By Senator Campbell

32-916C-05

A bill to be entitled

An act relating to nursing home facilities; amending s. 400.021, F.S.; defining additional terms related to nursing home facilities; amending s. 400.023, F.S.; requiring a resident or the resident's legal representative to include a certificate of compliance when a complaint alleging a violation of a resident's rights is filed with the clerk of court; amending s. 400.0233, F.S.; requiring that the presuit notice of a claim against a nursing home facility be given to each prospective defendant; requiring that certain specified information be included with the notice; providing that a defendant may request voluntary binding arbitration; authorizing the parties to toll designated time periods in order to mediate issues of liability and damages; amending s. 400.0234, F.S.; specifying that failing to provide certain records waives certain requirements; creating s. 400.02342, F.S.; providing that any party may elect to participate in voluntary binding arbitration; providing procedures to initiate and conduct a voluntary binding arbitration; requiring that a claimant agree to a damage award; providing exceptions and limitations; authorizing the Division of Administrative Hearings to adopt rules; authorizing the division to levy specified sanctions; authorizing the division to charge a party requesting binding

arbitration an administrative fee; permitting the parties to use private arbitrators; creating s. 400.02343, F.S.; requiring multiple defendants to a binding arbitration proceeding to apportion a damage award through a second arbitration proceeding; providing arbitration procedures for apportioning damage awards; providing that a participant has a cause of action for contribution from other defendants; creating s. 400.02344, F.S.; providing consequences for a claimant or defendant that fails to offer or rejects an offer to participate in binding arbitration; prescribing limitations if a party wishes to proceed to trial; creating s. 400.02345, F.S.; providing procedures for determining if a specific claim is subject to binding arbitration; creating s. 400.02347, F.S.; requiring a defendant to pay a damage award within a specified time period; creating s. 400.02348, F.S.; providing for an appeal of an arbitration or apportionment award; providing that an appeal does not stay an arbitration or apportionment award; permitting a party to an arbitration or apportionment proceeding to enforce an arbitration award or an apportionment of financial responsibility; providing enforcement procedures; providing exceptions; amending s. 400.141, F.S.; requiring a nursing home facility to maintain general and professional liability insurance with specified insurance

carriers; providing alternative methods to establish financial responsibility for claims filed against the nursing home; directing that the amount of financial responsibility be increased by the annual rate of inflation; providing exceptions; amending s. 400.151, F.S.; providing criteria for a resident's contract which include arbitration or dispute-resolution provisions; requiring prominent notice of arbitration provisions; requiring notice of which claims are subject to arbitration; amending s. 409.907, F.S.; prohibiting the Agency for Health Care Administration from renewing a Medicaid provider agreement with a chronically poor-performing nursing home facility after a specified date; providing that a chronically poor-performing nursing home facility may not participate in voluntary binding arbitration after a specified date; amending s. 409.908, F.S.; deleting obsolete provisions; requiring the agency to recognize increases in the costs of professional liability insurance by providing a pass-through of professional liability insurance in a specified amount; authorizing the agency to impose an assessment fee for quality assurance; amending s. 400.147, F.S.; conforming a cross-reference; reenacting s. 430.80(3)(h), F.S., relating to a teaching nursing home pilot project, to incorporate the amendment made to s. 400.141, F.S., in a

reference thereto; requiring that arbitration limits be adjusted annually for inflation; providing legislative intent that the Agency for Health Care Administration not renew a Medicaid provider agreement with a nursing home facility that has a pattern of harming its residents; directing the agency to consult with certain specified private organizations to identify and improve poor-performing nursing homes; requiring the agency to prepare a report of the Medicaid Up-or-Out Program; providing legislative intent that a study be conducted by the Institute on Aging at the University of South Florida of all federal and state enforcement sanctions and remedies available to the agency to use with nursing home facilities; providing the subjects to be studied; requiring that a report of the findings of the study be submitted by a specified date; requiring the Agency for Health Care Administration to establish a health care quality improvement system for nursing home facilities; providing guidelines; requiring each nursing home facility to pay an annual assessment on each licensed bed after a specified date; providing for the use of the funds collected; providing a method by which the assessment will be determined; providing for nonseverability; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 400.021, Florida Statutes, is amended to read:

400.021 Definitions.--When used in this part, unless the context otherwise requires, the term:

(1) "Administrator" means the licensed individual who has the general administrative charge of a facility.

(2) "Agency" means the Agency for Health Care Administration, which is the licensing agency under this part.

(3) "Bed reservation policy" means the number of consecutive days and the number of days per year that a resident may leave the nursing home facility for overnight therapeutic visits with family or friends or for hospitalization for an acute condition before the licensee may discharge the resident due to his or her absence from the facility.

(4) "Board" means the Board of Nursing Home Administrators.

