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**HOUSE OF REPRESENTATIVES  
AS FURTHER REVISED BY THE  
FISCAL RESPONSIBILITY COUNCIL  
ANALYSIS**

**BILL #:** CS/HB 1879 (PCB ELT 01-01)  
**RELATING TO:** Long-Term Care  
**SPONSOR(S):** Fiscal Responsibility Council; Committee on Elder & Long-Term Care and Representative Green  
**TIED BILL(S):** HB 1881

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

- (1) ELDER & LONG-TERM CARE YEAS 13 NAYS 0
- (2) COUNCIL FOR READY INFRASTRUCTURE YEAS 19 NAYS 0
- (3) COUNCIL FOR HEALTHY COMMUNITIES YEAS 15 NAYS 0
- (4) FISCAL RESPONSIBILITY COUNCIL YEAS 19 NAYS 2
- (5)

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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 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.

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.

Provisions are made to evaluate the Managed Care Community Diversion Projects.

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

CS/HB 1879 has a fiscal impact need of \$23,648,763 in General Revenue funds and \$27,206,735 in Medicaid matching funds. The House proposed appropriations bill has \$20,100,000 in General Revenue funds and \$26,100,000 in Medicaid matching funds in support of nursing home quality improvement.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

- |                                   |   |                             |   |
|-----------------------------------|---|-----------------------------|---|
| 1. <u>Less Government</u>         | Yes <input type="checkbox"/>            | No <input type="checkbox"/> | N/A <input checked="" type="checkbox"/> |
| 2. <u>Lower Taxes</u>             | Yes <input type="checkbox"/>            | No <input type="checkbox"/> | N/A <input checked="" type="checkbox"/> |
| 3. <u>Individual Freedom</u>      | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/>            |
| 4. <u>Personal Responsibility</u> | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/>            |
| 5. <u>Family Empowerment</u>      | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/>            |

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.<sup>1</sup>

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 are increasing. 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 have 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 (AHRQ) examined the data reported by all nursing homes to the Federal Health Care Financing Administration (HCFA) to identify deficiencies in nursing home care. <sup>ii</sup>

**Percent of Nursing Homes Cited for Staffing Deficiencies**

| <b>YEAR</b> | <b>% NATIONAL</b> | <b>% FLORIDA</b> |
|-------------|-------------------|------------------|
| 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 and from the importance of maximizing function and productivity.<sup>iii</sup> 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**

|                         | <b>1995</b> | <b>1996</b> | <b>1997</b> | <b>1998</b> |
|-------------------------|-------------|-------------|-------------|-------------|
| <b>National Average</b> | 8.1%        | 8.1%        | 8.3%        | 8.1%        |
| <b>Florida Average</b>  | 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 AHRQ and during the eight month study period, the facility had savings of more than \$230,000 for the prevention program versus treatment costs.

| <b>TYPE CITATION</b> | <b>NATIONAL %</b> | <b>FLORIDA %</b> |
|----------------------|-------------------|------------------|
| 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 there from. 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**

| <b>Indicator</b>          | <b>National %</b> | <b>Florida %</b> |
|---------------------------|-------------------|------------------|
| 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<sup>iv</sup>

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.”<sup>v</sup>

### **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.<sup>vi</sup>

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.”<sup>vii</sup> 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.*<sup>viii</sup>

### 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."<sup>ix</sup>

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. 4<sup>th</sup> 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 and 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. All facilities are required to establish a resident grievance resolution process.

Staffing

Requirements for direct care staff are provided in statute and enhanced to a total of 2.6 hours per resident per day for certified nursing assistants. The bill improves the qualifications for facility's medical directors.

D. SECTION-BY-SECTION ANALYSIS:

**Section 1.** Amends section 400.0073, F.S., to direct a member of an ombudsman council who is in a nursing facility to investigate a resident's complaint or to conduct an inspection to verify and record the number of residents and 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. Provisions are effective January 1, 2002.

