



MEMORANDUM

An Overview of the New “Get Tough” Health Care Fraud Policies

In the 2009 regular session of the Florida Legislature, a health care regulation bill was passed as legislators sought to “get tough” on alleged perpetrators of health care fraud. The new bill provisions are contained in CS/CS/SB 1986 which is now codified as Ch. 2009-223, Laws of Florida. While every reasonable person can agree that health care fraud should not be tolerated, the new bill raises significant issues for health care providers, especially licensed home health agencies who may be affected by some of the bill’s more draconian measures. This article provides a summary of the bill’s key provisions, as well as a discussion of possible legal defenses to those who may be affected by this sweeping effort to crack down on abuses in the health care reimbursement system.

The Background to the New Bill

In 2007, the US Department of Health and Human Services and the US Department of Justice Health Care Fraud and Abuse Control Program Annual Report described recent federal efforts to crack down on health care fraud in Florida. This included criminal prosecutions with indictments against 120 defendants who were charged with overbilling the federal Medicare program more than \$400 million primarily for durable medical equipment (DME) and infusion therapy services for HIV patients. A recent report of the US Government Accountability Office (GAO) finds that Florida has one of the highest growth rates for home health spending (over 90% increase from 2002-2006), while the number of Medicare beneficiaries grew by only 28% during the same time frame. The GAO report concludes Miami-Dade County in particular shows evidence of fraudulent upcoding of Medicare home health claims based upon an abnormally high number of outlier cases.

Florida’s Office of Program Policy Analysis and Government Accountability published reports in 2004, 2006, and 2008 pointing to the rising problems of Medicaid fraud and abuse and recommending legislative action to bring Medicaid fraud under control.

Recent years also saw an explosion of new home health agency licensure particularly in Miami-Dade County. In 2007, there were 431 new licensure applications for home health agencies, with 58.5% of those applications in Miami-Dade County. In 2008-2009 another 331 applications were received by AHCA. From 1999 to March of 2009 the number of licensed home health agencies in Miami-Dade County increased from 216 to 895 or 75% increase in licenses. Florida’s Medicaid Fraud Control Unit, reported that between 2005 and 2007, questionable practices of home health agencies in Miami-Dade County were documented including:

- Home health aides reporting that they worked 20-25 hour days
- Patient brokering by aides
- Alteration of medical records
- Billing for skilled nursing services that were not provided
- Payment made to physicians for referrals
- Payments to patients
- Patients receiving services that were not medically necessary
- Physicians holding financial investment interests in the home health agency to which they refer patients

The Legislative Response and the 2008 Bill Changes

The legislative reaction to these reports culminated in significant changes to home health agency licensing, and overall health care facility licensing that passed in 2008. Some of the key provisions in the 2008 bill included:

- AHCA cannot issue an initial or change of ownership license to an applicant for a home health agency that shares common controlling interests with another home health agency that is located within 10 miles of the applicant in the same county.
- Applications for licensure cannot be transferred to a new entity before the license is issued.
- An applicant must submit proof of application for accreditation from the Joint Commission, CHAP, or ACHC, and must pass a survey by one of these accrediting organizations.

While these measures slowed the pace of new home health agency licenses, continued reports of possible Medicare fraud resulted in the sweeping changes ushered in by the 2009 Legislature.

The 2009 Legislative Response

The 2009 Legislature adopted a broad range of new measures to curb perceived abuses in the health care reimbursement system. Some of these changes may be subject to constitutional challenges, as the new laws in some instances appear to impose new penalties for past violations of law that were resolved through settlement or otherwise through an adjudicatory process. It is beyond the scope of this article to provide a detailed legal analysis of the merits of such constitutional attacks on these new provisions of law; however, the application of new penalties for acts already taken and adjudicated clearly raises constitutional issues of ex post facto application of law, and due process rights of individuals or entities that resolved past allegations of wrongful conduct. Any person facing the non-renewal, suspension, or revocation of their license should seek legal counsel to further investigate the constitutionality of applying the new laws on the basis of past conduct.

The following is a section-by-section analysis of the provisions of Chapter 2009-223, Laws of Florida, as adopted by the Legislature and effective as of July 1, 2009.

Section 1: In an unprecedented move, the Legislature has officially designated Miami-Dade County as a health care fraud crisis area for purposes of implementing increased scrutiny of home health agencies, home medical equipment providers, health care clinics, and other health care providers in Miami-Dade County.

