

# BB REVIEW

## What's Inside . . .

### I FRAUD & ABUSE

- *CMS Proposes Changes to Stark Rule*
- *Sale of Surgery Center to Hospital May Trigger OIG Sanctions*
- *11<sup>th</sup> Circuit Vacates Convictions in Florida Medicare Case*

### II TAX

- *IRS Revises Form 990*

### III MANAGED CARE

- *Physician Win Preliminary Settlement with BCBS*

### IV PUBLIC HEALTH

- *OSHA Releases Guidelines on Pandemic Flu*

### V EMPLOYMENT

- *Supreme Court Rules Home Health Workers Exempt from Overtime Pay*

### VI ANTITRUST

- *Court Refuses to Dismiss Nurses' Claims Alleging Salary-Fixing by Hospitals*

### VII PRIVACY

- *Georgia DHR Release Personal Child-Birth Information*
- *Georgia Supreme Court Overturns Law Requiring Medical Record Release*

### VIII MEDICARE

- *Discharge Rule Change*

### IX MEDICAID

- *Alabama Becomes First State to Add Medicaid Self-Directed Services*
- *Georgia Receives "Money Follows the Person" Grant from CMS*

### X COMMENTARY

- *Georgia False Claims Act*

## Healthcare News July 2007

### FRAUD & ABUSE

#### CMS Proposes Significant Changes to Stark Rule

The Centers for Medicare & Medicaid Services (CMS) recently proposed several revisions to Stark (physician self-referral rules) including an anti-markup provision on diagnostic testing services. The purpose behind such an imposition would be to restrict the ability of physicians and group practices to profit from such tests billed to Medicare. CMS hopes to make these changes to the proposed calendar year 2008 Medicare physician fee schedule after similar previously suggested changes were included in the 2007 physician fee schedule due to numerous public comments received on the matter.

The anti-markup provision stems partially from CMS' concern over inappropriate contractual arrangements that are exempted from Stark rule coverage and involve the reassignment of Medicare billing rights for diagnostic testing services furnished in a centralized building

CMS also proposed future changes to the in-office ancillary services exception. CMS is requesting comments on whether certain services be excluded from the exception, whether changes should be made to the definition of same building and centralized building, whether the exception should cover non-specialist physicians in certain cases, and whether there should be restrictions on ownership and investment in certain services. CMS proposed that space and equipment leases not include unit-of-service based payments to a physician lessor for services rendered by an entity lessee to patients referred by a physician lessor to the entity.

CMS also proposed changes to the percentage compensation arrangements, a revised exception for obstetrical malpractice insurance subsidies and an exclusion from the definition of ownership and investment interests of a physician's (or family member's) interest in a

retirement plan offered as a result of employment.

Comments on all of CMS' proposed changes are due August 31, 2007.

#### Sale of Part of Physician-Owned Ambulatory Surgery Center to Hospital May Trigger OIG Sanctions

On June 19, 2007, OIG posted Advisory Opinion No. 07-05 stating that the sale of part of an ambulatory surgery center ("ASC") to a nonprofit hospital could potentially generate prohibited remuneration under the Anti-Kickback Statute and could lead to administrative sanctions. In particular, a company with three orthopedic surgeon-investors holding about 94% of the company's equity requested an opinion regarding its proposal to sell 40% of the ASC to a nonprofit hospital for fair market value. For the hospital to own 40% of the ASC, the three orthopedic surgeons would each sell a portion of their ownership units, receiving an amount that exceeds the amount they originally invested.

OIG reasoned that because the hospital is in a position to make or influence referrals directly or indirectly to the ASC or its orthopedic surgeon-investors, any physicians employed by the hospital would be prohibited from making referrals to the ASC. The opinion stated that the proposed arrangement does not qualify for safe harbor protection. OIG also found that it was not clear, under the Anti-Kickback Statute, whether the proposed arrangement was related, at least in part, to referrals of Federal health care program business. OIG was concerned that only the orthopedic surgeons would be selling shares (and not other physician investors) thereby making it possible that the nonprofit hospital's investment was made with the purpose of rewarding or influencing that particular subset of investing physicians whose referrals of patients to the hospital or to the ASC were of particular value.