**Section 4:** Substantially revises s. 400.023, F.S., providing for civil enforcement of resident's rights. A negligence standard is incorporated for all causes of action brought pursuant to this section for a violation of the resident's rights or negligence. The section provides that a licensee, person or entity has a duty to exercise reasonable care, which is that degree of care a reasonably careful licensee, person, or entity would use under like circumstances. A nurse licensed under Part I of chapter 464, F.S., has a duty to exercise care consistent with the prevailing professional standard of care for a nurse. A violation of any right contained in s. 400.022, F.S., is evidence of negligence, but does not constitute negligence per se or strict liability. An action alleging a claim for resident's rights or negligence that caused the death of the resident requires the claimant to elect either survival damages pursuant to s. 46.021, F.S., or wrongful death damages pursuant to s. 768.21, F.S. A resident who prevails in seeking injunctive relief or a claim for an administrative remedy is entitled to recover costs, and attorney's fees not to exceed \$25,000. This section eliminates the recovery of attorney's fees for cases involving injury or death. This section expressly provides that the medical malpractice provisions of chapter 766, F.S., do not apply. This section applies to causes of action accruing on or after July 1, 2001.

**Section 5:** Creates s. 400.0233, F.S., to provide for presuit investigation, notification, discovery, and mediation requirements. Prior to bringing a lawsuit, the claimant's attorney must conduct a reasonable investigation that gives rise to a good faith belief that grounds exist for an action against a defendant. The attorney is required to provide each prospective defendant with written notification of the asserted claim, identifying the rights that were violated and the negligence that caused the incident and injuries. After receiving notice of the claim, the defendant must conduct an investigation to evaluate the potential liability and damages. The investigation must be completed no later than 75 days after receipt of the notice. The statute of limitations is tolled during the 75-day investigation period. During the investigation, the parties may engage in informal discovery, which includes the production of records and documents, as well as the taking of unsworn statements of parties. The discovery materials generated by this presuit process are not discoverable or admissible in any civil action, for any purpose, by the opposing party. Upon completing its presuit investigation, a defendant can reject the claim or make a settlement offer. If the defendant makes an offer, the claimant has 15 days from the date of the receipt of the offer to accept it by written notice. If the defendant rejects the claim or the claimant does not accept an offer from the defendant, the parties must meet in mediation within 30 days of the defendant's response to the

claim. This section is effective July 1, 2001, and applies to causes of action accruing on or after that date.

**Section 6:** Creates s. 400.0234, F.S., to provide that failure to furnish complete copies of a resident's records, including all medical records, which are in the possession and control of a facility, shall constitute evidence of a failure of that party to comply with good faith discovery requirements and shall waive the good faith certificate and presuit notice requirements for the requesting party.

**Section 7.** Creates s. 400.0235, F.S., to expressly provide that any claim for long-term care facility negligence is not a claim for medical malpractice and that the provisions of s. 768.21(8), F.S., do not apply to a claim alleging the death of a resident.

**Section 8.** Creating s. 400.0236, F.S., to provide a statute of limitations. Actions for long-term care facility negligence must be commenced within 2 years from the time the incident occurred or within 2 years from the time the incident is discovered or should have been discovered with the exercise of due diligence. However, the action may not be brought later than 4 years from the date of the incident or occurrence. When it can be shown that fraudulent concealment or intentional misrepresentation of fact prevented the discovery of the injury, the period of limitations is extended forward 2 years from the time the injury is discovered with the exercise of due diligence, but in no event to exceed 6 years from the date of the incident. This section applies to causes of action that have accrued prior to the effective date of this act. However, a savings clause is instituted to preserve those claims that would not have been barred under prior law.

**Section 9.** Creating s. 400.0237, F.S., to provide standards relating to the pleading and recovery of punitive damages. To recover punitive damages, a claimant must prove by clear and convincing evidence that a defendant was personally guilty of intentional misconduct or gross negligence, as those terms are defined in this section. An employer will be responsible for punitive damages resulting from an employee's conduct only if: (1) the employer actively and knowingly participated in the employee's conduct; (2) the officers, directors, or managers of the employer knowingly condoned, ratified, or consented to the employee's conduct; or (3) the employer engaged in conduct that constitutes gross negligence that contributed to the loss, damages, or injury suffered by the claimant. The "greater weight of the evidence" standard applies to the amount of punitive damages. This section is remedial in nature and takes effect upon becoming law.