Section 2: This section of the bill amends existing Florida law on “Qui Tam” actions commonly known as Whistleblower suits. Under current law, a person who reports fraud may receive an award from any recovery of funds that is based on the reported fraudulent activity. The new provision in the law requires that 10% of any funds recovered through Qui Tam lawsuits that are related to the State Medicaid program, shall be placed into the State’s Legal Affairs Revolving Trust Fund to be earmarked for funding rewards for persons who report and provide information related to fraud.

Section 3: This law change makes it more difficult for a health care provider accused of fraud in a “Qui Tam” or whistleblower action to recover attorney fees and costs if the accused provider proves that the claim of fraud is not warranted, and is found not liable for the alleged fraudulent activities. Under prior Florida law, a defendant was entitled to recovery of reasonable attorney fees from the person bringing the unfounded charge of fraud. Under the new law, the Court may award fees only if the Court finds that the action was clearly frivolous, clearly vexatious, or brought primarily for the purpose of harassment. Thus, the new law will encourage potential “whistleblowers” to bring allegations of fraud against health care providers without fear of having to pay attorney fees if the claims cannot be proven.

Section 4: This section of the bill is unrelated to the general topic of health care fraud. The provision allows licensed children's hospitals to provide open heart and interventional cardiology services to adults with congenital heart defects.

Section 5. This change in law places Miami-Dade home health agencies squarely in the legislative cross-hairs, and provides that AHCA shall not issue a renewal license for any home health agency that has been administratively sanctioned in the past two years for various offenses. On its face, the bill applies to any county that has more than one home health agency per 5000 persons – but it has been acknowledged by AHCA that this population criterion is only met in Miami-Dade County. The offenses that will result in non-renewal of home health agency license include:

- An intentional act or negligent act that materially affects the health or safety of a client.
- Knowingly providing home health services in an unlicensed ALF (unless the home health agency reports the ALF within 72 hours.
- Preparing or maintaining fraudulent patient records (e.g. recording vital signs or symptoms not personally taken at the time indicated; borrowing patient records from other HHAs to pass a survey; falsifying signatures).
- Failing to provide at least 1 service for a period of 60 days.
- A “pattern” (at least 3 instances) of falsifying documents related to the training of home health aides or CNAs, or falsifying health statements for staff who provide direct care.
- A “pattern” (3 instances) of failing to provide a service specified in the plan of care or agreement with client (unless reduction was required by Medicare or Medicaid).
- Payment of any kind of remuneration (cash, in kind, etc.) for patient referrals to discharge planners, case managers, facility staff from hospital or nursing homes or others who refer patients.
- Payment of cash or equivalent to a Medicare or Medicaid beneficiary.
- A pattern (at least 2 instances) of providing services that were not medically necessary as determined in a final order.
- Providing services to residents in ALFs for which the home health agency does not receive fair market value remuneration.

- Providing staffing to an ALF if the home health agency does not receive fair market value remuneration.

This section of the new bill further prohibits AHCA from approving any new applications for home health agencies in Miami-Dade or Broward Counties. The bill is written to apply to any county with fewer than 1,200 persons age 65 and over per home health agency, but AHCA has acknowledged that only Broward and Miami-Dade meet this criterion.

This section of the Bill is potentially devastating to existing and planned home health agency providers in Broward and Miami-Dade. Possible legal options for home health agencies affected by these new provisions include:

- Seeking a declaratory judgment from a circuit court that the bill is unconstitutional as applied to the extent it is imposing a new penalty of license forfeiture for past conduct that was resolved. This is especially egregious in instances where a home health agency provider may have resolved an alleged prior violation by stipulation to pay a minor penalty – and is now faced with licensure non-renewal as an unknown additional penalty and consequence.
- Seeking a declaratory judgment that this section of the bill is unconstitutional on its face because the bill: a) violates equal protection of laws by singling out Miami-Dade and Broward County for treatment that is different from other similarly situated counties; b) sets arbitrary and capricious population thresholds; c) is a local law that was not properly adopted using state constitutional notice provisions applicable to such local law adoption; d) amounts to an impairment of existing contractual rights; e) results in an improper taking of property rights without compensation; e) denies applicants due process rights.
- Pursuing a formal administrative hearing under Section 120.57, Florida Statutes, to challenge the factual underpinnings of any decision by AHCA to refuse to renew a license based on alleged prior violations.

Each of these legal avenues will need to be thoroughly researched by competent legal counsel prior to initiation of any lawsuit. However, given the high stakes involved, including the possible loss of an established business, such legal strategies may be warranted.