(5) "Claim for resident's rights violation or negligence" means a negligence claim alleging injury to or the death of a resident arising out of an asserted violation of the rights of a resident under s. 400.022 or an asserted deviation from the applicable standard of care. At the time of the filing of the notice of claim and based on information provided to the claimant or claimant's representative, all known incidents,regardless of origin, alleged to have caused injury or damages to the resident must be included. This subsection does not abrogate the rights of parties to amend claims subject to the Florida Rules of Civil Procedure. No further presuit requirement will be applicable if the new information should have been provided to the claimant or the claimant's representative.

(6) "Claimant" means a person, including a decedent's estate, filing a claim for a violation of the rights of a resident or negligence under this chapter. All persons claiming to have sustained damages as a result of the bodily injury or death of a resident are considered a single claimant with the exception of minor children.

(7)~~(5)~~ "Controlling interest" means:

(a) The applicant for licensure or a licensee;

(b) A person or entity that serves as an officer of, is on the board of directors of, or has a 5 percent or greater ownership interest in the management company or other entity, related or unrelated, which the applicant or licensee may contract with to operate the facility; or

(c) A person or entity that serves as an officer of, is on the board of directors of, or has a 5 percent or greater ownership interest in the applicant or licensee.

The term does not include a voluntary board member.

(8)~~(6)~~ "Custodial service" means care for a person which entails observation of diet and sleeping habits and maintenance of a watchfulness over the general health, safety, and well-being of the aged or infirm.

(9)~~(7)~~ "Department" means the Department of Children and Family Services.

(10) "Economic damages" means a financial loss that would not have occurred but for the injury giving rise to that cause of action. The term includes, but is not limited to, past and future medical expenses, 80 percent of the claimant's wage loss, and the loss of earning capacity to the extent the claimant is entitled to recover these damages under general

law, including the Wrongful Death Act, s. 46.021, or s. 400.023.

(11)~~(8)~~ "Facility" means any institution, building, residence, private home, or other place, whether operated for profit or not, including a place operated by a county or municipality, which undertakes through its ownership or management to provide for a period exceeding 24-hour nursing care, personal care, or custodial care for three or more persons not related to the owner or manager by blood or marriage, who by reason of illness, physical infirmity, or advanced age require such services, but does not include any place providing care and treatment primarily for the acutely ill. A facility offering services for fewer than three persons is within the meaning of this definition if it holds itself out to the public to be an establishment which regularly provides such services.

(12) "Financial responsibility" means demonstrating the minimum financial responsibility requirements as provided in s. 400.141(20).

(13)~~(9)~~ "Geriatric outpatient clinic" means a site for providing outpatient health care to persons 60 years of age or older, which is staffed by a registered nurse or a physician assistant.

(14)~~(10)~~ "Geriatric patient" means any patient who is 60 years of age or older.

(15) "Incident" means any event, action, or conduct alleged to have caused injury or damages to the resident while in the control of the facility.

(16) "Insurer" means any self-insurer authorized under s. 627.357, liability insurance carrier, joint underwriting association, or uninsured prospective defendant.

(17)~~(11)~~ "Local ombudsman council" means a local long-term care ombudsman council established under ~~pursuant to~~ s. 400.0069, located within the Older Americans Act planning and service areas.

(18) "Noneconomic damages" means nonfinancial losses that would not have occurred but for the injury giving rise to the cause of action, including bodily injury, pain and suffering, disability, scarring, inconvenience, physical impairment, mental anguish, disfigurement, loss of capacity for enjoyment of life, and other nonfinancial losses to the extent the claimant is entitled to recover such damages under general law, including such noneconomic damages under the Wrongful Death Act, s. 46.021, or s. 400.023.

(19)~~(12)~~ "Nursing home bed" means an accommodation which is ready for immediate occupancy, or is capable of being made ready for occupancy within 48 hours, excluding provision of staffing; and which conforms to minimum space requirements, including the availability of appropriate equipment and furnishings within the 48 hours, as specified by rule of the agency, for the provision of services specified in this part to a single resident.

(20)~~(13)~~ "Nursing home facility" means any facility which provides nursing services as defined in part I of chapter 464 and which is licensed according to this part.

(21)~~(14)~~ "Nursing service" means such services or acts as may be rendered, directly or indirectly, to and in behalf of a person by individuals as defined in s. 464.003.

(22)~~(15)~~ "Planning and service area" means the geographic area in which the Older Americans Act programs are administered and services are delivered by the Department of Elderly Affairs.

(23)~~(16)~~ "Respite care" means admission to a nursing home for the purpose of providing a short period of rest or relief or emergency alternative care for the primary caregiver of an individual receiving care at home who, without home-based care, would otherwise require institutional care.

(24)~~(17)~~ "Resident care plan" means a written plan developed, maintained, and reviewed not less than quarterly by a registered nurse, with participation from other facility staff and the resident or his or her designee or legal representative, which includes a comprehensive assessment of the needs of an individual resident; the type and frequency of services required to provide the necessary care for the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being; a listing of services provided within or outside the facility to meet those needs; and an explanation of service goals. The resident care plan must be signed by the director of nursing or another registered nurse employed by the facility to whom institutional responsibilities have been delegated and by the resident, the resident's designee, or the resident's legal representative. The facility may not use an agency or temporary registered nurse to satisfy the foregoing requirement and must document the institutional responsibilities that have been delegated to the registered nurse.