**Section 10.** Creates s. 400.0238, F.S., to provide limitations on punitive damages. This section provides that punitive damages are generally limited to three times compensatory damages or \$1,000,000 which ever is greater. However, there is no cap on the punitive damages if: (1) the defendant's conduct is found beyond a reasonable doubt to have been motivated primarily by unreasonable financial gain and that the unreasonably dangerous nature of the conduct, together with the high likelihood of injury resulting from the conduct, was actually known by the defendant or (2) at the time of injury the defendant had a specific intent to harm the claimant and the conduct did in fact harm the claimant. This section is remedial in nature and takes effect upon becoming law.

**Section 11.** Amends s. 768.735, F.S., relating to exceptions to punitive damages standards in certain sections of ch. 768, F.S., to conform this section with changes made by this act. This section is remedial in nature and takes effect upon becoming law.

**Section 12.** Amends s. 415.1111, F.S., relating to civil actions for abuse, neglect or exploitation of vulnerable adults, to provide that it does not apply to any licensee or entity who establishes, controls, conducts, manages, or operates a nursing home or assisted living facility.



**Section 13.** 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 14.** Amends section 400.102, F.S., to add subsections related to the grounds on which the agency can take action against a licensee to include (e) the fraudulent altering, defacing, or falsifying of any nursing home record or causing or procuring any of these offenses; (f) a demonstrated pattern of deficient practice; (g) failure to pay outstanding fines; (h) exclusion from Medicare and Medicaid programs.

**Section 15.** 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 catheterization, 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 assisting 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 16.** Creates section 400.1183, F.S., "Resident Grievance and 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 may investigate any grievance at any time. The agency may impose administrative sanctions.

**Section 17.** 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 18.** 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, vacant beds, and settlements, judgments, or civil verdicts related to medical negligence, wrongful death or violations of residents' rights.

**Section 19.** 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 20.** 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 or reasonably suspects that any fraudulent alteration, falsification or defacement has been committed.

**Section 21.** 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 22.** 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 23.** Amends subsection (2) of and adds subsection (4) to 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 24.** Amends subsections (2), (3), (7), and (8) of section 400.23, F.S., and adds subsections (10) and (11). 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 25.** Amends subsection (3) of section 400.241, F.S., to make a technical change.

**Section 27.** Amends paragraph (b) of subsection 400.407(3), F.S., to make a technical and conforming change.

**Section 27.** 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 28.** 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 29.** Substantially revises s. 400.429, F.S., relating to civil actions to enforce assisted living facility resident's rights. A negligence standard is incorporated for all causes of action brought pursuant to this section for a violation of the resident's rights or negligence. The section provides that a licensee, person or entity has a duty to exercise reasonable care, which is that degree of care a reasonably careful licensee, person, or entity would use under like circumstances. A nurse licensed under Part I of chapter 464, F.S., has a duty to exercise care consistent with the prevailing professional standard of care for a nurse. A violation of any right contained in s. 400.428, F.S., is evidence of negligence, but does not constitute negligence per se or strict liability. An action alleging a claim for resident's rights or negligence that caused the death of the resident requires the claimant to elect either survival damages pursuant to s. 46.021, F.S., or wrongful death damages pursuant to s. 768.21, F.S. A resident who prevails in seeking injunctive relief or a claim for an administrative remedy is entitled to recover costs, and attorney's fees not to exceed \$25,000. This section eliminates the recovery of attorney's fees for cases involving injury or death. This section expressly provides that the medical malpractice provisions of chapter 766, F.S., do not apply. The resident, upon filing a complaint with the clerk of court, shall provide a copy of such complaint with the Agency for Health Care Administration. This section applies to causes of action accruing on or after July 1, 2001.

