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HOUSE OF REPRESENTATIVES
COMMITTEE ON
ELDER & LONG TERM CARE
ANALYSIS

BILL #: HB 1879 (Formerly PCB ELT 01-01)

RELATING TO: Long Term Care

SPONSOR(S): Committee on Elder & Long Term Care and Representative Green

TIED BILL(S): SB 1202

ORIGINATING COMMITTEE(S)/COUNCIL(S)/COMMITTEE(S) OF REFERENCE:

(1) ELDER & LONG TERM CARE YEAS 13 NAYS 0
(2)
(3)
(4)
(5)

I. SUMMARY:

This bill strengthens the Agency for Health Care Administration's authority to deny licensure to persons who have a history of poor performance in this state or others, and requires disclosure of all significant ownership or controlling interests in the application process.

The bill requires that facilities establish an internal risk management process, a quality assurance program, and a resident grievance and complaint procedure. Direct care staffing requirements are established in statute and increased over current levels prescribed in the agency's administrative rule. Revisions and new provisions related to the quality, training, and continuing education of staff are provided. The fines that the state must levy are revised. Sanctions related to false charting are strengthened. The Medicaid reimbursement plan in chapter 409 is revised.

This bill significantly revises the processes and remedies available to nursing home and assisted living facility residents whose rights are violated. It creates an exclusive remedy for any civil action against a licensee, owner, administrator or staff for recovery of damages from personal injury or death of residents arising out of negligence or deprivation of rights. The bill creates a presuit screening and investigation process and an opportunity to arbitrate damages. Also, in certain cases, a portion of punitive damages will go to a quality of care trust fund to improve the long term care system.

Provisions are made to evaluate the Managed Care Community Diversion Projects. $100,000 is appropriated to the Office of the Statewide Public Guardian and $948,782 is appropriated to the State Long Term Care Ombudsman Program.

Chapter 2000-350, L.O.F. is reenacted.

The fiscal impact to Medicaid related to the increases in staffing is approximately $135.1 million dollars in General Revenue.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No []	N/A [x]
2.	Lower Taxes	Yes []	No []	N/A [x]
3.	Individual Freedom	Yes [x]	No []	N/A []
4.	Personal Responsibility	Yes [x]	No []	N/A []
5.	Family Empowerment	Yes [x]	No []	N/A []

For any principle that received a "no" above, please explain:

B. PRESENT SITUATION:

HB 1993: 2000 Legislative Session
The Task Force on the Availability and Affordability of Long-Term Care

The Legislature created, in the 2000 Session, the Task Force on the Availability and Affordability of Long-Term Care. The purpose of the task force was to assess the current long-term care system in terms of the availability of alternatives to nursing homes, the quality of care in nursing homes and the impact of lawsuits against nursing homes and other long-term care facilities on the costs of care and the financial stability of the long-term care industry. On February 16, 2001, the task force submitted an extensive report to the Legislature. The full report is available electronically at:
http://www.fpeca.usf.edu/Task%20Force/Publications/Documents/finalreportnew.PDF

Poor Houses to the Social Security Act

Public financial support for elderly poor persons has been a burden assumed since the colonial era. This support has bought care and services ranging from auctioning off the needy to families willing to provide room and board in exchange for labor to congregate housing arrangements frequently called "poor houses." The phrase "over-the-hill" is reported to come from a popular song of the late 1800's about an old woman cast out of her own home by her children and forced to go "over the hill" to live in a government-run workhouse.

Scandals in these government run poor-houses and work-houses, coupled with changing expectations, and new ideas about public responsibility for the needy were threads that merged into the Social Security Act of 1935 with its provisions for old age pensions, and cash grants to the blind and disabled. The Act specifically provided that no cash social security payments could be made to any "inmate of public institution." This was the beginning of a system of predictable payment for privately owned convalescent, old age, and nursing homes. [i]

Medicaid

The second great infusion of public financing began in 1965 when Congress created the Medicaid program to assist poor elders and disabled persons with payments for health care. Medicaid, a state and federal partnership, assigned the majority of regulation in the early years to the states.

Some states used a "Certificates of Need" (CON) process to control the supply of nursing home beds in many states. Flat rate, cost-reimbursement, and other plans indexed to patient acuity were developed.

Increasing Need for Long Term Care

Most states are facing an increasingly aged and disabled population in need of long-term, supportive services at the same time as demands on resources in other areas increased. Florida's elderly population is currently 2.9 million individuals, 18.3% of the state's population. "Baby boomers" will add 600,000 to that number by 2010. While the majority of Florida's elders live independent and healthy lives, the number of frail elders in need of long-term care services in nursing homes, assisted living facilities and formal home care programs is expected to increase over the next ten years.

Long-term care generally means care that is provided on a continual basis to persons with chronic disabilities. This care is often supportive, rather than curative. Medicare differentiates between "skilled care" that requires the care of registered nurses and "custodial care" that requires less nursing intervention and more hands-on assistance. Currently, many persons in nursing homes are more acutely ill, more in need of skilled care and more disabled than in prior years.

Medicare versus Medicaid

Medicare primarily pays for short-term transitional care in nursing homes. Medicaid pays for longer-term care. Assisted living facilities provide supportive care to individuals who require assistance with the activities of daily living, but who do not require continuous nursing care. Medicaid and Medicare do not generally pay for care in assisted living facilities; however, Florida has an assisted living facility waiver program which allows Medicaid to reimburse additional care required by severely disabled assisted living facility residents.

A major impediment for states in planning an efficient long-term care system has been the difficulty of managing the interrelationship of incentives between the Medicare and Medicaid financing systems, and the effect that care of acute illnesses has on the eventual need for long-term care. States often have little control over the admission of a patient into a nursing home since Medicare or other sources usually finance the initial portion of a nursing home stay. Once these resources are exhausted (often after community support systems have unraveled) state Medicaid programs become responsible for financing continuing stays.

Quality of Care

The quality of care provided to persons who live in nursing home facilities has been a concern both at the state and national level for at least two decades. Numerous reports, studies, task forces, hearings, and other efforts have been written to explain the factors that contribute to quality care, to creating a regulatory and reimbursement framework that enhances the likelihood of good care, and to finding sanctions that positively affect the performance of facilities that deliver poor care.

Staffing

The number and training of bedside staff seem to be associated with the quality of care provided to residents. The quality of care provided to residents is associated with the incidence of acute illnesses, malnutrition, dehydration, and other costly diminutions in the well-being of residents. A research team led Charlene Harrington in a study partially supported by the Agency for Healthcare

Research and Quality examined the data reported by all nursing homes to the Federal Health Care Financing Administration (HCFA) to identify deficiencies in nursing home care. [ii]

Percent of Nursing Homes Cited for Staffing Deficiencies

YEAR	% NATIONAL	% FLORIDA
1992	6.0	4.8
1993	6.2	5.6
1994	7.0	7.1
1995	5.7	9.3
1996	4.2	10.9
1997	3.8	10.8
1998	4.6	13.9
1999	5.7	12.4

Harrington Report 2000

The requirements for nursing facility staffing are prescribed in the Florida Administrative Code (59A-4.108). Each facility must provide 1.7 certified nursing assistant (CNA) hours per resident per day and .6 licensed nursing hours per resident per day. There are no requirements for staffing according to shifts. The industry reports approximately 100% turnover among CNAs every year. The State Long Term Care Ombudsman reports that the most frequent complaint received by that office is the lack of adequate numbers of staff to appropriately care for nursing home residents.

Residents of long-term care facilities require both health and social programs. Residents' service needs stem both from health conditions that may necessitate medical treatments but also from the importance of maximizing function and productivity.[iii] Florida's nursing home residents are older, more medically complex, more dependent in activities of daily living, and more likely to have cognitive impairment than ever before. The changing characteristics of the resident population has implications for nursing home quality in so far as sicker and more debilitated residents are more difficult to care for and require more expertise on the part of clinical staff.

Title 42 of the Code of Federal Regulation, Section 483.30 Nursing Services, provides the following requirement related to nursing staff:

> The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

Malnutrition/Dehydration

According to experts, malnutrition is not a response to normal aging: it can arise from many causes. Its presence may signal the worsening of a life-threatening illness, and it should always be seen as a dramatic indicator of the risk of sudden decline in the elderly. Dehydration is a condition in which water or fluid loss far exceeds fluid intake. The body becomes less able to maintain adequate blood pressure, deliver sufficient oxygen and nutrients to the cells, and rid itself of wastes. Malnutrition and dehydration are often precursors to pressure sores.

Percent of Nursing Homes Cited for Nutrition Deficiencies

	1995	1996	1997	1998
National Average	8.1%	8.1%	8.3%	8.1%
Florida Average	16.2%	16.6%	15.9%	13.2%

Harrington Report 2000

Pressure Sores

A pressure ulcer or pressure sore is any lesion caused by unrelieved pressure resulting in damage of underlying tissue. In 1992, the total estimated costs for all settings were $1.3 billion. Prevention is the main goal according to experts in long-term care.

Minimizing pressure over bony prominences is the most recommended and most difficult prevention practice to achieve consistently. Turning and repositioning the patient every two hours is usually the strategy used to accomplish this goal. Pressure-relieving pads, mattresses and beds have been designed and used and the Task Force reported that there was limited data indicating that older patients who received various aggressive preventive measures in the long-term care settings had significantly reduced incidence of pressure ulcers and more ulcer-free days than patients in the no prevention group.