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Overall, OIG found that although none of the factors it considered would indicate fraud or abuse on its own, when taken together, they pose a heightened risk of fraud and abuse.

**11th Circuit Vacates Convictions in FL Medicare Fraud Case**

The 11th Circuit Court of Appeals recently vacated, in part, the criminal convictions and sentences of three defendants found guilty in Florida in 2005 in connection with an alleged \$10 million durable medical equipment (“DME”) and prescription drug Medicare billing scheme (*United States v. Medina*). Three defendants took part in the appeal stemming from their 2005 conviction in a scheme that paid kickbacks to patient recruiters and directly to patients, so they could obtain Medicare beneficiaries’ names and identification numbers in order to bill Medicare for medical equipment and prescription drugs.

A three-judge panel considered the appeal and found that federal prosecutors did not produce sufficient evidence to warrant the convictions and that the court erred in sentencing the women because it failed to calculate specifically the fraud’s monetary loss to Medicare. *The court said that the paying of kickbacks alone was not sufficient to establish health care fraud.* The court also held that submitting prescriptions with a forged signature and for an unusually large number of refills alone does not constitute fraud, particularly when no evidence exists that the prescriptions drugs or DME involved were not needed or received by the patients. Additionally, the court found that the trial court erred by failing to make a factual finding as to the amount of loss.

Although the three-judge panel vacated three of the 15 health care fraud counts against the first defendant, it affirmed her other 12 health fraud counts, including convictions of conspiracy and substantive money laundering counts. The panel vacated all convictions of health care fraud against the second defendant, but affirmed her conspiracy conviction. Both of these defendants will now be re-sentenced by the district court. For the third defendant, the court vacated all convictions and sentences on all counts and ordered the lower court to dismiss the charges.

**TAX**

**IRS Revises Form 990**

The Internal Revenue Services (“IRS”) released a revised draft Form 990 on June 14. Form 990 has not been overhauled since 1979. Draft 990 adds four new schedules, including one for hospitals. The new 990 will focus on modern hot topics such as excessive compensation, loans to

insiders, easement valuations, and questionable donations. Although the new form will ask more questions, it will be easier for organizations to complete, aiming to enhance transparency, promote compliance and minimize burden.

Organizations that operate at least one facility that provides hospital or medical care will now be required to report aggregate community benefit for all facilities, and certain information concerning billings, collections and joint ventures. Organizations must list the facilities and describe the types of services provided at each facility. Policies and activities to communities served by the organization must also be reported. A summary page will describe the organization’s mission and top activities as well as a summary of revenues, expenses and net assets.

The IRS hopes to implement the new form by 2009 (for the 2008 filing year). The initial comment period will last until September 14th. There will be a longer comment period once a more formalized draft is available. The IRS is particularly interested in feedback on whether it should use the Catholic Health Association’s model for reporting the community benefit. Other areas the IRS has a heightened interest in feedback include: defining “relatedness” for compensation and other purposes, including arrangement in joint ventures and with for-profit subsidiaries, and whether the filing threshold for filing 990 should be raised from its current \$25,000 annual gross receipts standard.

**MANAGED CARE**

**Physicians Win Preliminary Approval of Settlement with Blue Cross and Blue Shield**

A federal district court in Florida has conditionally approved a settlement between 23 Blue Cross and Blue Shield (“BCBS”) health plans and a nationwide class of approximately 900,000 physicians. The class action – *Love et al. v. Blue Cross Blue Shield Association, et al.* – was filed in 2003. The complaint identified numerous BCBS plans as defendants in an alleged scheme to defraud physicians in violation of the federal Racketeer Influenced and Corrupt Organizations Act. The settlement, dated May 31, will require BCBS to pay \$128 million to a fund “from which physicians may seek compensation or select a charitable organization to receive their payment.” Physicians would be able to resubmit claims previously denied to be paid out of the fund.