**Section 30.** Creates s. 400.4293, F.S., to provide presuit notice, investigation, discovery, and mediation requirements. Prior to bringing a lawsuit, the claimant's attorney must conduct a reasonable investigation that gives rise to a good faith belief that grounds exist for an action against a defendant. The attorney is also required to provide each prospective defendant with written notification of the asserted claim, which must identify the rights that were violated and the negligence that caused the incident and injuries. After receiving notice of the claim, the defendant must conduct an investigation to evaluate the potential liability and damages. The investigation must be completed no later than 75 days after receipt of the notice. The statute of limitations is tolled during the 75-day investigation period. During the investigation, the parties may engage in informal discovery, which includes the production of records and documents, as well as the taking of unsworn statements of parties. The discovery materials generated by this presuit process are not discoverable or admissible in any civil action, for any purpose, by the opposing party. Upon completing its presuit investigation, a defendant can reject the claim or make a settlement offer. If the defendant makes an offer, the claimant has 15 days from the date of the receipt of the offer to accept it by written notice. If the defendant rejects the claim or the claimant does not accept an offer from the defendant, the parties must meet in mediation within 30 days of the defendant's response to the claim. This section is effective July 1, 2001, and applies to causes of action accruing on or after that date.

**Section 31.** Creates s. 400.4294, F.S., to provide that failure to furnish complete copies of a resident's records, including all medical records, which are in the possession and control of a facility, shall constitute evidence of a failure of that party to comply with good faith discovery requirements and shall waive the good faith certificate and presuit notice requirements for the requesting party.

**Section 32.** Creates s. 400.4295, F.S., to expressly provide that a claim for long-term care facility negligence is not a claim for medical malpractice and that the provisions of s. 768.21(8), F.S., do not apply to a claim alleging the death of a resident.

**Section 33.** Creates s. 400.4296, F.S., to provide a statute of limitations. Actions for long-term care facility negligence must be commenced within 2 years from the time the incident occurred or within 2 years from the time the incident is discovered or should have been discovered with the exercise of due diligence. However, the action may not be brought later than 4 years from the date of the incident or occurrence. When it can be shown that fraudulent concealment or intentional misrepresentation of fact prevented the discovery of the injury, the period of limitations is extended forward 2 years from the time the injury is discovered with the exercise of due diligence, but in no event to exceed 6 years from the date of the incident. This section applies to causes of action that have accrued prior to the effective date of this act. However, a savings clause is instituted to preserve those claims that would not have been barred under prior law.

**Section 34.** Creating s. 400.0237, F.S., to provide standards relating to the pleading and recovery of punitive damages. To recover punitive damages, a claimant must prove by clear and convincing evidence that a defendant was personally guilty of intentional misconduct or gross negligence, as those terms are defined in this section. An employer will be responsible for punitive damages resulting from an employee's conduct only if: (1) the employer actively and knowingly participated in the employee's conduct; (2) the officers, directors, or managers of the employer knowingly condoned, ratified, or consented to the employee's conduct; or (3) the employer engaged in conduct that constitutes gross negligence that contributed to the loss, damages, or injury suffered by the claimant. The "greater weight of the evidence" standard applies to the amount of punitive damages. This section is remedial in nature and takes effect upon becoming law.

**Section 35.** Creates s. 400.0238, F.S., to provide limitations on punitive damages. This section provides that punitive damages are generally limited to three times compensatory damages or \$1,000,000 which ever is greater. However, there is no cap on the punitive damages if: (1) the defendant's conduct is found beyond a reasonable doubt to have been motivated primarily by unreasonable financial gain and that the unreasonably dangerous nature of the conduct, together with the high likelihood of injury resulting from the conduct, was actually known by the defendant or (2) at the time of injury the defendant had a specific intent to harm the claimant and the conduct did in fact harm the claimant. This section is remedial in nature and takes effect upon becoming law.

**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.** 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 38.** 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 39.** Amends subsection (3) of section 435.04, F.S., to make a technical conforming change.

**Section 40.** 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 41.** 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 42.** Amends subsection (1) of section 101.655, F.S., to make a technical and conforming change.

**Section 43.** Amends subsection (2) of section 397.405, F.S., to make a technical and conforming change.

**Section 44.** Amends subsection (3) of section 400.0069, F.S., to make a technical and conforming change.

**Section 45.** 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 46.** 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 47.** Provides that the Board of Nursing is directed to develop a way to recognize excellent nurses working in long-term care.

