should be appropriately treated by pediatric dentists.

- Pediatric dentists want to work with them to root out fraud, waste and abuse, which hurts the entire program and the children—but there are good ways to go about it and bad ways. State legislators must also be continually educated on this point.
- Dentistry is only 1-2 percent of Medicaid expenditures and estimates of dental Medicaid fraud (as noted above) are also extremely low.
- Pediatric dentists can help determine whether or not a case represents serious fraud. Working with your state dental association, it may be a good idea to form a pediatric dentistry peer review group and demand that the state engage such peer review before any further steps are taken in a FCA investigation.
- Policy-wise, there are now many Medicaid dental success stories when fees are raised to market-based levels. This also removes some of the perverse incentives in the system.

¹The Federal False Claims Act, 31 U.S.C. § 3729 et. seq. is the primary litigation tool used by the government and whistleblowers against individuals and entities to recover funds alleged to be wrongfully obtained from the federal treasury. It imposes liability for anyone who knowingly submits false or fraudulent claims for payment; much recent government use of FCA has been in the health care industry.

FCA damages are for three times the amount of damages which the government sustains. Many court cases have dealt with the meaning of "damages." Historically, this has meant the difference between what was paid versus what should have been paid. However, nothing in the FCA or its legislative history indicated a single measure of damages. As a result, courts may look at other measures of damages based on the particular facts of the case: 1) contract price or full value of the contract (more common when defective or modified goods are delivered); 2) defendant's ineligibility for any payment; or 3) unjust profits.

Under the FCA, there is potential liability from the inception of the receipt of federal funds until termination of participation in a federally funded program.

²For those who enjoy latin legal terms, such lawsuits are called *qui tam* actions.

³Reasonable compliance steps for the day-to-day workings of a practice will be addressed in a future column.

⁴Such legal expenses may be reimbursable under your professional liability insurance coverage. I'll discuss this in more detail in a future column.

Of course, if you are the subject of a FCA investigation, securing an experienced health care attorney would be prudent.⁴

Special thanks to Ross Wezmar (Scranton, Pa.), chair of the AAPD Pediatric Medicaid and SCHIP Advisory Committee, for his valuable insights on this topic. For further information, please contact Deputy Executive Director and General Counsel C. Scott Litch at (312) 337-2169 or slitch@aapd.org.

Posterior Pediatric Esthetic White Crowns

19.95
EACH

THE C.F. CROWN FOR
PEDIATRIC PRIMARY MOLARS

Practice Enhancing Benefits and Advantages:

- Easy to Fit and Seat
- Patient & Parent Pleasing
- Seven Sizes for Each Tooth
- Matches Natural Tooth Color
- Less Tooth Reduction Needed
- Pre-Crimped & Pre-Contoured
- Thin Contact Areas Reduce Bulk
- Only Buccal & Occlusal Composite

480-300 Starter Kit - \$320.00

Kit Includes:

- 16 First Primary crowns
 - Sizes 2,3,4,5 - 1 of each size
 - upper & lower, right & left
- Replacements \$19.95 each

Ordering is easy,
Call us today at

800-423-3270

or visit us on the web at:

www.appliancetherapygroup.com



A Member of The Appliance Therapy Group