Additionally, the settlement requires BCBS to revise its claims handling and business practices in ways that will make it easier for physicians to work with the companies.

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Some of the business practice changes BCBS will implement include:

- Allowing non-capitated participating physicians to view their complete fee schedules for each CPT Code typically used by the participating physician;
- Reducing the number of services and supplies requiring pre-certification, and posting to the Provider Website all services for which pre-certification is required for its products;
- Providing at least 90 days’ written notice of changes to each policy and procedure and annual changes to the fee schedule;
- Establishing a Billing Dispute External Review Process to resolve certain billing disputes; and,
- Commencing the credentialing process of physicians prior to the time a physician formally changes employment or location, and notifying physicians whether her or she is credentialed within 90 days of receiving a completed application

The court will hold a November 14, 2007 hearing on any objections potential class members or affected parties may have. The November hearing will also determine whether the requested \$49 million in attorneys’ fees, costs and expenses, as well as payments to class representatives, should be approved. The settlement will be the third legal settlement between physicians and large health insurers. In 2003, both Aetna and CIGNA Healthcare reached settlements for \$170 and \$540 million, respectively.

## **PUBLIC HEALTH**

### **OSHA Releases Guidelines on Pandemic Flu Preparation in Health Care Workplace**

Following OSHA’s distribution of pandemic guidelines for general workplaces in February, OSHA released health care guidance to help both health care employers and employees in May. The document, Pandemic Influenza Preparedness and Response Guidance for Healthcare Workers and Healthcare Employers, includes technical information on infection control, stockpiling checklists, and a sample pandemic plan. The guidelines are based on traditional infection control and industrial hygiene practices and are consistent with DHHS guidance, including guidance on the use of surgical masks and respirators in health care settings.

OSHA intends for the guidance to reduce the risk of infection in health care settings and aid

health care settings in workplace preparation and planning issues. Guidance on a number of “standards of special importance” is also included. During a pandemic, the document may need to be revised, or additional guidance issued.

A number of helpful and valuable appendixes are attached to the document. These include: pandemic influence Internet resources; infection control communication tools for health care workers; implementation and planning for respiratory protection programs in health care settings; self-triage and home care resources for health care workers and patients; references for diagnosis and treatment of staff during an influenza pandemic; pandemic planning checklists and sample plans; risk communication resources; and sample supply checklists for pandemic planning.

The OSHA pandemic flu guidance for health care works and employers is available at: [http://www.osha.gov/Publications/OSHA\\_pandemic\\_health.pdf](http://www.osha.gov/Publications/OSHA_pandemic_health.pdf)

## **Employment**

### **Supreme Rules that Home Health Workers are Exempt from Overtime Pay**

On June 11, a unanimous U.S. Supreme Court upheld a Department of Labor (“DOL”) regulation that exempted home health workers employed by third parties (i.e., not by the family for whom they provide services) from the overtime requirements of the Fair Labor Standards Act (“FLSA”).

Section 13 of the FLSA exempts from the statute’s minimum wage and overtime requirements protections:

any employee employed in domestic service employment to provide companionship services for individuals who (because of age or infirmity) are unable to care for themselves (as such terms are defined and delimited by regulations of the Secretary [of Labor]).” 29 U.S.C. § 213(a)(15).

At issue were two seemingly inconsistent DOL regulations. The first defined “domestic service employment” to mean “services of a household nature performed by an employee in or about a private home . . . of the person by whom he or she is employed.” 29 C.F.R. § 522.109(a). The second, in a subsection titled “Interpretations,” exempted companionship employees “who are employed by an employer or agency other than the family or household using their services. 29 C.F.R. § 552.109(a).