Recent research has made important progress in providing cost-effectiveness of preventive pressure ulcer care. By following consistent, research-based skin care protocols, an 830-bed facility was able to reduce the cost of treatment from $5.35 per ulcer per day to $3.74. Another facility instituted practice guidelines recommended by AHQR and during the eight month study period, the facility had savings of more than $230,000 for the prevention program versus treatment costs.

TYPE CITATION	NATIONAL %	FLORIDA %
Pressure Sores	17.1	20.5

Licensure, Certification, Deficiencies

All nursing homes operating in the state must be licensed by the state. Nursing home facilities may elect to participate in the Medicaid or Medicare programs. Facilities must meet federal "certification" standards in addition to being licensed if they would participate in Medicaid or Medicare.

As required under federal regulations, the Agency for Health Care Administration (AHCA) inspects facilities approximately every nine to fifteen months by making unannounced survey visits. AHCA inspectors review the physical environment of the facility, the medical records of some patients, and interview patients and family members. Deficiencies in the standards required of a nursing home are rated as Classes I, II, or III.

Class I deficiencies are those which the agency determines present an imminent danger to the residents or guests of the nursing home facility or a substantial probability that death or serious physical harm would result therefrom. Under current law, AHCA is authorized to issue a fine in the range of $5,000 to $25,000.

Class II deficiencies are those which the agency determines have a direct or immediate relationship to the health, safety, or security of the nursing home facility residents, other than class I deficiencies. Under current law, AHCA is authorized to issue a fine in the range of $1,000 to $10,000.

Class III deficiencies are those which the agency determines have an indirect or potential relationship to the health, safety, or security of the nursing home facility residents, other than class I or class II deficiencies. Under current law, AHCA is authorized to issue a fine in the range of $500 to $2,500.

Despite increasing patient acuity, staffing ratios, education requirements and skill levels of staff have not been changed significantly to reflect new patient needs. Nor has the ongoing training required for the clinical care "backbone" of the nursing home—the certified nursing assistant--changed. While nationwide, the percentage of facilities receiving deficiency citations for inadequate staffing has remained relatively stable, the deficiency citation for inadequate staffing on the part of Florida nursing homes has increased from 5.6% in 1993 to 12.4% in 1999 (Harrington, et.al, 2000). Florida nursing homes staff at a higher ratio than the national average, and staffing levels have increased consistently over the past eight years (Harrington, et.al, 2000).

Percent of Nursing Homes Cited for Top Ten Deficiencies

Indicator	**National %**	**Florida %**
Food Sanitation	23.7	30.5
Dignity	14.1	24.7
Quality of Care	17.2	20.3
Pressure Sores	17.1	20.5
Comprehensive Care Plan	15.2	24.8
Comprehensive Assessments	15.1	17.7
Physical Restraints	13.7	13.5
Accident Prevention	17.7	10.0
Accidents	18	10.8
Housekeeping	14.4	13.3

Harrington Report 2000[iv]

The percent of residents in Florida with severe conditions, such as contractures, appears to be increasing from a low of 16.5% in 1993 to 18.3% in 1999. While, the overall rates of residents with contractures are increasing nationwide, rates in Florida remain below the nationwide averages. On the Assessments, Food Sanitation, Care Planning, Dignity, and Florida received more citations than other states; on staffing deficiencies: between 1993 and 1999, citations increased from 5.6% in 1993 to a high of 13.9% in 1998, and then there was a slight decrease in 1999.

The Task Force document concluded: "Many of these outcomes are directly related to nurse staffing. Higher nurse staffing positively impacts resident outcomes. More staff is needed in homes and the state needs to adjust payment rates to reflect the additional cost of care." [v]

Reimbursement

Nursing home care is paid by Medicare (up to 100 days following a qualifying hospitalization), Medicaid, private insurance, the Veteran's Administration, and finally by individuals and their families. According to the Task Force, "in general, Medicare pays for allowable post-hospital nursing home care. Until the Balanced Budget Act of 1997 it was generally believed that Medicare payments were quite generous, meeting the costs incurred by most nursing homes in providing care to Medicare patients."

The Medicaid agency is required to develop and file with HCFA a "state plan" that describes how reimbursement will be made to participating nursing facilities. The current reimbursement plan is referred to as the "Gainesville Plan" (apparently because Gainesville was a convenient location for a set of meetings in which core elements of the plan were discussed by stakeholders in 1983).

Reimbursement would be calculated using a single rate that reflected costs in four major domains: operating expenses, patient care, property, and return on equity. Rates reflect prior costs, with an adjustment for inflation, and intentionally meet the full costs experienced by a proportion of the state's nursing homes. Operating efficiently enough to be among those organizations with reimbursement rates that meet costs is the major incentive to make management, staffing or other changes that control or reduce costs. **It must be clearly understood that the program intends to meet the documented costs of some, but not all of the state's nursing homes.** In 1985 then HCFA Administrator Bruce Vladek described the tacit, if not explicit agreement, between public dollars and private providers of nursing home care:

> *Take care of our [government] clients exactly the way that you take care of your private customers…and we will pay the costs associated with that care*.

In the current Florida context, the adequacy of Medicaid reimbursement for nursing homes is of primary interest. Any assessment must acknowledge that current rates reflect the intended consequences of legislative and administrative actions to contain costs and to protect residents. [vi]

Florida's Medicaid payment program for nursing home services provides reimbursement that is adequate to meet most of the costs experienced by most of the recipient organizations, most of the time. There are four areas of exception to this general conclusion: the cost of improving the quality of care provided; the costs associated with increasing acuity of patients' medical circumstances; the philosophical questions regarding payment for return on equity; and reimbursement for the costs of liability or liability insurance.

Corporate Bankruptcies

In his testimony before the U.S. Senate Select Committee on Aging, John Ransom, an equity analyst for the nursing home industry described how reimbursement incentives changed in the Medicare program when prospective payment system (PPS) was implemented. According to Ransom, under the cost-based reimbursement system in place in the early 1990's investors enjoyed 30 percent annual increases in Medicare payments for skilled nursing facility care. These increases, in his analysis, promoted the nursing home chains to convert beds from Medicaid to

Medicare and make consolidations many of which were debt-financed. This led, he testified to a transactional debt of $5 billion in the industry. With the Balanced Budget Act and the implementation of the prospective payment system (PPS), the revenue growth Medicare had known declined, the daily rate declined, and the labor shortage and liability issues contributed to the weakening of the industry. According to Ransom, "The result was capital flight and bankruptcy."[vii] The Associate Director of Health Financing and Public Health Issues in the Health, Education, and Human Services Division of the U.S. General Accounting Office (GAO) recently reported in testimony to the Special Committee on Aging, United States Senate on the adequacy of Medicare's payment rates for skilled nursing services furnished in nursing homes, the relationship between the changes wrought by the federal Balanced Budget Act (BBA) and recent nursing home bankruptcies. She testified:

> *The problems experienced by some providers of nursing home and ancillary services are therefore the result of business decisions made during a period when Medicare exercised too little control over its payments.* [viii]

The Real Estate Business

One of the large for-profit chain corporations that the GAO studied is operating in bankruptcy. Between 1997 and 1999, reports indicate that it had a four-fold increase in rental costs. This significant increase was due to a business decision to separate the property side of the business from the operating side.

After the division, the new real estate company leased the physical premises to the licensee or operating company. This arrangement drove the nursing home rental expenses up from $42 million in 1997 to $171 million in 1999, without a commensurate decline in other capital costs. The GAO report found that if the company's capital costs had continued at the 1997 level, "profits from their nursing home operations would have fallen 9 percent between 1997 and 1999, due primarily to reductions in nursing home revenues effected by the BBA. Instead, the company's profits from the nursing home's operations fell 78 percent.[ix]

According to Charles Phillips, director of Myers Research Institute, "They *[the large for-profit chains*] were more interested in real estate transactions than healthcare. They shuffled properties back and forth between subsidiaries, jacking up property costs to increase reimbursement. Our current long-term-care system is fundamentally a creature of government policy. Those real estate ventures became the source of corporate empires." The number of nursing homes rose from 13,000 in 1967 to more than 23,000 in 1969.

Ancillary Services

According to most of the corporations that have filed for bankruptcy had invested heavily in the business of furnishing ancillary services to their own nursing homes and others. Two companies attributed about 25 percent of their total corporate revenues in 1998 to their ancillary service lines of business, while one company attributed almost half. But the new Medicare payment system has made all nursing homes price sensitive when purchasing contracted services. Without the expectation of what the GAO report called "the prospect of overly generous, rapidly rising Medicare revenues" some publicly owned corporations had to post what are known as "asset impairment losses" on their balance sheets.

Paper Losses

Generally accepted accounting principles require businesses to calculate these potential future losses to inform investors that future expected revenue streams will be lower than anticipated. Losses from asset impairment and sales account for much of the bankrupt corporations' reported total shortfalls, but reflect business and accounting practices rather than losses from current operations. Further, the GAO report described these losses as, "paper losses that do not contribute to the companies' bankruptcy filings, although they do affect calculations of the companies' worth."

The GAO concluded its evaluation of the bankruptcies saying that the protections under the U.S. Bankruptcy code were such that it was, in their view, unlikely that homes would close and residents would have to be transferred.