(25)~~(18)~~ "Resident designee" means a person, other than the owner, administrator, or employee of the facility, designated in writing by a resident or a resident's guardian, if the resident is adjudicated incompetent, to be the resident's representative for a specific, limited purpose.

(26)~~(19)~~ "State ombudsman council" means the State Long-Term Care Ombudsman Council established under ~~pursuant to~~ s. 400.0067.

(27)~~(20)~~ "Voluntary board member" means a director of a not-for-profit corporation or organization who serves solely in a voluntary capacity for the corporation or organization, does not receive any remuneration for his or her services on the board of directors, and has no financial interest in the corporation or organization. The agency shall recognize a person as a voluntary board member following submission of a statement to the agency by the director and the not-for-profit corporation or organization which affirms that the director conforms to this definition. The statement affirming the status of the director must be submitted to the agency on a form provided by the agency.

Section 2. Subsections (4) and (6) of section 400.023, Florida Statutes, are amended to read:

400.023 Civil enforcement.--

(4) A licensee is liable for ~~In~~ any claim for resident's rights violation or negligence by a nurse licensed under part I of chapter 464 who is practicing under the direction of the licensee. The~~, such~~ nurse shall have the duty to exercise care consistent with the prevailing professional standard of care for a nurse. The prevailing professional standard of care for a nurse shall be 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 nurses.

(6) The resident or the resident's legal representative shall serve a copy of any complaint alleging in whole or in part a violation of any rights specified in this

part to the Agency for Health Care Administration at the time of filing the initial complaint with the clerk of the court for the county in which the action is pursued. The initial complaint must contain a certificate certifying compliance with this subsection. The requirement of providing a copy of the complaint to the agency and certifying compliance with this subsection does not impair the resident's legal rights or ability to seek relief for his or her claim.

Section 3. Section 400.0233, Florida Statutes, is amended to read:

400.0233 Presuit notice; investigation; notification of violation of resident's rights or alleged negligence; claims evaluation procedure; informal discovery; review; settlement offer; mediation.--

~~(1) As used in this section, the term:~~

~~(a) "Claim for resident's rights violation or negligence" means a negligence claim alleging injury to or the death of a resident arising out of an asserted violation of the rights of a resident under s. 400.022 or an asserted deviation from the applicable standard of care.~~

~~(b) "Insurer" means any self insurer authorized under s. 627.357, liability insurance carrier, joint underwriting association, or uninsured prospective defendant.~~

(1)~~(2)~~ A claimant's initial notice ~~Prior to filing a claim for a violation of a resident's rights or a claim for negligence, a claimant~~ alleging injury to or the death of a resident shall be provided to ~~notify~~ each prospective defendant by certified mail, return receipt requested, asserting a ~~of an asserted~~ violation of a resident's rights provided in s. 400.022 or deviation from the standard of care. The ~~Such~~ notification must be made before filing a claim and

it must ~~shall~~ include an identification of the rights the prospective defendant has violated and the negligence alleged to have caused the incident or incidents and a brief description of the injuries sustained by the resident which are reasonably identifiable at the time of notice. The notice shall contain a certificate of counsel that counsel's reasonable investigation gave rise to a good faith belief that grounds exist for an action against each prospective defendant. The notice of intent must contain a medical-information release that allows a defendant, or his or her legal representative, to obtain all medical records potentially relevant to the claimant's alleged injury, including all records of nonparty care, death certificates, autopsy records, and other records related to the claim. If the initial notice of claim does not contain a medical release as required in this subsection, the time for the defendant to submit a written response under paragraph (2)(b) is tolled until the release is given to the defendant. Once the defendant receives the release from the claimant, the defendant has the remainder of the 75-day time period in which to exercise the options described in paragraph (b).

(2)(a)~~(3)(a)~~ A ~~No~~ suit may not be filed for a period of 75 days after notice is mailed to any prospective defendant. During the 75-day period, the prospective defendants or their insurers shall conduct an evaluation of the claim to determine the liability of each defendant and to evaluate the damages of the claimants. Each defendant or insurer of the defendant shall have a procedure for the prompt evaluation of claims during the 75-day period. The procedure must ~~shall~~ include one or more of the following:

1. Internal review by a duly qualified facility risk manager or claims adjuster;

2. Internal review by counsel for each prospective defendant;

3. A quality assurance committee authorized under any applicable state or federal statutes or regulations; or

4. Any other similar procedure that fairly and promptly evaluates the claims.

Each defendant or insurer of the defendant shall evaluate the claim in good faith.

(b) At or before the end of the 75 days, the defendant or insurer of the defendant shall provide the claimant with a written response:

1. Rejecting the claim; ~~or~~

2. Making a settlement offer<u>; or</u>

<u>3. Making an offer to voluntarily arbitrate under s. 400.02342 in which liability is admitted and binding arbitration is conducted only on the issue of damages. The offer to arbitrate may be made contingent upon limiting general damages. A request for voluntary binding arbitration does not prevent the parties from continued settlement discussions or settlement offers</u>.