The plaintiff argued that the first definition controlled, and that the Department’s second regulation was not owed any deference by the



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court. The Supreme Court disagreed on several grounds. First, the Supreme Court held that the plaintiff's interpretation would be inconsistent with Congressional intent. Second, the Court found that as a matter of statutory construction, "specific" regulations govern "general" ones. Consequently, in this case, the specific definition that excluded home health workers employed by third parties governed the more general, and somewhat contradictory, definition of "domestic service employment." Third, while conceding that the DOL may have interpreted these regulations differently at different times, the Supreme Court held, nonetheless, that such interpretative changes did not create any unfair surprise because of the DOL's reliance on notice-and-comment rulemaking. Fourth, the DOL's most recent interpretation—apparently written in response to plaintiff's lawsuit—was not a post hoc rationalization, but rather a "fair and considered judgment on the matter in question." Fifth, the Supreme Court rejected the plaintiff's argument that the second regulation was "advisory" and, thus, carried no legal weight, or that the rulemaking process was somehow procedurally defective.

Because this ruling maintains the status quo, its impact is somewhat limited. However, it does provide clarity—home health care companies that paid overtime out of an abundance of caution can now rest easy. But that rest may be short lived. Democrats in Congress, most notably Senator Edward Kennedy, are calling for the decision to be legislatively overturned. Of course, a new, Democratic administration could rewrite the regulation. As health care becomes an ever increasing part of the U.S. economy, employers should not expect this decision to be the last word on this controversial issue.

The case is styled *Long Island Care at Home v. Coke*, U.S., No. 06-593, and can be found online at <http://www.supremecourt.us/opinions/06pdf/06-593.pdf>.

## **Antitrust**

### **Court Refuses to Dismiss Nurses' Claims Alleging Salary-Fixing Conspiracy by Hospitals**

A federal district court in Tennessee has ruled that it would not dismiss an action filed by a class of Memphis-area nurses against a Memphis hospital system, alleging that the hospitals conspired to depress their wages in violation of the Sherman Antitrust Act (*Clarke v. Baptist Mem'l Healthcare Corp.*). The plaintiff-nurses claimed that they were underpaid approximately \$14,000 annually

because of the alleged conspiracy. The complaint alleges that the hospital system agreed to exchange detailed, nonpublic information about the wages it paid or would pay registered nurses. Allegedly, there was an agreement or understanding among the hospitals that the information was being shared for the purpose of containing nurse wages.

The class of nurses claimed that they intend to prove that the defendant hospitals paid RN employees the same or nearly the same salary and jointly recruited nurses at job fairs in order to avoid competing with each other. Additionally, the plaintiffs allege that the defendants set nurse salaries below the competitive market level, something that likely could not be accomplished without conspiratorial efforts.

## **PRIVACY**

### **Georgia DHR Release of Personal Child-Birth Information**

The Georgia Department of Public Health ("GDPH") recently notified the public of a Department of Human Resources ("DHR") lapse of security through press releases, direct mailings, and website updates. DHR discarded unshredded birth records in a manner that exposed parents' social security numbers, race and education of the parents, information about the pregnancy care, risks and history of the mother, and information about the delivery. The parent's name, child's name and date of birth were not released in the record disclosure. The breach affects parents whose children were born between April 1, 2006 and March 16, 2007.

In a letter dated May 21, 2007, DHR recommended that birth mothers share this information with the child's father. As of the date of publication, no evidence existed of fraudulent use of the disclosed information. However, the GDPH recommends that all parents affected by the information disclosure follow-up with credit card bureaus and review their credit and other financial information. All Georgia adults are eligible to receive two free credit reports each year by law.

DHR has taken corrective actions to prevent such a mishap in the future, including new Confidentiality Policy and Procedures that went into effect on May 15, 2007, retraining of all Vital Records staff on how to properly dispose of confidential information and updating all shredding equipment. The website links for the three credit bureaus (Experian, Equifax and TransUnion) along with further instructions can be accessed by going to the GDPH website: <http://health.state.ga.us>.