Filing for bankruptcy protection under Chapter 11 allows these providers time to restructure their debts and streamline their operations while continuing to care for their nursing home residents. The seemingly illogical fact that these companies can generate profits in their nursing home operations and at the same time file for bankruptcy can largely be explained by the losses from their ancillary service lines.

Bankruptcy, Not What It Appears

Nursing facilities frequently cite low Medicaid reimbursement rates as the primary reason why the "sufficiency and adequacy of staffing" is repeatedly cited as a deficiency in this state and others. Florida has also experienced a "wave" of bankruptcies over the last few years that has many observers concerned that a crisis or shortage of care may be on the horizon. The bankruptcies, however, do not seem to conform to the common understanding of "broke." For example, one facility in Arkansas reported a loss of $859,000 for the fiscal year ending June 1998. In cost reports filed with the state, the corporation reported that the loss included $309,000 in management fees and home office costs that were paid to the corporate headquarters. Statements provided to shareholders indicated that three of the top executives each received more than $1 million in compensation during 1997.

Cost-consciousness is more evident in the wages paid to CNAs. The average certified nursing assistant in Florida receives $8.08 per hour. It has been widely reported that CNAs are the "back bone" of the industry, that they deliver the majority of direct, hands-on care for residents.

Protecting Nursing Home Residents

Patient advocates, family members of people in nursing homes and attorneys representing nursing home residents often have taken the position that the state system for assuring quality and humane care in nursing homes has failed and that recourse to the courts is the method of last resort to force nursing homes to provide quality care and to punish those who do not.

For more than 20 years, the State of Florida has grappled with issues relating to the quality of care that nursing homes provide to their residents. A staff analysis for Committee Substitute for Senate Bill 1218 (1980), describes the findings of a Dade County grand jury convened to investigate nursing homes operating in that county. At the time, there were 331 state-licensed nursing homes operating in Florida. The analysis states:

> The report described health hazards and deficiencies in patient care that allegedly have been allowed to continue for years. Of the 38 Dade County nursing homes surveyed by the Grand Jury, 60 percent provided either generally unacceptable or consistently very poor care. The Jury found that sanctions against homes are invoked "rarely, timidly, and

> ineffectively,'" and that once a deficiency is identified, on-site follow-up visits are too infrequent to ensure correction. [p. 1, *Senate Staff Analysis and Economic Impact Statement*, June 10, 1980]

The quality of nursing home care continues to be a concern because residents are generally showing increasing levels of acuity and disability and require increasingly more complex treatments. These concerns about problems in the quality of long-term care persist despite some improvements in recent years, and are reflected in, and spurred by, recent government reports, congressional hearings, newspaper stories, and criminal and civil court cases. Debate also continues over the effectiveness and appropriate scope of state and national policies to regulate long-term care, reduce poor performance of providers, and improve the health and well being of those receiving care. These questions and debates extend beyond nursing homes to home and community-based services and residential care facilities.

Civil Enforcement for Violations of Resident Rights

Currently, any nursing home resident whose rights as specified in s. 400.022, F.S., are deprived or infringed upon has a civil cause of action against any licensee responsible for the violation. Sections 400.428 and 400.429, F.S., contain similar provisions for assisted living facilities. Prevailing plaintiffs may be entitled to recover reasonable attorney's fees, and costs of the action, along with actual and punitive damages. Prevailing defendants may be entitled to receive attorney's fees. The statutes require that attorney's fees be based on a number of factors including time and labor involved, difficulty of the case and other similar factors.

Suits may be brought by the resident, the resident's guardian, a person or organization acting on behalf of the resident, or the personal representative of the estate of a deceased resident. If the suit alleges a deprivation of the right to receive adequate and appropriate health care which results in injury or death, claimants (the persons bringing the suit) are required to conduct an investigation which includes a review of the case by a physician or registered nurse familiar with standards of care for nursing home residents, and a statement that the deprivation of the right occurred during the resident's stay in the nursing home.

Punitive damages may be awarded for conduct that is willful, wanton, gross or flagrant, reckless, or consciously indifferent to the rights of the resident. In addition to any other standards for punitive damages, any award for punitive damages must be reasonable in light of actual harm suffered, and the egregiousness of the conduct that caused the harm. Section 768.735, F.S., limits punitive damages against nursing homes pursuant to chapter 400, F.S., to three times compensatory damages unless the claimant demonstrates to the court by clear and convincing evidence that an award in excess of the limitation is not excessive in light of the facts and circumstances that were presented.

Other Causes of Action

In addition to bringing actions under the civil enforcement provisions of ss. 400.023 and 400.429, F.S., residents can also sue nursing homes and assisted living facilities under a variety of statutory and common law theories. If a resident is injured or dies, the facility may be liable, depending on the particular facts of the situation, under theories of common law negligence, common law intentional torts such as battery, or abuse of a vulnerable adult under s. 415.1111, F.S. Most of these lawsuits must be filed within four years of the injury or two years of the resident's death. Although each of these legal theories has different elements, the common element the resident must prove in all of the causes of action is that the resident suffered actual damages as a result of

the facility's conduct. Typically, these damages are related to the injury or death and are called compensatory damages, which are economic (i.e. medical bills, lost wages, etc.) and noneconomic (i.e. pain, suffering, mental anguish, etc.) in nature.

In some cases, the resident may recover punitive damages when the defendant's conduct is particularly egregious. Currently, residents of nursing homes can recover punitive damages under s. 400.023(5), F.S., when the nursing home's conduct is willful, wanton, gross or flagrant, reckless, or consciously indifferent to the rights of the resident. Residents of assisted living facilities can recover punitive damages under s. 400.429(1), F.S., when the facility's conduct is malicious, wanton, or a willful disregard of the rights of others. If the resident pursues his or her case under a common law negligence theory, he or she may recover punitive damages when the facility's conduct is of a "gross and flagrant character, evincing reckless disregard of human life, or of the safety of persons exposed to its dangerous effects, or there is that entire want of care which would raise the presumption of a conscious indifference to consequences, or which shows wantonness or recklessness, or grossly careless disregard of the safety and welfare of the public, or that reckless indifference to the rights of others which is the equivalent to an intentional violation of them." *See White Construction Co. v. Dupont,* 455 So.2d 1026, 1029 (Fla. 1984). Florida courts have interpreted the punitive damages provisions of s. 400.023(5), F.S., as being the equivalent of the common law punitive damage standard. *See e.g., First Healthcare Corp. v. Hamilton,* 740 So.2d 1189, 1197 (Fla. 4th D.C.A. 1999)

In 1999, ch. 99-225, L.O.F., was enacted and provided a series of measures that established new standards for pleading, proving, and recovering punitive damages in civil actions. These changes, found in ss. 768.72-768.737, F.S., also provided new limitations on the amount of punitive damages that could be recovered. However, civil actions under chapter 400, including actions against nursing homes and assisted living facilities, were expressly exempted from the new standards in s. 768.735(1), F.S., and the provisions under s. 768.735(2), F.S., apply.

Medical Malpractice Actions

Chapter 766, F.S., provides for standards of recovery in medical negligence cases. In any action for recovery of damages based on the death or personal injury of any person in which it is alleged that such death or injury resulted from the negligence of a health care provider, the claimant has the burden of proving the alleged actions of the health care provider represented a breach of the prevailing standard of care for that health care provider (s. 766.102(1), F.S.). The prevailing professional standard of care for a given health care provider is that level of care, skill, and treatment which, in light of all relevant, surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers. *Id.*

Section 766.104(1), F.S., provides that no action shall be filed for personal injury or wrongful death arising out of medical negligence unless the attorney filing the action has made a reasonable investigation to determine there are grounds for a good faith belief there has been negligence in the care or treatment of the claimant. This statute provides a safe harbor for the attorney's good faith determination, as good faith may be shown to exist if the claimant or his counsel has received a written opinion of an expert as defined in s. 766.102, F.S., that there appears to be evidence of medical negligence. Section 766.102(2), F.S., sets forth the qualifications of the health care provider who may testify as an expert in a medical negligence action, and who, pursuant to s. 766.104(1), F.S., may provide an opinion supporting the attorney's good faith presuit belief there has been medical negligence.

Section 766.106, F.S., provides a statutory scheme for presuit screening of medical malpractice claims. After completion of the presuit investigation under s. 766.203, F.S., a claimant must notify each prospective defendant of the claimant's intent to initiate litigation for medical malpractice prior to filing a lawsuit. Pursuant to s. 766.106(3), F.S., no suit may be filed for a period of 90 days after the notice of intent is mailed to any prospective defendant. During the 90-day period, the defendant's insurer is required to conduct a review to determine the liability of the defendant. To facilitate the review, s. 766.106(6), F.S., requires the parties to engage in fairly extensive informal discovery.

One of the mechanisms of informal discovery is the taking of unsworn statements as provided in s. 766.106(7)(a), F.S. Any party may require other parties to appear for the taking of an unsworn statement. Such statements may be used only for the purpose of presuit screening and are not discoverable or admissible in any civil action by any party. Non-parties cannot be required to have their unsworn statements taken.