(c) The response shall be delivered to the claimant if not represented by counsel or to the claimant's attorney, by certified mail, return receipt requested. Failure of the prospective defendant or insurer of the defendant to reply to the notice within 75 days after receipt <u>is</u> ~~shall be~~ deemed a rejection of the claim for purposes of this section.

<u>(3)</u>~~(4)~~ The notification of a violation of a resident's rights or alleged negligence shall be served within the

applicable statute of limitations period; however, during the 75-day period, the statute of limitations is tolled as to all prospective defendants. Upon stipulation by the parties, the 75-day period may be extended and the statute of limitations is tolled during any ~~such~~ extension. Upon receiving written notice by certified mail, return receipt requested, of termination of negotiations in an extended period, the claimant has ~~shall have~~ 60 days or the remainder of the period of the statute of limitations, whichever is greater, within which to file suit.

(4)~~(5)~~ No statement, discussion, written document, report, or other work product generated by presuit claims evaluation procedures under this section is discoverable or admissible in any civil action for any purpose by the opposing party. All participants, including, but not limited to, physicians, investigators, witnesses, and employees or associates of the defendant, are immune from civil liability arising from participation in the presuit claims evaluation procedure. Any licensed physician or registered nurse may be retained by either party to provide an opinion regarding the reasonable basis of the claim. The presuit opinions of the expert are not discoverable or admissible in any civil action for any purpose by the opposing party.

(5)~~(6)~~ Upon receipt by a prospective defendant of a notice of claim, the parties shall make discoverable information available without formal discovery as provided in subsection(6)~~(7)~~.

(6)~~(7)~~ Informal discovery may be used by a party to obtain unsworn statements and the production of documents or things as follows:

(a) Unsworn statements.--Any party may require other parties to appear for the taking of an unsworn statement. These ~~Such~~ statements may be used only for the purpose of claims evaluation and are not discoverable or admissible in any civil action for any purpose by any party. A party seeking to take the unsworn statement of any party must give reasonable notice in writing to all parties. The notice must state the time and place for taking the statement and the name and address of the party to be examined. Unless otherwise impractical, the examination of any party must be done at the same time by all other parties. Any party may be represented by counsel at the taking of an unsworn statement. An unsworn statement may be recorded electronically, stenographically, or on videotape. The taking of unsworn statements is subject to the provisions of the Florida Rules of Civil Procedure and may be terminated for abuses.

(b) Documents or things.--Any party may request discovery of relevant documents or things. The documents or things must be produced, at the expense of the requesting party, within 20 days after the date of receipt of the request. A party is required to produce relevant and discoverable documents or things within that party's possession or control, if in good faith it can reasonably be done within the timeframe of the claims evaluation process.

(7)~~(8)~~ Each request for and notice concerning informal discovery under ~~pursuant to~~ this section must be in writing, and a copy thereof must be sent to all parties. The ~~Such a~~ request or notice must bear a certificate of service identifying the name and address of the person to whom the request or notice is served, the date of the request or notice, and the manner of service thereof.

(8)~~(9)~~ If a prospective defendant makes a written settlement offer, the claimant shall have 15 days from the date of receipt to accept the offer. An offer shall be deemed rejected unless accepted by delivery of a written notice of acceptance.

(9)~~(10)~~ To the extent not inconsistent with this part, the provisions of the Florida Mediation Code, Florida Rules of Civil Procedure, shall be applicable to these ~~such~~ proceedings.

(10)~~(11)~~ ~~Within 30 days~~ After the claimant's receipt of the defendant's response to the claim, the parties or their designated representatives may stipulate to toll the statute of limitations for 90 days in order to ~~shall~~ meet in mediation to discuss the issues of liability and damages in accordance with the mediation rules of practice and procedures adopted by the Supreme Court. Upon stipulation of the parties, this 90-day ~~30 day~~ period may be extended and the statute of limitations is tolled during the mediation and any ~~such~~ extension. At the conclusion of mediation, the claimant shall have 60 days or the remainder of the period of the statute of limitations, whichever is greater, within which to file suit.

Section 4. Section 400.0234, Florida Statutes, is amended to read:

400.0234 Availability of facility records for investigation of resident's rights violations and defenses; penalty.--

(1) Failure to provide complete copies of a resident's records, including, but not limited to, all medical records and the resident's chart, within the control or possession of the facility in accordance with s. 400.145 shall constitute evidence of failure of that party to comply with good faith

discovery requirements and shall waive the good faith certificate, ~~and~~ presuit notice, voluntary binding arbitration, and mediation requirements under this part by the requesting party.

(2) No facility shall be held liable for any civil damages as a result of complying with this section.

Section 5. Section 400.02342, Florida Statutes, is created to read:

400.02342 Voluntary binding arbitration of claims for resident's rights violation or negligence.--

(1) Voluntary binding arbitration under this part does not apply to causes of action involving the state or its agencies or subdivisions, or the officers, employees, or agents thereof under s. 768.28.