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**Georgia Supreme Court Overturns Law  
Requiring Medical Record Release**

The Supreme Court of Georgia handed down its opinion in *Allen v. Wright*, overturning a Georgia statute (Ga. Code Ann. § 9-11-9.2) that required medical malpractice plaintiffs to file a medical record release authorization with their complaint. The court held that the statute was preempted by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). The medical records release statute conflicted with HIPAA because it established requirements for authorizations that were less stringent than those established by federal law.

For example, the state law did not provide for authorizations to contain a notice of a right to revoke the authorization, thus patients may not understand their right to fully protect their health information. Nor did the Georgia law provide a specific and meaningful identification of the information to be disclosed. It also did not provide an expiration date or termination event.

As a result of the decision, defense lawyers will have to get medical information from plaintiffs through traditional discovery methods: specific discovery requests and nonparty requests. Defense attorneys argue that the court’s opinion goes against the state’s long-recognized provision that when a plaintiff puts his medical treatment at issue in a case, he’s also putting his medical history on trial.

The court deferred to the Legislature to modify the statute so that it will comply with the HIPAA Privacy Rule. While the court rendered its opinion on May 21, the Legislature does not meet again until January 2008.

**MEDICARE**

**Discharge Rule Change**

During a recent call, CMS officials clarified the applicability of Medicare’s rule on inpatient-to-inpatient transfers. CMS officials stated that hospitals do not need to provide a follow-up notice if a patient is being transferred to another inpatient setting, and the transfer hospital is required to provide the patient with an initial notice only if that hospital is not part of the same facility as the first hospital.

CMS also release a revised version of the notice that hospitals must give patients to inform them about their discharge rights. The revised notice is available on the DHHS website at: [http://www.cms.hhs.gov/BNI/12\\_HospitalDischargeAppealNotices.asp](http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp).

**MEDICAID**

**Alabama Becomes First State to Add  
Medicaid Self-Directed Services**

The Department of Health and Human Services announced in May that Alabama is the first state to receive federal approval to allow self-directed personal assistance services as a feature for its Medicaid plan. The Deficit Reduction Act of 2005 (DRA) has a provision that enables states to offer Medicaid beneficiaries the opportunity to direct their own personal care services as a feature of their programs. These services may be offered upon receipt of federal approval without states needing to repeatedly request Section 115 or 1915(c) waivers.

The Alabama self-directed services program will permit participants to direct their own personal care, homemaker, unskilled respite and companion services. Participants will be able to hire legally liable relatives to provide care and to use their service budgets to pay for items that increase their independence or substitute for human service. Participants will also receive some “cash” so that they can purchase goods and services directly.

The State of Alabama will be responsible for ensuring that participants have the necessary information, counseling, training, and assistance to enable them to successfully manage their own care. Advantages of self-directed care include fewer unnecessary institutional placements, higher levels of beneficiary satisfaction, fewer unmet needs, less worker turnover and an efficient use of community services and supports. Alabama’s state plan will likely serve as a model for other states interested in implementing self-directed Medicaid services.

**Georgia Receives “Money Follows the  
Person” Grant from CMS**

Georgia was recently awarded over \$34 million in grant money, the 5th largest of 14 grants made to states and the District of Columbia in the second phase of the “Money Follows the Person” initiative. The initiative, included in the Deficit Reduction Act of 2005 and spanning five years (2007-2011), is a component of the New Freedom Initiative. The “Money Follows the Person” program intends to help shift Medicaid long-term care programs from institutional care to home and community-based services. The second phase will distribute \$547 million in grant funds, part of \$1.75 billion in grants that will be distributed over the life of the initiative.