At or before the end of the 90 day presuit screening period, the defendant's insurer must, under s. 766.106(3)(b), F.S., respond to the claimant by rejecting the claim, making a settlement offer, or making an offer of admission of liability and for arbitration on the issue of damages. If the defendant makes an offer to arbitrate, the claimant has 50 days, under s. 766.106(10), F.S., to accept or reject the offer. The claimant cannot force the defendant to arbitrate under s. 766.106, F.S. Acceptance of the offer waives recourse to any other remedy by the parties. The parties then have 30 days to settle the amount of damages and, if they cannot reach a settlement, they must proceed to binding arbitration to determine the amount of damages. Under s. 766.106(12), F.S., the provisions of the Florida Arbitration Code contained in chapter 682, F.S., are applicable to the arbitration proceeding. The parties then provide written arguments to the arbitration panel and a one-day hearing is subsequently held, wherein the rules of evidence and civil procedure do not apply. No later than two weeks after the hearing the arbitrators are required to notify the parties of their award and the court has jurisdiction to enforce any award.

In 1988, the Legislature enacted major amendments to chapter 766, F.S., in response to dramatic increases in medical malpractice insurance premiums that resulted in increased medical care costs for most patients and functional unavailability of malpractice insurance for some physicians. It was the intent of the Legislature to provide a plan for the prompt resolution of medical malpractice claims. The plan consisted of two separate components, presuit investigation and presuit arbitration. Presuit investigation became mandatory and applied to all medical negligence claims and defenses, while presuit arbitration was voluntary. Arbitration was supposed to provide:

- Substantial incentives for both claimants and defendants to submit cases to binding arbitration;
- A conditional limitation on noneconomic damages where the defendant concedes willingness to pay economic damages and reasonable attorney's fees; and
- Limitations on the noneconomic damage components of large awards to provide increased predictability of outcome of the claims resolution process for insurer anticipated losses planning, and to facilitate early resolution of medical negligence claims. (See s. 766.201, F.S.)

Sections 766.203-766.206, F.S., set out the presuit investigation procedure that both the claimant and defendant must follow before a medical negligence claim may be brought in court. The first step is for the claimant to determine whether reasonable grounds exist to believe that a defendant acted negligently in the claimant's care or treatment, and that this negligence caused the claimant's injury. The claim must be corroborated by a verified written medical expert opinion before giving notice to a

defendant. After the claimant has established the reasonable grounds to believe that medical negligence occurred, the defendant or defendant's insurer is required to conduct a presuit investigation.

Currently, under s. 766.207, F.S., upon completion of the pre-suit investigation, either party may elect to have damages determined by an arbitration panel. The election may be initiated by either party serving a request for voluntary binding arbitration of damages within 90 days after service on the defendant of the claimant's notice of intent to initiate litigation. Upon receipt of a party's request for arbitration, the opposing party may accept the offer of voluntary binding arbitration within 30 days. However, a defendant is not required to respond to a request for arbitration submitted earlier than 90 days after service of the notice of intent to initiate litigation.

The arbitration panel is composed of three arbitrators with one selected by the claimant and one selected by the defendant. The third arbitrator is an administrative law judge furnished by the Division of Administrative Hearings, who serves as the chief arbitrator. The arbitrators are to be independent of all parties, witnesses and legal counsel. The arbitration is conducted pursuant to rules promulgated by the Division of Administrative Hearings and evidentiary standards under ss. 120.569(2)(g) and 120.57(1)(c), F.S., (Administrative Procedure Act).

Voluntary arbitration under s. 766.207, F.S., precludes recourse to any other remedy by the claimant against any participating defendant and is undertaken with the following understandings:

- Net economic damages are awardable, subject to an offset for collateral source payments, but past and future wage losses and loss of earning capacity are limited to 80%;
- Noneconomic damages are limited to a maximum of $250,000 per incident and are reduced according to the percentage reduction in the claimant's capacity to enjoy life;
- Damages for future economic losses must be offset by future collateral source payments and must be paid by periodic payments;
- Punitive damages may not be awarded;
- The defendant is responsible for the payment of interest on all accrued damages;
- The defendant must pay the claimant's reasonable attorney's fees and costs, as determined by the arbitration panel, but in no event more than 15% of the award after it is reduced to present value;
- The defendant must pay all the costs of the arbitration proceeding and the fees of the arbitrators, other than the administrative hearing officer;
- Each defendant submitting to arbitration is jointly and severally liable for all damages awarded;
- A defendant's or claimant's offer to arbitrate cannot be used in evidence or in argument during any subsequent litigation of the claim following the rejection thereof;
- The fact of making or accepting an offer to arbitrate is not admissible as evidence in any collateral or subsequent proceeding on the claim;
- Any offer by a claimant to arbitrate must be made to each defendant against whom the claimant has made a claim; and
- Any offer by a defendant to arbitrate must be made to each claimant who has joined in the notice of intent to initiate litigation.

If the defendant refuses the claimant's offer to arbitrate, then the claim must proceed to trial without any limitation on damages. Under s. 766.209(3), F.S., upon proving medical negligence, the claimant is entitled to recover prejudgment interest and reasonable attorney's fees, up to 25% of the award reduced to present value. The claimant's award will be reduced by any damages recovered by the claimant from arbitrating codefendants. If the claimant rejects a defendant's offer to arbitrate, the damages awardable at trial will be limited to net economic damages reduced to present value. Past and future lost wages and lost earning capacity are limited to 80%. Net economic damages are also

offset by future collateral source payments. Furthermore, noneconomic damages are limited to $350,000 per incident.

Currently, an arbitration award is a final agency action for purposes of s. 120.68, F.S., and any appeal under s. 766.212, F.S., shall be limited to review of the record and otherwise proceed in accordance with s. 120.68, F.S. The amount of an arbitration award, the evidence in support of it and the procedure by which it is determined are subject to heightened judicial scrutiny that will be overturned on appeal only when there is an abuse of discretion that amounts to a manifest injustice. *University of Miami v. Echarte*, 618 So.2d 189, 194 (Fla. 1993).

Hospital Adverse Incident Reporting

Ambulatory surgical centers and hospitals are licensed under chapter 395, F.S. These facilities must have an internal risk management program. The risk management program must include the reporting of adverse incidents that result in serious patient injury. Ambulatory surgical centers and hospitals, under s. 395.0197(8), F.S., must report the following incidents, within 15 calendar days after they occur, to the Agency for Health Care Administration: death of a patient; brain or spinal damage to a patient; performance of a surgical procedure on the wrong patient; performance of a wrong-site surgical procedure; performance of a wrong surgical procedure; performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition; surgical repair of damage resulting to the patient from a planned surgical procedure where damage is not a recognized specific risk, as disclosed to the patient and documented through the informed consent process; or performance of procedures to remove unplanned foreign objects remaining in a patient following surgery.

Under s. 395.0197(8), F.S., the incident reports filed with AHCA are not a public record, and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the Department of Health or the appropriate regulatory board. The incident reports may not be made available to the public as part of the records of investigation for and prosecution in disciplinary proceedings that are made available to the public. The Department of Health or the appropriate regulatory board must make available, upon written request by a health care professional against whom probable cause has been found, any such records which form the basis of the determination of probable cause. The Department of Health must review each incident and determine whether it potentially involved conduct by the health care professional who is subject to disciplinary action under the provisions of s. 456.073, F.S.

C. EFFECT OF PROPOSED CHANGES:

Licensure and Inspection

The bill strengthens the responsibility and capacity of the Agency for Health Care Administration to cite deficiencies and impose a specific fine based on the type, severity, and repetition of the violation. To strengthen the licensure process and prevent owners who have been sanctioned in the Medicaid or Medicare program previously from acquiring new properties, new definitions of "controlling interest" and "voluntary board member" have been created. The bill ensures that the agency will be informed more promptly than is current practice of ownership changes, changes in management companies, staffing levels, staff turnover, and vacant, available beds.

Civil Enforcement

This proposal substantially amends current law. It establishes a negligence standard of recovery and a two-year statute of limitations for personal injury and wrongful death claims involving nursing home and assisted living facility residents. It eliminates the current statutory framework for the award of attorney fees to prevailing plaintiffs but allows for an award of up to $25,000 for attorney fees to a prevailing party for violation of rights not involving personal injury or death or for administrative remedy or injunctive relief. Current standards for recovery of punitive damages are maintained but those damages are capped according to whether arbitration is agreed upon, requested or declined. Indeed, the bill creates a new presuit screening and investigation process and a voluntary binding arbitration program for nursing homes and assisted living facilities.

Resident Protection & Advocacy
Residents are provided with a right to have video and audio monitoring in their own rooms at their expense. The Ombudsman assumes more responsibility for assuring adequate staffing, and $948,782 is appropriated to that Office. The Office of the Statewide Public Guardian is appropriated $100,000 to assist in the provision of guardian services to indigent persons in need of guardianship. All facilities are required to establish a resident grievance and complaint resolution process.

Staffing
Requirements for direct care staff are provided in statute and enhanced to a total of 2.9 hours per resident per day for certified nursing assistants, 0.5 hours per resident per day for registered nurses and 1.0 hour per resident per day for licensed practical nurses. The bill improves the qualifications for facility's medical directors.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Directs that whenever a member of an ombudsman council is in a nursing facility to investigate a resident's complaint or to conduct an inspection, the ombudsman shall verify and record the number of direct care staff on duty and report the information to the State Long Term Care Ombudsman. The State Ombudsman must report that information to the legislature quarterly. Whenever a member of an ombudsman council is in a nursing facility, the ombudsman shall determine if the facility is compliance with the requirements that names of staff on duty are posted. Refusing to allow an ombudsman to enter is a Class I deficiency under Part II or Part III of chapter 400.