Section 6: This section of the bill amends the existing law on Administrative Penalties applicable to home health agencies, and allows AHCA to impose a fine of \$5,000 for various violations. This section also adds a new violation to the list of violations that may be a basis for AHCA fines: a “pattern” (at least two instances) of billing Medicaid for services that are medically unnecessary as determined in a final order.

Based on these new sanctions for violations, home health agencies faced with an Administrative Complaint should consider exercising their rights to a formal administrative hearing pursuant to Section 120.57(1), Florida Statutes. While in the past many violations were

resolved through a simple entry of an admission and minimal fine, the new provisions on non-renewal and suspension of license for such violations may force a greater need to contest even minor proposed fines.

One positive feature of this section of the bill is incorporation of the federal stark “safe harbor” provisions. In the 2008 legislative changes, there was an effort to impose a complete prohibition on any type of financial remuneration for physicians other than a single medical director. The incorporation of the federal safe harbors will allow for such arrangements as renting office space from physicians for fair market value, and contracts with physicians for consulting or medical director services. This raises a potential problem, however, as AHCA seeks to enforce the strong anti-fraud tone of the new bill, but still apply and interpret the federal safe harbors in a reasonable manner. Any provider who is accused of violation of state anti-kickback provisions due to financial arrangements with physicians or other providers should consult legal counsel on possible applicability of safe harbor provisions. Moreover, proactive planning and review of such ongoing relationships and contracts with physicians and others who make referrals is advisable for home health agencies seeking to ensure ongoing compliance.

Section 7: This section applies only to Nurse Registries and provides an exemption from anti-kickback provisions for Nurse Registries that do not participate in Medicaid or Medicare programs.

Section 8: This section of the bill includes enhanced licensure requirements for home health agencies, DME or home medical equipment providers, and health care clinics. These include for initial and change of ownership (CHOW) applications, the following:

- A demonstration of financial ability to operate, including independent evidence of start up and working capital funds, and contingency financing.
- Pro formas financial projections to demonstrate sufficient revenues to support financially feasible operations.
- Statement of estimated project costs, and source of funds, through breakeven point, showing at least 3 months average expenses to cover startup costs, working capital and contingency financing. Contingency funding must be available for at least 1 month’s average expenses.
- All such documentation must be signed by a CPA.

This section also imposes a \$500,000 surety bond requirement for any license application by a home health agency, DME or health care clinic where the controlling interest is a nonimmigrant alien.

Finally this section of the bill makes it a criminal third degree felony to offer services that require licensure without obtaining a license, to submit false or misleading information in a license application, or to otherwise violate the licensure requirements for home health agencies.

Section 9: This section imposes a mandatory obligation on all types of health care providers regulated by AHCA to report to AHCA changes in any information contained in a licensure application, or changes in provider's required insurance or bonds.

This section also requires all AHCA regulated health care providers to give a written notice to all clients/patients that includes an AHCA description of Medicaid fraud and the right to report fraud at a toll free number.

Section 10: This section mandates that AHCA shall deny a license application or renewal license for any regulated entity (not limited to home health agencies) if the applicant or any controlling interest in the applicant has been:

- Convicted or plead no contest to any felony under Florida law related to Medicaid (chapter 409, Fla. Stat), Fraudulent Practices (Chapter 817, Florida Statutes) or Drug Prevention and Control (Chapter 893, Florida Statutes), unless the sentence or probation for such violation ended more than 15 years before the application for license was submitted.
- Convicted of federal felonies under 21 USC ss. 801-970) (pertaining to offenses including possession, sale, or trafficking in drugs or controlled substances) or 42 USC ss. 1395-1396 (pertaining to Medicare fraud regulation) unless the sentence and prohibition period ended more than 15 years prior to the license application.
- Terminated for cause from the Florida Medicaid program unless the applicant has been in good standing for past 5 years.
- Terminated from federal Medicare or another State's Medicaid program, unless the applicant has been in good standing for past 5 years and the conviction or plea was at least 20 years prior to the Florida license application.

These provisions may have a significant effect on facilities where the controlling interest of the applicant has a prior drug offense. Again, this type of new penalty for past conduct may raise constitutional issues that deserve investigation by a party affected by these new provisions.

Section 11: This section creates another new provision aimed at home health agencies, and mandates that AHCA require prior authorization of services from Medicaid for visits not associated with a skilled nursing visit, where the home health agency's billing rates exceed the state average by 50%. Thus, the home health agency would be required to submit the plan of care and documentation to support the requested service prior to providing the service in order to be eligible for Medicaid reimbursement. This section also prohibits AHCA/Medicaid from paying for home health services, unless the services are medically necessary, and:

- Services are ordered by a physician.