(2) Any party may elect, with respect only to a claim arising out of the rendering of, or the failure to render, nursing home services to voluntarily submit the issue of damages to binding arbitration and have the issue determined by an arbitration panel. For purposes of arbitration under this part, the term "nursing home services" means those services that are rendered to a resident as a result of his or her needs or conditions and that would be customarily within the scope of care provided by the nursing facility, including:

(a) Skin care;

(b) Mobility and walking assistance;

(c) Nourishment;

(d) Hydration;

(e) Infection prevention;

(f) Skilled therapy;

(g) Skilled nursing services; and

(h) Fall prevention.

(3) Any party may initiate the process to elect voluntary binding arbitration. The election process is initiated when a party serves a request for voluntary binding arbitration of damages on the opposing party. The notice of election must be served no later than the conclusion of the 75-day pre-suit waiting period in accordance with s. 400.0233(2)(b) or the remainder of the period of the statute of limitations, whichever is greater, or no later than 30 days after the filing date of an amended complaint containing new claims that are subject to an offer of voluntary binding arbitration. The evidentiary standard for voluntary binding arbitration of claims arising out of the rendering of, or the failure to render, nursing home services is by a greater weight of the evidence as in s. 400.023(2) and chapter 90.

(4) The opposing party may accept the offer of voluntary binding arbitration no later than 30 days after receiving the other party's request for arbitration. Acceptance within the time period is a binding commitment to comply with the decision of the arbitration panel as to the appropriate level of damages, if any, which may be awarded.

(5) The arbitration panel must include three arbitrators: one selected by the claimant, one selected by the defendant, and an administrative law judge furnished by the Division of Administrative Hearings. The administrative law judge shall serve as the chief arbitrator. If the claim involves multiple claimants or multiple defendants, one arbitrator must be selected by the side with multiple parties as the choice of those parties. If the multiple parties cannot reach agreement as to their arbitrator, each of the multiple parties must submit a nominee to the director of the division

who shall choose the arbitrator for the side having multiple parties.

(6) Discovery in voluntary binding arbitration cases is governed by the Florida Rules of Civil Procedure.

(7) The arbitrators shall be independent of all parties, witnesses, and legal counsel, and an officer, director, affiliate, subsidiary, or employee of a party, witness, or legal counsel may not serve as an arbitrator in the proceeding.

(8) The rate of compensation for arbitrators, other than the administrative law judge, shall be set by the division and may not exceed the ordinary and customary fees paid to court-approved mediators in the circuit in which the claim would be filed. The costs of compensation for the arbitrators must be borne by the party requesting arbitration.

(9) A party participating in arbitration under this section may not use any other forum against a participating defendant during the course of the arbitration.

(10) A participating claimant agrees that damages be awarded according to this part, subject to the following limitations:

(a) The defendant has offered not to contest liability and causation and has agreed to arbitration on the issue of damages as provided in this section.

(b) Net economic damages, if any, are awardable, including, but not limited to, past and future medical and health care expenses, offset by collateral source payments, to the extent that the claimant is entitled to recover damages under general law, including the Wrongful Death Act, s. 46.021, or s. 400.023.

(c) Total noneconomic damages, if any, which may be awarded for the claim arising out of the care and services rendered to a nursing home resident, including any claim available under the Wrongful Death Act, s. 46.021, or s. 400.023, are limited to a maximum of $500,000, regardless of the number of individual claimants or defendants.

(d) Punitive damages may not be awarded.

(e) The defendant is responsible for the payment of interest on all accrued damages with respect to which interest would be awarded at trial.

(f) The party requesting binding arbitration shall pay the fees of the arbitrators and the costs of the division associated with arbitration, as assessed by the division. If the division determines that the plaintiff is indigent and unable to pay, the defendant shall pay the fees and costs as assessed by the division, and the defendant shall have a claim for reimbursement against the estate of the plaintiff.

(g) A defendant who agrees to particate in arbitration under this section is jointly and severally liable for all damages assessed under this section.

(h) A defendant's obligation to pay the claimant's damages applies only to arbitration under this part. A defendant's or claimant's offer to arbitrate may not be used in evidence or in argument during any subsequent litigation of the claim following rejection thereof.

(i) The fact of making or rejecting an offer to arbitrate is not admissible as evidence of liability in any collateral or subsequent proceeding on the claim.

(j) An offer by a claimant to arbitrate must be made to each defendant against whom the claimant has made a claim. An offer by a defendant to arbitrate must be made to each

claimant. A defendant who rejects a claimant's offer to arbitrate is subject to s. 400.02344(3). A claimant who rejects a defendant's offer to arbitrate is subject to s. 400.02344(4).