Section 2. Amends section 400.021, F.S., to add definitions of "controlling interest" and "voluntary board member."

Section 3. Creates a new section, 400.0223, F.S., "Resident's right to have electronic monitoring devices in room". It requires that nursing facilities allow residents or a resident's legal representative to monitor the resident through the use of audio, video, video telephone, and an Internet video surveillance device. The costs associated with such monitoring must be borne totally by the resident. A nursing facility may request a resident to conduct electronic monitoring within plain view.

Section 4. Substantially rewords s. 400.023, F.S., providing for civil actions to enforce nursing home residents' rights, to provide that part II of chapter 400, F.S., constitutes the exclusive remedy for any civil action against a licensee, owner, administrator or staff for recovery of damages from personal injury to, or death of, a resident arising out of negligence or deprivation of rights. The bill specifically provides that these new changes do not prohibit a resident from seeking administrative remedy, injunctive relief or seeking damages for violations of residents' rights that do not result in personal injury or death. In any of these cases the prevailing party is entitled to costs and attorney

fees up to $25,000, awarded in a manner consistent with federal case law involving an action under Title VII of the Civil Rights Act.

This section maintains current law regarding who may bring suit. A claim may be brought by the resident, the resident's legal guardian, a person or organization acting on behalf of a resident with the consent of the resident, or the personal representative of the deceased resident's estate. The claimant has the burden of proving by a preponderance of the evidence that each defendant had an established duty to the resident, each defendant breached that duty, the breach is the proximate cause of the resident's personal injury, death or deprivation of rights, and the proximate cause of the personal injury, death or deprivation of rights resulted in damages to the resident.

A nursing home breaches its established duty to a resident when it fails to provide a standard of care that a reasonably prudent nursing home would have provided to the resident under similar circumstances. A deprivation of the rights specified in s. 400.022, F.S., as well as a deprivation of standards and regulations, are evidence of a breach of duty by a nursing home. Moreover, a nursing home is not liable for the medical negligence of any physician rendering care to a resident.

An action for damages must be commenced within 2 years of the date of the incident, the date of discovery of the incident, or the date the incident should have been discovered, but in no circumstance may an action be commenced later than 4 years after the date of the incident. However, if it is demonstrated that fraud, concealment or intentional misrepresentation prevented discovery of the harm, the time limit is extended by 2 years, but in no event shall it exceed 7 years from the date of the incident.

This section defines the terms "claimant," "licensee," "medical expert," and "resident" for purposes of the sections relating to civil actions.

Sections 768.16-768.26, F.S., the "Florida Wrongful Death Act," apply to a claim in which a resident has died as a result of a nursing home's breach of an established duty to the resident. A deceased resident's personal representative may also recover on behalf of the resident's estate noneconomic damages from the time of the incident until the time of death. Furthermore, adult children or the parents of adult children are not prohibited from bringing suit as they currently are under s. 768.21(8), F.S., in medical malpractice situations.

Current language regarding punitive damages is retained in this section. Punitive damages may be awarded for conduct which is willful, wanton, gross or flagrant, reckless or consciously indifferent to the rights of the resident.

Any portion of any agreement or judicial determination that conceals information relating to the settlement or resolution of any claim or action brought pursuant to this part is contrary to public policy, void and unenforceable, and any person or governmental entity has standing to contest such impermissible agreement or determination by means of a motion or action for declaratory judgment in the appropriate circuit court.

The defendant in any action brought under this part must provide to the agency a copy of any resolution of any claim or action within 90 days, and failure to do so results in a fine of $500 for each day the report is overdue. The agency is authorized to develop necessary forms and rules for reporting.

Section 5. Provides for effective dates for certain subsections of s. 400.023, F.S., as created in Section 4 of the bill.

Section 6. Creates s. 400.0235, F.S., to: require a claimant under this part to engage in the presuit screening process prescribed in s. 400.0236, F.S.; require the claimant to notify each potential defendant of the claimant's intent to initiate litigation; require the claimant and each potential defendant to engage in the presuit investigation process described in s. 400.0237, F.S.; provide for binding arbitration as described in s. 400.0238, F.S.; and provide that if the parties do not engage in binding arbitration, the claimant may file an action in circuit court under the provisions of s. 400.0243, F.S.

Section 7. Creates s. 400.0236, F.S., to require that, prior to issuing a notice of intent to initiate litigation under s. 400.0237, F.S., the claimant must engage in presuit screening to ascertain that there are reasonable grounds to believe that a defendant breached an established duty owed to a resident which proximately caused harm to the resident, and if the claim involves personal injury, the claimant must obtain a corroborating opinion from a medical expert.

Section 8. Creates s. 400.0237, F.S., to provide that upon completing the presuit requirements in s. 400.0236, F.S., the claimant must notify each prospective defendant of an intent to initiate litigation. The claimant must include in the notice a corroborating medical expert opinion. Each defendant or defendant's insurer must conduct a review of applicable liability within 90 days of receipt of the notice of intent. The bill precludes the filing of suit until at least 90 days after the defendant receives notice.

The notice of intent must be served during the time limits (statute of limitations) set by s. 400.023(6), F.S., and the 90-day waiting period tolls the statute of limitations as to all potential defendants. The 90-day tolling may be extended and upon completion of the 90-day period or extension of time, the claimant has the greater of 60 days or the remainder of the statute of limitations within which to file suit.

Each defendant or insurer of each defendant must have a procedure for promptly evaluating a claim during the 90-day period. If the defendant rejects the claim, a corroborating medical opinion must be included with the notice of rejection to the claimant. The parties are required to engage in informal discovery pursuant to s. 766.106(5)-(9), F.S. Failure to provide access to information within the party's control is grounds for dismissal of any applicable claim or defense.

Section 9. Creates s. 400.0238, F.S., to provide for voluntary binding arbitration. Arbitration is one remedy available to a claimant under this section and if selected by both parties any award shall consist of all net economic damages (except wage loss and loss of earning capacity is recovered at 80%) plus noneconomic damages, which may be awarded up to $500,000 per incident. Under arbitration, punitive damages may be awarded up to but not exceeding three times the compensatory damages with the award split 50/50 between the plaintiff and a state-operated quality of care trust fund.

This section provides that the defendant must pay for: interest on accrued damages; the claimant's costs; attorney's fees up to 15 percent of the award; and the costs of arbitration. Liability is not contested and all defendants are jointly and severally liable for the damages assessed by the panel. Either party's offer to arbitrate shall not be admissible as evidence in any subsequent litigation should an offer to arbitrate be rejected. Any offer of arbitration is applicable to all claimants and all defendants and any party that rejects an offer of arbitration is subject to s. 400.0243, F.S.

All three arbitrators must conduct the hearing and a majority of the 3 may make a finding of fact and render a final decision. The chief arbitrator, an administrative law judge from the Division of Administrative Hearings, must decide all evidentiary questions and provide the agency with a copy of the panel's final decision. This section does not preclude settlement at any time by the parties. Any issue between a defendant and the defendant's insurer must be determined under existing

principles of law and the insurer may not offer to arbitrate or accept a claimant's offer to arbitrate without the written consent of the defendant.

This section also creates a process when voluntary binding arbitration is not offered or accepted and provides that arbitration under this part is an alternative to jury trial and does not supersede the right of any party to a jury trial. If neither party requests arbitration, the claimant may file suit and the claim shall proceed to trial or other available legal alternative. Punitive damages are limited to three times compensatory damages, unless the plaintiff proves to a judge by clear and convincing evidence that the amount above the limit is not excessive. A facility's good record shall be considered a mitigating factor.

If the defendant rejects the claimant's offer of arbitration, the claim shall proceed to trial without any limitation on damages. Current law will apparently govern punitive damages at trial with no division between the plaintiff and a quality of care trust fund.

If the claimant rejects a defendant's offer of arbitration, then the claim shall proceed through the judicial process without limitation upon compensatory damages and punitive damages are limited to three times compensatory damages and must be evenly split between the plaintiff and a state-operated quality of care trust fund.

Section 10. Creates s. 400.0239, F.S., to provide that where multiple defendants have participated in arbitration under this part, within 20 days after the determination of the initial arbitration panel, the defendants must submit any dispute among them regarding apportionment of damages to a separate binding arbitration panel, comprised of the chief arbitrator from the initial panel and 2 additional arbitrators chosen by the defendants. The chief arbitrator must convene the new panel within 65 days of the initial arbitration determination for the purpose of allocating damages among the defendants. The new panel must allocate damages among all defendants named in the notice of intent, regardless of whether the defendant has submitted to arbitration, and the defendants must remain jointly and severally liable for the total of all damages. The defendants must pay their proportionate share of damages, and the panel's determination of percentage of liability of any defendant is not admissible as evidence in any subsequent legal proceeding. Payment by a defendant of the proportionate damages awarded by the panel extinguishes all that defendant's liability to both the claimants and all other defendants. Any defendant paying damages assessed under this section or s. 400.0238, F.S., has an action for contribution against any nonarbitrating person whose negligence contributed to the claimant's harm.

Section 11. Creates s. 400.024, F.S., to provide that the chief arbitrator determining a claim under s. 400.0238, F.S., may in the event of impasse dissolve the panel at any time and declare the proceeding concluded, or may dissolve the panel and appoint two new arbitrators from a list of names provided by each party, and may proceed in accordance with ss. 400.0238-400.0242, F.S.