- There is a written prescription prior to developing a plan of care and before any request requiring prior authorization.
- The physician is not employed, or under contract with the home health agency (there is an exemption for certain agencies associated with certain retirement communities and for fragile children).
- The physician ordering the service has examined the recipient within 30 days prior to the request for service, and biannually thereafter.
- The written prescription includes the acute or chronic condition or diagnosis, the home health services required, and frequency and duration of services.
- The physician's national provider identifier, Medicaid ID number, or Medical Practitioner license number must be on the written prescription, the claim for home health reimbursement, and any prior authorization request.

Section 12: This section is unrelated to the health care fraud initiative, and simply authorizes AHCA to enter Medicaid provider agreements with providers who are located outside of Florida but within 50 miles of the State line.

Sections 13, 14 15: These sections are unrelated to the health care fraud initiative.

Section 16: This section requires that AHCA track Medicaid provider prescription and billing patterns and evaluate claims for Medical necessity. AHCA is mandated to conduct review of claims to detect any abnormal increases in billing or payment of claims. Providers that are determined to have a pattern of submitting claims for unnecessary services shall be referred to the Medicaid Program Integrity office for investigation. AHCA must file an annual report on these efforts to control over-utilization.

Section 17: This section is not related specifically to the health care fraud initiative. The section establishes a new "Medical Home Pilot Project" to provide a continuum of care to Medicaid recipients including primary care, coordinated services to control chronic illness, pharmacy services, specialty services, and hospital inpatient and outpatient services. The new bill calls for AHCA to implement such pilot projects in at least two geographic areas in the state and evaluate the effectiveness for cost savings and quality of care.

Section 18: This section includes multiple amendments to the Medicaid provisions of Chapter 409, Florida Statutes, that are designed to sharpen AHCA's efforts to detect and prosecute Medicaid fraud through mandatory termination of providers when the provider or the controlling interest in the providers is found to have been engaged in criminal misconduct related to delivery of health care, health care professional standards, or physical abuse of neglect of patients, or has been terminated from Medicare or another state's Medicaid program.

The section also requires annual notification by all types of health care providers to all Medicaid recipients on how to report Medicaid fraud, and an explanation of the rewards available for reporting and successful prosecution of Medicaid fraud. AHCA is also mandated to post on its website a list of all providers that have been terminated or sanctioned by the Medicaid program. AHCA is to make use of information technology and resources in its anti-fraud efforts.

Section 19: The section expands Medicaid provider fraud provisions to extend to Managed Care Plans. Thus, the making of any false statements to a Managed Care Plan in order to seek payment for claims is made illegal, and punishable by AHCA or by criminal prosecution. The section imposes new felony criminal penalties for violations of Medicaid fraud provisions (including false statement to Managed Care Plans). In addition to any other criminal sanctions, the person convicted of such Medicaid fraud violations shall pay a fine equal to 5 times the amount improperly gained or unlawfully received, or the loss incurred by the Medicaid program or managed care program.

A person who reports fraud is provided with immunity from civil lawsuits unless the person acted with knowledge the claim of fraud was false or acted in reckless disregard for the truth or falsity of the claim of fraud.

Section 20: This section of the bill provides new rewards to persons who report fraud, not to exceed the lesser of 25% of the amount recovered in a lawsuit, with a maximum of \$500,000 in a single case. (The person reporting the fraud however cannot “double dip” and also receive an award in a Qui Tam or whistleblower type action.)

Section 21: This section mandates that the Department of Health assist AHCA in the anti-fraud campaign by prosecuting health care practitioners who did not remit Medicaid overpayments to AHCA.

Section 22: The Department of Health is also required to publish the fact of any physician or ARNP who is terminated from the state Medicaid program or who is sanctioned for Medicaid violations.

Section 23: This section adds “sleep clinics” to the list of health services that are exempted from the prohibition that physicians may not “self refer” patients to facilities in which the physician holds an investment interest. Thus, physicians may hold a financial interest in a sleep clinic to which the physician makes referrals.

Section 24: This provision applies to any health care professional or practitioner regulated by a professional Board with the Department of Health. No initial or renewal license may be issued to any health care professional if the applicant, or any principle, officer, agent, managing employee, or affiliated person of the applicant has been:

- Convicted or plead no contest to any felony under Florida law related to Medicaid (chapter 409, Fla. Stat), Fraudulent Practices (Chapter 817, Florida Statutes), or Drug Prevention and Control (Chapter 893, Florida Statutes), unless the sentence

or probation for such violation ended more than 15 years before the application for license was submitted.