(k) The hearing must be conducted by all the arbitrators, but a majority may determine any question of fact and render a final decision. The chief arbitrator shall decide all evidentiary matters in accordance with the Florida Evidence Code and the Florida Rules of Civil Procedure. The chief arbitrator shall file a copy of the final decision with the clerk of the Agency for Health Care Administration. If any member of the arbitration panel becomes unavailable, and as a result of the unavailability the panel is unable to reach a final majority decision, the chief arbitrator shall dissolve the arbitration panel, declare misarbitration and empanel a new arbitration panel under subsection (4).

(l) This part does not preclude settlement at any time by mutual agreement of the parties.

(m) If an award of damages is made to a claimant by the arbitration panel, the defendant must pay the damages no later than 20 days after entry of the decision of the arbitration panel.

(n) Damages and costs that are not paid within 20 days are subject to postjudgment interest.

(o) This part does not relieve a defendant who voluntarily participates in binding arbitration from timely paying damages and costs awarded by an arbitration panel.

(11) Any issue between the defendant and the defendant's insurer or self-insurer as to who shall control the defense of the claim and any responsibility for payment of an arbitration award shall be determined under existing

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

(12)(a) The Division of Administrative Hearings may adopt rules to implement this section.

(b) Rules adopted by the division under this section, s. 120.54, or s. 120.65, may authorize a reasonable sanction, except contempt, including, but not limited to, any sanction authorized by s. 57.105, against a party for violating a rule of the division or failing to comply with an order issued by an administrative law judge which is not under judicial review.

(13) The division may charge the party requesting binding arbitration an administrative fee for conducting the arbitration. The administrative fee may not exceed $1,000.

(14) This section does not prevent the parties from using a private arbitrator or arbitrators, in which instance the same procedures and limitations set forth in this section apply.

Section 6. Section 400.02343, Florida Statutes, is created to read:

400.02343 Arbitration to apportion financial responsibility among multiple defendants.--

(1) This section applies when more than one defendant participates in voluntary binding arbitration under s. 400.02342.

(2)(a) Defendants who agreed to voluntary binding arbitration must submit any dispute amongst themselves concerning apportionment of financial responsibility to a separate binding arbitration proceeding. The defendants must file a notice of the dispute with the administrative law judge

of the arbitration panel no later than 20 days after a determination of damages by the arbitration panel.

(b) The apportionment proceeding shall be conducted before a panel of three arbitrators. The panel must include the administrative law judge who presided in the arbitration proceeding and two nursing home arbitrators appointed by the defendants. If the defendants cannot agree on their selections to the apportionment panel, a list of not more than five nominees shall be submitted by each defendant to the director of the Division of Administrative Hearings. The director shall select the other arbitrators but may not select more than one from the list of nominees of any defendant.

(3) The administrative law judge shall serve as the chief arbitrator. The judge shall convene the apportionment panel no later than 65 days after the arbitration panel issues a damage award.

(4) The apportionment panel shall allocate financial responsibility among all defendants named in the notice of an asserted violation of a resident's rights or deviation from the standard of care, regardless of whether the defendant had submitted to arbitration. The defendants in the apportionment proceeding are responsible to one another for their proportionate share of the damage award, attorney's fees, and costs awarded by the arbitration panel. All defendants in the apportionment proceeding are jointly and severally liable for any damages assessed in arbitration. The determination of the percentage of fault of any nonarbitrating defendant is not binding against that defendant but is admissible in any subsequent legal proceeding.

(5) Payment by a defendant of the damages awarded by the arbitration panel in the arbitration proceeding

extinguishes the defendant's liability to the claimant for the incident described in the first arbitration and extinguishes the defendant's liability for contribution to any defendant who did not participate in arbitration.

(6) A defendant paying damages assessed under this section or s. 400.02342 has a cause of action for contribution against any arbitrating or nonarbitrating defendant whose negligence contributed to the injury.

Section 7. Section 400.02344, Florida Statutes, is created to read:

400.02344 Effect of a failure to offer or accept voluntary binding arbitration.--

(1) A proceeding for voluntary binding arbitration is an alternative to a jury trial and does not supersede the right of any party to a jury trial.

(2) If neither party requests or agrees to voluntary binding arbitration, the claim shall proceed to trial or to any available legal alternative such as offer of and demand for judgment under s. 768.79 or offer of settlement under s. 45.061.

(3) If a defendant rejects a claimant's offer to participate in voluntary binding arbitration, the claim shall proceed to trial as otherwise provided in this chapter without limits on noneconomic damages. If the claimant prevails at trial, the claimant is entitled to recover damages otherwise provided by law, prejudgment interest, and reasonable attorney's fees of up to 25 percent of the award when reduced to present value.

(4) If a claimant rejects a defendant's offer to enter into voluntary binding arbitration:

(a) Damages are limited to net economic damages and noneconomic damages of no more than $750,000 per claim. The total noneconomic damages, if any, which may be awarded for the claim arising out of the care and services rendered to the resident, including any claim under the Wrongful Death Act, are limited to a maximum of $750,000, regardless of the number of individual claimants or defendants. The Legislature expressly finds that the conditional limit on noneconomic damages is warranted by the claimant's refusal to accept arbitration and represents an appropriate balance between the interests of all residents who ultimately pay for rights and negligence losses and the interests of those residents who are injured as a result of negligence and violations of rights.