Section 12. Creates s. 400.0241, F.S., to provide that within 20 days of the determination of the panel under s. 400.0238, F.S., each defendant shall pay the monies owed to the claimant, or shall submit any dispute among multiple defendants to arbitration as provided in s. 400.0239, F.S., and that, commencing 90 days after the award of damages, interest shall begin to accrue on the award at 18 percent per year.

Section 13. Creates s. 400.0242, F.S., to provide that an arbitration award and an allocation of financial responsibility under this part are final agency action for purposes of s. 120.68, F.S., and are appealable only to the district court of appeal for the district in which the arbitration transpired under s. 120.68, F.S. An appeal does not operate to stay an arbitration award. An arbitrator or circuit court shall not stay an award, but a district court of appeal may order a stay to prevent

manifest injustice so long as such stay does not abrogate the provisions of s. 400.0241(2), F.S. Any party to an arbitration proceeding may enforce an arbitration award or allocation of financial responsibility by petition to the circuit court where the arbitration transpired. A petition may not be granted by the circuit court unless the time for appeal has expired and any stay has been lifted. If a petitioner under this section establishes the authenticity of the award or allocation of financial responsibility, shows that the time for appeal has expired and that no stay is in place, the court shall carry out the terms of the panel determination.

Section 14. Creates section 400.0245, F.S., related to protection of employees who report to an appropriate person or agency violations of law that create a specific and substantial danger to a nursing home resident's health, safety, or welfare, or who report allegations of improper use of or gross neglect of duty on the part of a nursing home. This section provides remedies and relief, it specifies defenses, and declares that other rights, privileges, or remedies of an employee under any other law or rule or under collective bargaining agreement or employment contract are not diminished.

Section 15. Amends subsections (2) and (5) of section 400.071, F.S., and renumbers subsections (9) and (10) as (10) and (11) related to the application for license as a nursing home. Applicants must submit a signed affidavit disclosing any financial or ownership interest that one of the specified persons has had in the last five years in any health or residential care entity that closed for any reason, had filed bankruptcy, had a receiver appointed, a license denied, suspended or revoked, or had an injunction against it that was issued by a regulatory agency. Copies of any civil settlement the applicant entered into in the last ten years must be reported to the agency. Further, as a condition of licensure each facility must submit with its application a plan for quality assurance and internal risk management.

Section 16. Amends section 400.102, F.S., to add a subsection (e) related to the grounds on which the agency can take action against a licensee to include the fraudulent altering, defacing, or falsifying of any nursing home record or causing or procuring any of these offenses.

Section 17. Amends section 400.118, F.S., related to the quality assurance and early warning system to require the agency to verify and record the number of staff on duty each time they enter a facility for specified activities. Provides that each resident must have a comprehensive assessment and a care plan developed by the multi-disciplinary team based on that assessment. This section provides certain requirements related to the provision of appropriate care, specifically related to the resident's ability to do his or her activities of daily living (ADLs), pressure sores, urinary continence and catherization, range of motion, mental or psychosocial adjustment, access to vision and hearing services, an appropriate drug regimen, and eating. This section provides that each resident receive adequate supervision and assistive devices to prevent accidents. It provides that a resident maintains acceptable parameters of nutritional status or receives a therapeutic diet when necessary. Residents may refuse any treatment, medication, or other component of the plan of care. The legal representative may exercise these rights on behalf of a resident who has been found to be incapacitated. The facility must continue to provide the other services on the care plan and must document the refusal in the medical record, signed by the resident or the legal guardian, and the physician.

Section 18. Creates section 400.1183, F.S., "Resident Grievance and Complaint Procedures" section. This section requires every nursing facility to have a grievance procedure available to residents and their families. This section provides that the agency shall investigate any complaint or grievance at any time. The agency shall impose administrative sanctions.

Section 19. Amends section 400.121, F.S., related to denial, suspension, revocation of licensure and other sanctions. This section provides that the agency shall deny an application when required

information demonstrates that any controlling interest had been the subject of adverse action by a regulatory agency. If the adverse action involved only the management company, the applicant may be given 30 days to replace the one that had been subject to an adverse action.

Section 20. Amends section 400.141, F.S., and adds new sections related to administration and management of facilities. Specifies each registered nurse is responsible for the proper practice of nursing; the experience required for persons designated as medical director or assistant director of nursing; and, requirements for the charge nurse on duty. It requires that the facility maintain for each patient a record of assistance with activities of daily living, and assistance with food and water offered by the certified nursing assistants. The facility must report to the agency information about management contracts, staffing and staff turnover, and vacant beds.

Section 21. Creates section 400.1413, F.S., "Internal Risk Management and Quality Assurance Program" and specifies that internal risk management is the responsibility of the administrator. It delineates adverse incidents that must be reported to the agency, and staff training requirements. It provides that if the agency through its receipt of the annual reports prescribed in chapter 400, or through any investigation, has a reasonable belief that conduct by a staff or employee of a licensed facility is grounds for disciplinary action by the appropriate regulatory board, the agency must report that information to the appropriate regulatory board.

Section 22. Amends section 400.1415, F.S., related to patient records, to provide that the facility is subject to a Class I fine if the agency finds, by a preponderance of the evidence, that any fraudulent alteration, falsification or defacement has been committed.

Section 23. Amends section 400.19, F.S., related to right of entry and inspection. It provides that AHCA will visit a facility every three months while it has a conditional license.

Section 24. Amends subsection (5) of section 400.191, F.S., related to the availability, distribution, and posting of reports and records, to require every facility post a copy of the most recent "Watch List" published by AHCA.

Section 25. Amends subsection (2) of section 400.211, F.S., related to the standards and requirements for persons employed as certified nursing assistants (CNAs). This section provides that a person who is on the CNA registry in another state and who has not been convicted of or entered a plea of guilty or *nolo contendere* to abuse, neglect, or exploitation in another state regardless of adjudication, may work up to four months while meeting the state certification requirement. It provides that CNAs who have worked for a year or more must be given a performance evaluation, and be given in-service education based on the results of the performance evaluation. The in-service education must be provided by the facility and be enough to ensure the continuing competence of the CNA, be no less than 18 hours per year, and include certain basic topics as prescribed.

Section 26. Amends subsections (2), (3), (7), and (8) of section 400.23, F.S., and adds subsection (10). The agency is given specific rulemaking authority for implementation of the consumer satisfaction surveys, distributing and posting of reports and records, the Gold Seal Program, and the nursing home quality assurance and risk management procedure. It sets minimum staffing requirements for direct care staffing, including certified nursing assistants, licensed practical nurses, and registered nurses. A facility that fails to comply with the minimum state staffing requirements two days of any seven day period are prohibited from accepting new admissions until the facility has achieved the minimum staffing requirements for seven consecutive days. Failure to post the names of staff on duty daily constitutes a class III deficiency. This section also provides that the agency will classify each deficiency it cites as to its nature and scope,

A class I deficiency is subject to a civil penalty ranging from $5,000 for an isolated deficiency to $10,000 for a patterned deficiency, and $15,000 for a widespread deficiency.

A class II deficiency is subject to a civil penalty of $2,500 for an isolated deficiency, $5,000 for a patterned deficiency, and $7,500 for a widespread deficiency.

A class III deficiency is subject to a civil penalty of $1,000 for an isolated deficiency, $2,000 for a patterned deficiency, and $3,000 for a widespread deficiency.

A class IV deficiency is created No civil penalty is imposed, and, if it is an isolated deficiency, no plan of correction is required.

This section requires the agency to submit an annual report to the legislature regarding staffing in nursing homes. This section also makes technical changes.

Section 27. Amends subsection (3) of section 400.241, F.S., to make a technical change.

Section 28. Amends paragraph (b) of subsection 400.407(3), F.S., to make a technical and conforming change.

Section 29. Amends section 400.426 to add a new subsection (4). This section provides that each ALF maintain for each resident a daily chart of activities of daily living.

Section 30. Amends paragraph (k) of subsection (1) of section 400.428, F.S., to require an assisted living facility to give 45 days notice to a resident of relocation, or termination of residency, instead of the current 30 days notice.

Section 31. Substantially rewords s. 400.029, F.S., providing for civil actions to enforce ALF residents' rights, to provide that part III of chapter 400, F.S., constitutes the exclusive remedy for any civil action against a licensee, owner, administrator or staff for recovery of damages from personal injury to, or death of, a resident arising out of negligence or deprivation of rights. The bill specifically provides that these new changes do not prohibit a resident from seeking administrative remedy, injunctive relief or seeking damages for violations of resident's rights that do not result in personal injury or death. In any of these cases the prevailing party is entitled to costs and attorney fees up to $25,000, awarded in a manner consistent with federal case law involving an action under Title VII of the Civil Rights Act.

This section maintains current law regarding who may bring suit. A claim may be brought by the resident, the resident's legal guardian, a person or organization acting on behalf of a resident with the consent of the resident, or the personal representative of the deceased resident's estate. The claimant has the burden of proving by a preponderance of the evidence that each defendant had an established duty to the resident, each defendant breached that duty, the breach is the proximate cause of the resident's personal injury, death or deprivation of rights, and the proximate cause of the personal injury, death or deprivation of rights resulted in damages to the resident.