- Convicted of federal felonies under 21 USC ss. 801-970) (pertaining to offenses including possession, sale, or trafficking in drugs or controlled substances) or 42 USC ss. 1395-1396 (pertaining to Medicare fraud regulation) unless the sentence and prohibition period ended more than 15 years prior to the license application.
- Terminated for cause from the Florida Medicaid program unless the applicant has been in good standing for past 5 years
- Terminated from federal Medicare or another State's Medicaid program, unless the applicant has been in good standing for past 5 years and the conviction or plea was at least 20 years prior to the license application.

This provision is reportedly already having an affect on renewal of licenses for health care professionals that have prior plea agreements or convictions for charges for which they have already served the sentence imposed. Such health care professionals affected by this new license non-renewal provision should consider whether to challenge the constitutionality of the new law. The deprivation of a person's livelihood based on past conduct that was already adjudicated raises serious constitutional questions.

Section 25: This section makes Medicaid or Medicare fraud in any state a basis for disciplinary action against a Florida health care professional. It further makes failure of a health care professional to remit an overpayment to Medicaid a basis for disciplinary action, such as imposition of additional fines, suspension or revocation of license.

Section 26: This section adds federal misdemeanors and felonies related to the Medicare and Medicaid programs as a basis for immediate suspension of a health practitioner's license.

Section 27-28: These sections amend existing laws with respect to pharmacy permits and disciplinary actions, and include the following among other provisions:

- Fingerprint card requirement for each person with 5% or more ownership interest and any person who directly or indirectly manages, oversees, or controls the operations, including officers, and members of the board of an applicant that is a corporation.
- For pharmacies having more than \$100 million of business taxable assets, the fingerprint card requirement also applies to the prescription department manager.
- A pharmacy permit shall be denied for any applicant that has:
 - Obtained a permit by misrepresentation or fraud.

- Been convicted or entered a no contest plea to any crime involving ability to practice in the profession of pharmacy.
 - Been convicted or plead no contest to any crime related to health care fraud.
 - Been terminated from the federal Medicare or another state's Medicaid program, unless the applicant has been in good standing for past 5 years and termination was at least 20 year ago.
 - Dispensed medication based on a prescription that the pharmacist knows is not based on a valid practitioner-patient relationship.
- Disciplinary sanctions against any licensed pharmacy are authorized for any of the above violations.
 - There is enhanced authority for revoking and other sanctions related to prior disciplinary action, convictions, or plea agreements.

This section of the bill could potentially have devastating impact on existing and planned pharmacies. Possible legal options include:

- Seeking a declaratory judgment from a circuit court that the bill is unconstitutional as applied to the extent it is imposing a new penalty of license forfeiture for past conduct that was resolved.
- Pursuing a formal administrative hearing under Section 120.57, Florida Statutes, to challenge the factual underpinnings of any decision by AHCA to refuse to renew a license based on alleged prior violations.

Section 29: This section enhances existing laws to protect against elder abuse by adding breach of fiduciary duty to the definition of exploitation of an elderly person.

Section 30: This section adds Medicaid fraud as a Level 7 criminal offense for criminal sentencing purposes.

Section 31: This section of the bill creates a new Pilot Project to monitor home health services in Miami-Dade County. It requires that AHCA implement the Pilot Project by contracting with a vendor to verify utilization and delivery of home health services. The Pilot Project will use "voice biometrics" and will audit the veracity of claims by contacting patients to determine what services were delivered.

Section 32: This section creates another Pilot Project to monitor home health services. This Section requires AHCA to implement a comprehensive care management project, including

face to face assessments by a licensed nurse, consultation with physicians ordering home health services, and on site or desk reviews of recipient's medical records in Miami-Dade County.

Sections 33-44: These sections repeal obsolete provisions of law; make minor "glitch" amendments to existing laws; and make some minor modifications to existing laws related to licensure of nursing homes.

Section 45: This section of the bill applies to clinics that provide magnetic resonance imaging services, and provides for a 1 year period after equipment replacement to obtain accreditation.

Section 46: This section makes minor amendments to the administrative penalty process for health care clinics.