CMS hopes that the grants will help states take necessary steps to remove barriers and rebalance the options for Medicaid-funded long-term care. The “Money Follows the Person” grants will be

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used to design programs with four major objectives: (1) increase the use of home and community-based, rather than institutional, long-term care services; (2) eliminate barriers or mechanisms that prevent Medicaid-eligible individuals from receiving support for appropriate and necessary long-term services in the settings of their choice; (3) increase the ability of the state Medicaid programs to assure continued provision of home and community based long-term care services to eligible individuals who choose to move from an institutional to a community setting; and (4) ensure that procedures are in place to provide quality assurance for individuals receiving Medicaid home and community-based long-term care services and to provide for continuous quality improvement in such services.

States receiving grant money also benefit by qualifying for a higher percentage of federal matching dollars to help cover the costs of moving people out of nursing homes and into community settings. The higher matching rate will be paid for one year after an individual moves out of an institution and into the community.

## **COMMENTARY**

### **Georgia False Claims Act**

On May 24, 2007, Governor Sonny Perdue signed into law HB 551, the "State False Medicaid Claims Act," which aims to protect Georgia's Medicaid funds by creating penalties for false or fraudulent claims knowingly submitted to Medicaid and likewise encouraging private citizens to file actions against providers for those claims. Georgia's new false claims law is part of a wave of similar state enactments over the past 18 months, resulting in more than 15 other states enacting similar laws to protect state Medicaid programs.

The Deficit Reduction Act ("DRA") of 2005, which President Bush signed in February of 2006, led to the sudden rise in state false claims acts. The DRA incentivizes states to pass such "whistleblower acts" by reducing the portion of recoveries that would otherwise have been reimbursed to the federal government commensurate with the percentage of Medicaid funding to that state. In order to qualify for the DRA incentive, the Inspector General of the U. S. Department of Health and Human Services must determine that a state False Claims Act is at least as effective in rewarding and facilitating private citizens' actions for false or fraudulent claims as the federal False Claims Act.

The new law aims to deter cheating Medicaid by classic fraudulent methods such as over-billing, upcoding, and billing for services not rendered.

The Act protects the State's Medicaid funds by allowing for treble damages and penalties of \$5,500 to \$11,000 for each false or fraudulent claim knowingly submitted to obtain payment by the State Medicaid Program. The new law also encourages private citizens to file civil actions against any party that submits false or fraudulent claims to Georgia Medicaid by permitting citizens to share up to 30% of the State's recovery of funds. The percentage of proceeds that private citizens may recover depends on whether the State intervenes in a case.

The Department of Community Health's Inspector General, Doug Colburn, has been speaking to groups of hospital executives around the state and country regarding both the new law and a new disclosure guideline that DCH has implemented in its Medicaid Policies and Procedures Manual, effective in April of this year. The new disclosure rules urge hospitals to self-audit in an effort to identify claims errors and overpayments. Upon identifying a claims error or overpayment, providers must alert DCH and work toward a resolution or refund. The new rules also require that, once a provider has identified claims that are potential overpayments, a self disclosure letter detailing the potential overpayments should be forwarded to the DCH Inspector General. The letter should be accompanied by a Corrective Action Plan (CAP) that details actions taken to correct the cause of the overpayment and steps to prevent future erroneous claims.

DCH must review and approve the self disclosure and CAP prior to its implementation. Once DCH makes a final determination of accuracy and approves the CAP, the rules state that it will enter into negotiations with the provider regarding a settlement. As a mandatory provision of the settlement agreement, DCH will require an audit of the hospital within a 12 month period to assure adherence to the CAP.

Combined, the new Medicaid self-disclosure rules and the false claims act create powerful tools for combating Medicaid fraud and abuse. We understand that DCH will mostly use the new law in certain circumstances: 1) DCH audits the provider, finds an overpayment, and the provider knew (or should have known) about it; and 2) the provider has self-disclosed and agreed upon a CAP with DCH, but, at the annual update audit, the agency determines that the provider failed to meet its obligations under the CAP. The providers in both these cases will be "pursued with the full power and authority of this office and the State of Georgia."

If providers haven't become familiar with the new law or Medicaid self-disclosure rules, it's time: there's a new sheriff in town.