An ALF breaches its established duty to a resident when it fails to provide a standard of care that a reasonably prudent ALF would have provided to the resident under similar circumstances. A deprivation of the rights specified in s. 400.028, F.S., as well as a deprivation of standards and regulations, are evidence of a breach of duty by an ALF. Moreover, an ALF is not liable for the medical negligence of any physician rendering care to a resident.

An action for damages must be commenced within two years of the date of the incident, the date of discovery of the incident, or the date the incident should have been discovered, but in no

circumstance may an action be commenced later than 4 years after the date of the incident. However, if it is demonstrated that fraud, concealment or intentional misrepresentation prevented discovery of the harm, the time limit is extended by 2 years, but in no event shall it exceed 7 years from the date of the incident.

This section defines the terms "claimant," "licensee," "medical expert," and "resident" for purposes of the sections relating to civil actions.

Sections 768.16-768.26, F.S., the "Florida Wrongful Death Act," apply to a claim in which a resident has died as a result of an ALF's breach of an established duty to the resident. A deceased resident's personal representative may also recover on behalf of the resident's estate noneconomic damages from the time of the incident until the time of death. Furthermore, adult children or the parents of adult children are not prohibited from bringing suit as they currently are under s. 768.21(8), F.S., in medical malpractice situations.

Language similar to current law regarding punitive damages is retained in this section. Punitive damages may be awarded for conduct, which is willful, wanton, gross or flagrant, reckless or consciously indifferent to the rights of the resident.

Any portion of any agreement or judicial determination that conceals information relating to the settlement or resolution of any claim or action brought pursuant to this part is contrary to public policy, void and unenforceable, and any person or governmental entity has standing to contest such impermissible agreement or determination by means of a motion or action for declaratory judgment in the appropriate circuit court.

The defendant in any action brought under this part must provide to the agency a copy of any resolution of any claim or action within 90 days, and failure to do so results in a fine of $500 for each day the report is overdue. The agency is authorized to develop necessary forms and rules for reporting.

Section 32. This section provides effective dates for certain subsections of section 400.429, F.S., as created in section 31 of the bill.

Section 33. Creates s. 400.430, F.S., to provide for voluntary binding arbitration.
Arbitration is one remedy available to a claimant under this section and if selected by both parties any award shall consist of all net economic damages (except wage loss and loss of earning capacity is recovered at 80%) plus noneconomic damages, which may be awarded up to $500,000 per incident. Under arbitration, punitive damages may be awarded up to, but not exceeding, three times the compensatory damages with the award split 50/50 between the plaintiff and a state-operated quality of care trust fund.

This section provides that the defendant must pay for: interest on accrued damages; the claimant's costs; attorney's fees up to 15 percent of the award; and the costs of arbitration. Liability is not contested and all defendants are jointly and severally liable for the damages assessed by the panel. Either party's offer to arbitrate shall not be admissible as evidence in any subsequent litigation should an offer to arbitrate be rejected. Any offer of arbitration is applicable to all claimants and all defendants and any party that rejects an offer of arbitration is subject to s. 400.0243, F.S.

All three arbitrators must conduct the hearing and a majority of the 3 may make a finding of fact and render a final decision. The chief arbitrator, an administrative law judge from the Division of Administrative Hearings, must decide all evidentiary questions and provide the agency with a copy of the panel's final decision. This section does not preclude settlement at any time by the parties.

Any issue between a defendant and the defendant's insurer must be determined under existing principles of law and the insurer may not offer to arbitrate or accept a claimant's offer to arbitrate without the written consent of the defendant.

This section also creates a process when voluntary binding arbitration is not offered or accepted and provides that arbitration under this part is an alternative to jury trial and does not supersede the right of any party to a jury trial. If neither party requests to arbitration, the claimant may file suit and the claim shall proceed to trial or other available legal alternative. Punitive damages are limited to three times compensatory damages, unless the plaintiff proves to a judge by clear and convincing evidence that the amount above the limit is not excessive. A facility's good record shall be considered a mitigating factor.

If the defendant rejects the claimant's offer of arbitration, the claim shall proceed to trial without any limitation on damages. Current law will apparently govern punitive damages at trial with no division between the plaintiff and a quality of care trust fund.

If the claimant rejects a defendant's offer of arbitration, then the claim shall proceed through the judicial process without limitation upon compensatory damages and punitive damages are limited to three times compensatory damages and must be evenly split between the plaintiff and a state-operated quality of care trust fund.

Finally, this section provides that causes of action pursuant to s. 400.430, F.S., shall be governed by the requirements for presuit screening and investigation provided in ss. 400.0235-.0237, F.S. It also states that arbitration to allocate responsibility when more than one defendant has participated in voluntary binding arbitration, procedures involving misarbitration, payment of an arbitration award, and appeal of an arbitration award shall be governed by the requirements provided in ss. 400.0239-.0242, F.S.

Section 34. Amends section 400.431, F.S., related to the closure of an assisted living facility. This section revises from 30 days to 45 days the notice that must be provided to the residents and to AHCA before the facility ceases operation.

Section 35. Creates section 400.455, F.S., to be known as the "Assisted Living Facility Whistleblower's Act." This section provides protection of employees who report to an appropriate person or agency violations of law that create a specific and substantial danger to a resident's health, safety, or welfare, or who reports allegations of improper use of or gross neglect of duty on the part of a facility. This section provides remedies and relief, it specifies defenses, and declares that it does not diminish other rights, privileges, or remedies of an employee under any other law or rule or under collective bargaining agreement or employment contract.

Section 36. Amends section 400.449, F.S., to prohibit falsifying records in an ALF. Provides that anyone who does so or causes or procures such an action is guilty of a second-degree misdemeanor. A conviction is grounds for restriction, suspension, or termination of the person's license or certification.

Section 37. Amends paragraph (b) of subsection (2) of section 409.908, F.S., modifying the long term care reimbursement plan for nursing homes under the Medicaid program. It creates a direct care subcomponent and an indirect care subcomponent of the patient care component for per diem rate calculations. It limits the direct care subcomponent to only the salaries and employee benefits of direct care staff who provide nursing service. It provides for separate cost-based class ceilings for each patient care subcomponent. It deletes provisions related to interim rate adjustments for the

costs associated with general or professional liability insurance for nursing homes. It also deletes requirements for computing case mix adjustments.

Section 38. Amends section 415.1111, F.S., related to civil actions against a perpetrator of abuse, neglect or exploitation of a vulnerable elderly or disabled person. This section of the bill provides that civil actions under this section of statute do not apply to licensees under parts II and III of chapter 400, F.S.

Section 39. Deletes subsection (3) of section 430.708, F.S., which provides rulemaking authority to the Department of Elderly Affairs (DOEA) related to reducing the number of Medicaid-supported nursing home beds.

Section 40. Amends subsections (2) and (3) of section 430.709, F.S., to require the agency to contract for an independent evaluation of the community diversion pilot projects and specifies questions to be answered by the evaluation contractor and data to be reported by the contractor to the agency and to the legislature. It requires that subsequent to the completion of the evaluation and submission of the report to the legislature, the agency, in consultation with the DOEA, shall make specific recommendations to the legislature as to the feasibility of implementing a managed long term care system statewide.

Section 41. Amends subsection (3) of section 435.04, F.S., to make a technical conforming change.

Section 42. Amends paragraph (a) of subsection (1) of section 464.201, F.S., to add a program offered by Enterprise Florida Jobs and Education Partnership Grant as an approved training program.

Section 43. Adds paragraph (e) of subsection (2) of section 464.2085, F.S., to require the Council on Certified Nursing Assistants under the Board of Nursing to develop special certifications for advanced competence in significant areas of nursing home practice.

Section 44. Amends subsection (1) of section 101.655, F.S., to make a technical and conforming change.

Section 45. Amends subsection (2) of section 397.405, F.S., to make a technical and conforming change.

Section 46. Amends subsection (3) of section 400.0069, F.S., to make a technical and conforming change.

Section 47. Directs the Auditor General to develop and submit to the agency by December 31, 2001, a standard chart of accounts to govern the content and manner of presentation of financial information to be submitted by Medicaid long term care providers in their costs reports. It directs the agency to amend the Florida Title XIX Long-Term Care Reimbursement Plan to incorporate this change.

Section 48. Directs AHCA to amend the Medicaid Title XIX Long-Term Care Reimbursement Plan to include a requirement that cost reports be filed electronically; to provide limitations on certain allowable costs; and to provide for recoupment of Medicaid funds paid to a provider for goods and services that were not delivered.

Section 49. Provides that the Board of Nursing is directed to develop a way to recognize excellent nurses working in long term care.

Section 50. Provides that a portion of each nursing facility's per diem rate paid by Medicaid be used exclusively for wage and benefit increases for nursing home direct care staff.

Sections 51 - 52. Reenacts provisions created by chapter 2000-350, L.O.F.

Section 53. Reenacts provisions created by chapter 2000-350 and section 58 of chapter 2000-367, L.O.F.

Section 54-56. Reenacts provisions created by chapter 2000-350, L.O.F.

Section 57. Reenacts provisions created by chapter 2000-350, and 2000-305, L.O.F.

Section 58. – 61. Reenacts provisions created by chapter 2000-350, L.O.F.

Section 63. Appropriates the sum of $948,782 from the General Revenue Fund to the DOEA for fiscal year 2001-2002, to fund the additional responsibilities of the Office of State Long-Term Care Ombudsman provided under this act including salaries and other administrative expenses.