Section 47: This section makes some amendments to AHCA's "core licensure process." The Section includes a minor amendment to the definition of "change of ownership," commonly referred to as a CHOW to expressly include a change in FEI number or taxpayer number as evidence of a CHOW; and amends the percentage ownership change that constitutes a CHOW from 45% to 51%. The section also clarifies that a request for license renewal must be submitted at least 60 days prior to license expiration but no more than 120 days prior to license expiration.

Section 48: This section makes minor changes to information that must be provided as part of the application process.

Section 49: This section allows AHCA to issue a provisional license to an applicant applying for a CHOW, for a period not to exceed 12 months.

Section 50: This section adds numerous additional offenses that must be included in background screening for persons who are required by law to undergo a Level I or Level II background screening. These offenses include Medicaid fraud; domestic violence; felony assault, battery or culpable negligence; burglary; fraudulent acts through mail, wire, radio, etc; false and fraudulent insurance claims; patient brokering; criminal use of personal identification; obtaining a credit card through fraud; fraudulent use of credit cards (felony level); forgery; uttering forged instruments; forging bank bills, checks, drafts or promissory notes; fraud in obtaining medicinal drugs; sale manufacture, delivery or possession with intent to sell counterfeit controlled substances.

Section 51: This section amends the Inspection provisions for health care providers, clarifying that AHCA may accept survey results of an accrediting organization; that deficiencies identified must be corrected within 30 days unless another time is specified by AHCA; and that a plan of correction must be provided with AHCA within 10 days after notification unless a different time frame is specified.

Section 52: This section amends AHCA's Administrative Fine authority against all types of providers regulated by AHCA. The Section establishes four classes of violations based on the

nature of the violation and the gravity of its probable effect on clients. The scope of the violation may be cited as:

- Isolated - affecting one or very limited number of clients, or occurred only occasionally or in very limited number of locations.
- Patterned - more than a very limited number of clients involved; or occurred in several locations; or same clients affected by the same deficient practice; but not pervasive.
- Widespread - problems are pervasive and represent systematic failure to comply.

The four classes of violations are:

- Class I - Imminent danger to clients; substantial probability of death or serious physical or emotional harm. Such violations shall be abated or eliminated within 24 hours, unless another time is stated by AHCA. AHCA shall impose a fine, notwithstanding correction.
- Class II - Violations that directly threaten physical or emotional health, safety or security, other than Class I violations. AHCA shall impose a fine notwithstanding correction of the violation.
- Class III - Violations are determined to indirectly or potentially threaten the physical or emotional health, safety and security of clients, other than Class I or Class II. AHCA must specify time frame for correction and if corrected in the time stated, then a fine may not be imposed.
- Class IV - Violations are those conditions or occurrences related to required report, forms or documents that do not have the potential of negatively affecting clients. Do not threaten patient or client health or safety or security. AHCA must specify a time for correction and if corrected in a timely manner, no fine may be imposed.

Section 53: Makes amendments to exemption provisions applicable to certain licensure requirements.

Sections 54 and 55: These sections amend and reorganize emergency management provisions of health care facility laws, and requires appointment of a safety liaison to serve as primary contact for emergency operations. Facilities that are damaged in an emergency can obtain inactive licenses during repair period. Facilities serving as a “receiving provider” during an emergency may exceed licensed capacity for the emergency period. AHCA may adopt rules related to emergency management communications and operations.

Section 56: Amends some provisions for the Florida 211 Network that serves as the point of coordination for information and referral for health and human services. Providers in the 211 Network must be fully accredited by the National Alliance of Information and Referral Services.

Sections 57-73: These provisions are not related to the health care fraud initiative, and are primarily reorganization of existing provisions of law, repeal of obsolete provisions and minor amendments. Section 68 clarifies that clinical labs that perform only “waived tests” under CLIAA, do not need to have separate state licensure.

CONCLUSION

Chapter 2009-223 is a massive revision to Florida health care law. Its primary focus is on stepping up enforcement and sanctions against providers suspected of being involved in health care fraud. The main target is home health care providers, and particularly those providers in Miami-Dade and Broward Counties. However, other health care professionals and providers are also caught up in the broad sweep of the law, particularly with respect to provisions that will prohibit license renewal for persons who may have been convicted of an offense in the past – and now find that offense coming back to haunt them unexpectedly. For those persons, a challenge to the constitutionality of the law may be the only recourse. For providers accused of violation of Medicaid rules or regulations, or facility and operational standards, careful consideration must now be given to whether the provider should exercise the right to a formal hearing to contest allegations and proposed fines that may be the basis later for non-renewal of suspension of the provider’s license.

If you would like more information on this bill, please contact us.

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