(b) Attorney's fees may not be awarded.

(c) Net economic damages may be awarded, including, but not limited to, past and future medical and health care expenses, loss of wages, and loss of earning capacity, offset by collateral source payments.

(d) Punitive damages may be awarded under ss. 400.0237 and 400.0238.

(5) Jury trial shall proceed in accordance with existing principles of law.

Section 8. Section 400.02345, Florida Statutes, is created to read:

400.02345 Determination of whether claim is subject to arbitration.--

(1) A court of competent jurisdiction shall determine if a claim is subject to voluntary arbitration under ss. 400.02342 and 400.02348 if the parties cannot agree. If a court determines that a claim is subject to binding arbitration, the parties must decide whether to voluntarily

arbitrate the claim no later than 30 days after the date the court enters its order. If the parties choose not to arbitrate, the limitations imposed by s. 400.02344 apply.

(2) If a plaintiff amends a complaint to allege facts that render the claim subject to binding arbitration under ss. 400.02342 and 400.02348, the parties must decide whether to participate in binding arbitration no later than 30 days after the plaintiff files the amended complaint. If the parties choose not to arbitrate, the limitations imposed upon the parties under ss. 400.02343 and 400.02344 apply.

Section 9. Section 400.02347, Florida Statutes, is created to read:

400.02347 Payment of arbitration award; interest.--

(1) No later than 20 days after the arbitration panel makes a finding of damages, if any, under s. 400.02342, a defendant shall:

(a) Pay the arbitration award to the claimant; and

(b) Submit any dispute among multiple defendants to arbitration under s. 400.02343.

(2) Beginning 20 days after a damage award is issued by the arbitration panel under s. 400.02342, the award shall begin to accrue interest at the rate of 18 percent per year.

Section 10. Section 400.02348, Florida Statutes, is created to read:

400.02348 Appeal of arbitration awards and apportionment of financial responsibility.--

(1) An arbitration award and an apportionment of financial responsibility are final agency action for purposes of s. 120.68. An appeal must be taken to the district court of appeal for the district in which the arbitration or apportionment took place. The appeal is limited to a review of

the record and must proceed according to s. 120.68. The amount of an arbitration award or an order apportioning financial responsibility, the evidence in support of either, and the procedure by which either is determined are subject to judicial review only in a proceeding instituted under this section.

(2) An appeal does not stay an arbitration or apportionment award. An arbitration or apportionment panel, arbitration panel member, or circuit court may not stay an arbitration or apportionment award. A district court of appeal may stay an award to prevent manifest injustice, but a district court of appeal may not abrogate the provisions of s. 400.02347(2).

(3) A party to an arbitration proceeding may enforce an arbitration award or an apportionment of financial responsibility by filing a petition in the circuit court for the circuit in which the arbitration or apportionment took place. A petition may not be granted unless the time for appeal has expired. If an appeal has been taken, a petition may not be granted with respect to an arbitration award or an apportionment of financial responsibility that has been stayed.

(4) If the petitioner establishes the authenticity of the arbitration award or of the apportionment of financial responsibility, shows that the time for appeal has expired, and demonstrates that no stay is in place, the court shall enter the orders and judgments as are required to carry out the terms of the arbitration award or apportionment of financial responsibility. The orders are enforceable by the contempt powers of the court, and execution shall issue upon the request of a party for the judgment.

Section 11. Section 400.141, Florida Statutes, is amended to read:

400.141 Administration and management of nursing home facilities.--Every licensed facility shall comply with all applicable standards and rules of the agency and shall:

(1) Be under the administrative direction and charge of a licensed administrator.

(2) Appoint a medical director licensed pursuant to chapter 458 or chapter 459. The agency may establish by rule more specific criteria for the appointment of a medical director.

(3) Have available the regular, consultative, and emergency services of physicians licensed by the state.

(4) Provide for resident use of a community pharmacy as specified in s. 400.022(1)(q). Any other law to the contrary notwithstanding, a registered pharmacist licensed in Florida, that is under contract with a facility licensed under this chapter, shall repackage a nursing facility resident's bulk prescription medication which has been packaged by another pharmacist licensed in any state in the United States into a unit dose system compatible with the system used by the nursing facility, if the pharmacist is requested to offer such service. In order to be eligible for the repackaging, a resident or the resident's spouse must receive prescription medication benefits provided through a former employer as part of his or her retirement benefits, a qualified pension plan as specified in s. 4972 of the Internal Revenue Code, a federal retirement program as specified under 5 C.F.R. s. 831, or a long-term care policy as defined in s. 627.9404(1). A pharmacist who correctly repackages and relabels the medication and the nursing facility which correctly

administers such repackaged medication under the provisions of this subsection shall not be held liable in any civil or administrative action arising from the repackaging. In order to be eligible for the repackaging, a nursing facility resident for whom the medication is to be repackaged shall sign an informed consent form provided by the facility which includes an explanation of the repackaging process and which notifies the resident of the immunities from liability provided herein. A pharmacist who repackages and relabels prescription medications, as authorized under this subsection, may charge a reasonable fee for costs resulting from the implementation of this provision.