**Section 48.** 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.

**Section 49.** Reenacts provisions created by chapter 2000-350, L.O.F., related to definitions.

**Section 50.** Reenacts provisions created by chapter 2000-350, L.O.F., related to consumer satisfaction surveys.

**Section 51.** Reenacts provisions created by chapter 2000-350, L.O.F., related to resident transfer or discharge.

**Section 52.** Reenacts provisions created by chapter 2000-350, L.O.F., related to administration and management of nursing home facilities.

**Section 53.** Reenacts provisions created by chapter 2000-350, L.O.F., related to reports and records.

**Sections 54-58.** Reenacts provisions created by chapter 2000-350, L.O.F., related to licensure.

**Section 59.** Reenacts a provision created by chapter 2000-350, L.O.F., related to feasibility study on using automated medication dispensing machines in nursing homes.

**Section 60.** Provides legislative intent on reenactment of certain provisions of the act.

**Section 61.** Continues the requirement for background screening .

**Section 62.** Provides that provisions of the act are contingent upon specific appropriations in the General Appropriations Act for such purposes.

**Section 63.** 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:

According to the Agency for Health Care Administration's analysis, the following expenditures are required:

|  | GR         | TF         | TOTAL      | FTE  |
|--|------------|------------|------------|------|
| Nursing Home Risk Management               |            |            |            |      |
| Reporting Requirements                     | 435,962    | 209,908    | 645,870    | 3.0  |
| Facilities Investigation                   | 575,023    | -          | 575,023    | 11.0 |
| Health Care Practitioners Investigation    | 688,018    | -          | 688,018    | 11.5 |
| CNA In-Service Training                    | 1,936,837  | 2,510,549  | 4,447,386  | -    |
| CNA Staffing Hours                         | 18,601,349 | 24,111,278 | 42,712,627 | -    |
| Independent Evaluation of Waiver           | 125,000    | 125,000    | 250,000    | -    |
| Electronic Filing of Medicaid Cost Reports | 250,000    | 250,000    | 500,000    | -    |
| Increased Fine Authority                   | 87,792     | -          | 87,792     | 2.0  |

|       |            |            |            |      |
|-------|------------|------------|------------|------|
|       |            |            |            |      |
| TOTAL | 22,699,981 | 27,206,735 | 49,906,716 | 27.5 |

According to the Department of Elderly Affairs' analysis, the following expenditures for the State Long-Term Care Ombudsman Council are required"

|                                | GR      | FTE |
|--------------------------------|---------|-----|
| Four Additional Local Councils | 308,867 | 4.0 |
| Conversion of OPS Staff        | 74,469  | 2.0 |
| Training Resources             | 415,446 | 1.0 |
| Travel Reimbursement           | 100,000 |     |
| Public Education               | 50,000  |     |
| TOTAL                          | 948,782 | 7.0 |

**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.

**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:**

HB 1807, the House General Appropriations Act, includes \$20,100,000 in General Revenue Funds and \$26,100,000 in matching Medicaid funds for nursing home quality improvement to implement this legislation.

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

**A. APPLICABILITY OF THE MANDATES PROVISION:**

This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds.

**B. REDUCTION OF REVENUE RAISING AUTHORITY:**

This bill does not reduce the authority that municipalities or counties have to raise revenues in the aggregate.

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

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

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.*



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:

N/A

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On April 24, 2001 the Fiscal Responsibility Council adopted 18 amendments to the bill or amendments traveling with the bill and reported HB 1879 as a committee substitute.

VII. SIGNATURES:

COMMITTEE ON ELDER & LONG-TERM CARE:

Prepared by:

Melanie Meyer

Staff Director:

Tom Batchelor, Ph.D.

AS REVISED BY THE COUNCIL FOR READY INFRASTRUCTURE:

Prepared by:

Randy L. Havlicak

Council Director:

Thomas J. Randle

AS FURTHER REVISED BY THE COUNCIL FOR HEALTHY COMMUNITIES:

Prepared by:

Melanie Meyer

Council Director:

Mary Pat Moore

AS FURTHER REVISED BY THE FISCAL RESPONSIBILITY COUNCIL:

Prepared by:

Stephanie Massengale

Council Director:

David Coburn

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END NOTES

<sup>i</sup> 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*.