Section 64. Appropriates the sum of $100,000 from the General Revenue Fund for fiscal year 2001-2002, to fund the additional responsibilities of the Office of the Statewide Public Guardianship for training and for costs associated with providing guardianship services for residents of long term care facilities licensed under chapter 400.

Section 65. Provides that except as otherwise provided, this bill will take effect upon becoming law.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None are projected at this time.

2. Expenditures:

Based on a preliminary analysis by AHCA, the costs to Medicaid to implement the staffing increases are approximately $135.1 million dollars in General Revenue. This analysis is also based on staffing reported ***before*** the Direct Care Staffing Adjustment (authorized in HB 1971) was implemented. There should be an approximate ***$32 million dollar reduction*** in costs if the total amount available was, in fact, used for increasing staff.

The estimates included in these calculations include about $35 million dollars for nursing homes that are operating below the state minimum CNA staffing requirements currently and $1.4 million in GR costs for nursing homes that are operating below the state minimums for nursing staff. The funds for staffing at the required levels have already been accounted for in the budget process and should not be added in here to determine the amount of new money that will be needed to meet the costs associated with the increased staffing requirements proposed in this bill.

These projections are also based on a blended "nursing" rate that counts registered nurses and licensed practical nurses without distinction. The bill proposes specific requirements for each type of nurse. A more refined analysis is likely to change those cost estimates. The break out of federal and General Revenue is as follows:

Hours are per resident/per day	**General Revenue**	**Medicaid Match**	**TOTAL Cost**
Nursing Care at 1.5 hours	$7.2 million	$17.2 million	$24.4 million
CNAs at 2.9 hours	$139.7 million	$165 million	$253 million
TOTAL	$146.9 million	$182.2 million	$278.5 million
Minus $ for facilities not currently at minimum staff	*-$11.8 million*	*-$27.2 million*	*-$35 million*
TOTAL NEW DOLLARS	**$135.1million**	**$155 million**	**$243.5 million**

Costs to DOEA

According to preliminary analysis by the Department of Elder Affairs, the increased ombudsman responsibilities will require additional volunteer ombudsman and additional training for volunteer ombudsmen. The State Long-Term Care Ombudsman has proposed creating 4 additional local councils to serve the most populated Florida regions, converting current OPS staff to FTEs, increasing travel expenditures, increasing training, updating the information system, and adding public education programs. The cost of these changes are as follows:

ITEM	**FTEs**	**COST**
Four additional local councils	4	$308,867
Conversion of current OPS staff	2	$74,469
Additional training resources	1	$415,446
Travel reimbursement	-	$100,000
Public education	0	$ 50,000
TOTAL	**7**	**$948,782**

The Department of Elder Affairs will incur costs under section 13 of the bill for approving dementia-specific training courses and providers.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

A limited fiscal impact is projected for the few nursing facilities that are owned by counties. A more detailed analysis is being prepared by the agency.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

To the extent that staffing enhancements result in costs that nursing facilities cannot absorb within existing resources, private pay and non-public third party payers may experience an increase in the per diem charged by facilities that have to add staff to meet the new standards.

D. FISCAL COMMENTS:

The Agency for Health Care Administration is currently reconciling the data that were submitted to close out the year on the Direct Care Staff Adjustment appropriation provided in the 1999 legislative session. Until that analysis is complete, the agency cannot make final estimates of the costs to Medicaid of increasing the minimum staffing standards. It appears that many nursing homes in the state may already be providing at least 2.4 hours per resident per day of C.N.A. care. According to the Harrington report, the average combined direct care hours per day in the state are approximately 3.3.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

None.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

None.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

None.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

Article I, Section 21 of the Florida Constitution, entitled “Access to courts”, provides that the courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial or delay. In *Kluger v. White,* 281 So.2d 1 (Fla. 1973), the Florida Supreme Court held that:

> [w]here a right of access to the courts for redress for a particular injury has been provided…the Legislature is without power to abolish such a right without providing a reasonable alternative to protect the rights of the people of the State to redress for injuries, unless the Legislature can show an overpowering public necessity for the abolishment of such right, and no alternative method of meeting such public necessity can be shown. (*Kluger,* 281 So.2d at 4.)

The Florida Supreme Court in *Kluger* invalidated a statute that required a minimum of $550 in property damages arising from an automobile accident before a lawsuit could be brought. Based upon the *Kluger* test, the Florida Supreme Court has also invalidated a portion of a tort reform statute that placed a cap on all noneconomic damages because the statute did not provide claimants with a commensurate benefit. *See Smith v. Dept. of Insurance,* 507 So.2d 1080 (Fla. 1987). Thus, the Legislature cannot restrict damages by either enacting a minimum damage amount or a monetary cap on damages without meeting the *Kluger* test. *Id.*

The caps on noneconomic damages in medical malpractice cases, found in ss. 766.207 and 766.209, F.S., have been found by the Florida Supreme Court to meet the *Kluger* test and are not violative of the access to courts provision in the Florida Constitution. In *University of Miami v. Echarte,* 618 So.2d 189 (Fla. 1993), the court ruled that the arbitration scheme met both prongs of the *Kluger* test. First, the court stated that the arbitration scheme provided claimants with a commensurate benefit for the loss of the right to fully recover noneconomic damages as the claimant has the opportunity to receive prompt recovery without the risk and uncertainty of litigation or having to prove fault in a civil trial. Additionally, the claimant benefits from: reduced costs of attorney's and expert witness fees which would be required to prove liability; joint and several liability of multiple defendants; prompt payment of damages after determination by the arbitration panel; interest penalties against the defendant for failure to promptly pay the arbitration award; and limited appellate review of the arbitration award.

Second, the court in *Echarte* ruled that, even if the medical malpractice arbitration statutes did not provide a commensurate benefit, the statutes satisfied the second prong of *Kluger* which requires a legislative finding that an overpowering public necessity exists, and further that no alternative method of meeting such public necessity can be shown. *Echarte,* 618 So.2d at 195. The court found that the Legislature's factual and policy findings of a medical malpractice crisis constituted an overpowering public necessity. *Id.* at 196. The court also ruled that the record supported the conclusion that no alternative or less onerous method existed for meeting the public necessity of ending the medical malpractice crisis. *Id.* at 197. The court stated, "…it is clear that both the arbitration statute, with its conditional limits on recovery of noneconomic damages, and the strengthened regulation of the medical profession are necessary to meet the medical malpractice insurance crisis." *Id.*

When this bill was a proposed committee bill, it contained not only a limitation on the recovery of noneconomic damages in arbitration, it also limited recovery for noneconomic damages at trial. If the bill were to ever be amended to include such a limitation and, if challenged, the courts would scrutinize this limitation based on the rulings in *Kluger* and its progeny. Accordingly, the courts would have to determine whether the bill provided a claimant with a reasonable alternative to the right to recover full noneconomic damages. If not, the courts would look to see whether the bill was a response to an overpowering public necessity and that no alternative method of meeting such public necessity could have been shown. Based on the *Echarte* decision, the crucial factors would be whether the arbitration scheme provides a reasonable alternative to the right to recover full noneconomic damages under the current process and, if not, whether the current insurance situation for nursing homes and assisted living facilities was an overpowering public necessity and that there was no less onerous or alternative method other than the arbitration scheme and the quality of care measures designed to strengthen the regulation of the facilities.

B. RULE-MAKING AUTHORITY:

The agency is authorized to make rules related to consumer satisfaction surveys, distributing and posting of reports, standards for nursing home Medical Directors, and the Gold Seal program.

C. OTHER COMMENTS:

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

VII. SIGNATURES:

COMMITTEE ON ELDER & LONG TERM CARE:

Prepared by:	Staff Director:
Melanie Meyer	Tom Batchelor, Ph.D.

END NOTES

[i] The Reluctant Welfare State: A History of American Social Welfare Policies: Bruce S. Janssen. 1988, California. Page 36-37

[ii] Agency for Healthcare Research and Quality grant number HSO7574. Nursing home staffing and its relationship to deficiencies," by Dr. Harrington, David Zimmerman, and Sarita L. Karon: Journal of Gerontology: Social Sciences 55 (5) pp.S278-S287. Agency for Healthcare Research and Quality (AHRQ) Home Page, formerly the Agency for Health Care Policy and Research. Internet cite: http://www.ahcpr.gov/

[iii] Institute of Medicine, 2000 Study. Improving The Quality Of Long-Term Care. Page 7, quoted in Informational Report of the Task Force on Availability and Affordability of Long-Term Care for the Florida Legislature in Response to House Bill 1993 Volume 1: Synopsis, Executive Summary, Options, Task Force Members' Responses, prepared by the Florida Policy Exchange Center on Aging, University of South Florida, Tampa, FL 33620. February 16, 2001.

[iv] *Ibid*, page 500

[v] *Ibid*

[vi] Page 46 Task Force: Historically, nursing homes and other long-term care providers have been paid for the services they provide from three major sources. Patient/Residents pay for services through their own means.

[vii] Article by Toby Edelman, esq. published by the National Senior Citizen's Law Center, based on testimony provided to the U.S. Senate Select Committee on Aging.

[viii] Nursing Homes: Aggregate Medicare Payments Are Adequate Despite Bankruptcies. Testimony, 09/05/2000, to Senate Select Committee on Aging, by General Accounting Office, (GAO/T-HEHS-00-192);

[ix] Ibid.