(5) Provide for the access of the facility residents to dental and other health-related services, recreational services, rehabilitative services, and social work services appropriate to their needs and conditions and not directly furnished by the licensee. When a geriatric outpatient nurse clinic is conducted in accordance with rules adopted by the agency, outpatients attending such clinic shall not be counted as part of the general resident population of the nursing home facility, nor shall the nursing staff of the geriatric outpatient clinic be counted as part of the nursing staff of the facility, until the outpatient clinic load exceeds 15 a day.

(6) Be allowed and encouraged by the agency to provide other needed services under certain conditions. If the facility has a standard licensure status, and has had no class I or class II deficiencies during the past 2 years or has been awarded a Gold Seal under the program established in s. 400.235, it may be encouraged by the agency to provide services, including, but not limited to, respite and adult day

services, which enable individuals to move in and out of the facility. A facility is not subject to any additional licensure requirements for providing these services. Respite care may be offered to persons in need of short-term or temporary nursing home services. Respite care must be provided in accordance with this part and rules adopted by the agency. However, the agency shall, by rule, adopt modified requirements for resident assessment, resident care plans, resident contracts, physician orders, and other provisions, as appropriate, for short-term or temporary nursing home services. The agency shall allow for shared programming and staff in a facility which meets minimum standards and offers services pursuant to this subsection, but, if the facility is cited for deficiencies in patient care, may require additional staff and programs appropriate to the needs of service recipients. A person who receives respite care may not be counted as a resident of the facility for purposes of the facility's licensed capacity unless that person receives 24-hour respite care. A person receiving either respite care for 24 hours or longer or adult day services must be included when calculating minimum staffing for the facility. Any costs and revenues generated by a nursing home facility from nonresidential programs or services shall be excluded from the calculations of Medicaid per diems for nursing home institutional care reimbursement.

(7) If the facility has a standard license or is a Gold Seal facility, exceeds the minimum required hours of licensed nursing and certified nursing assistant direct care per resident per day, and is part of a continuing care facility licensed under chapter 651 or a retirement community that offers other services <u>under</u> ~~pursuant to~~ part III, part

IV, or part V on a single campus, be allowed to share programming and staff. At the time of inspection and in the semiannual report required pursuant to subsection (15), a continuing care facility or retirement community that uses this option must demonstrate through staffing records that minimum staffing requirements for the facility were met. Licensed nurses and certified nursing assistants who work in the nursing home facility may be used to provide services elsewhere on campus if the facility exceeds the minimum number of direct care hours required per resident per day and the total number of residents receiving direct care services from a licensed nurse or a certified nursing assistant does not cause the facility to violate the staffing ratios required under s. 400.23(3)(a). Compliance with the minimum staffing ratios shall be based on total number of residents receiving direct care services, regardless of where they reside on campus. If the facility receives a conditional license, it may not share staff until the conditional license status ends. This subsection does not restrict the agency's authority under federal or state law to require additional staff if a facility is cited for deficiencies in care which are caused by an insufficient number of certified nursing assistants or licensed nurses. The agency may adopt rules for the documentation necessary to determine compliance with this provision.

(8) Maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner.

(9) If the licensee furnishes food service, provide a wholesome and nourishing diet sufficient to meet generally accepted standards of proper nutrition for its residents and provide such therapeutic diets as may be prescribed by

attending physicians. In making rules to implement this subsection, the agency shall be guided by standards recommended by nationally recognized professional groups and associations with knowledge of dietetics.

(10) Keep full records of resident admissions and discharges; medical and general health status, including medical records, personal and social history, and identity and address of next of kin or other persons who may have responsibility for the affairs of the residents; and individual resident care plans including, but not limited to, prescribed services, service frequency and duration, and service goals. The records shall be open to inspection by the agency.

(11) Keep such fiscal records of its operations and conditions as may be necessary to provide information under ~~pursuant to~~ this part.

(12) Furnish copies of personnel records for employees affiliated with the ~~such~~ facility, to any other facility licensed by this state requesting this information pursuant to this part. The ~~Such~~ information contained in the records may include, but is not limited to, disciplinary matters and any reason for termination. Any facility releasing such records under ~~pursuant to~~ this part shall be considered to be acting in good faith and may not be held liable for information contained in such records, absent a showing that the facility maliciously falsified such records.

(13) Publicly display a poster provided by the agency containing the names, addresses, and telephone numbers for the state's abuse hotline, the State Long-Term Care Ombudsman, the Agency for Health Care Administration consumer hotline, the Advocacy Center for Persons with Disabilities, the Florida

Statewide Advocacy Council, and the Medicaid Fraud Control Unit, with a clear description of the assistance to be expected from each.

(14) Submit to the agency the information specified in s. 400.071(2)(e) for a management company within 30 days after the effective date of the management agreement.

(15) Submit semiannually to the agency, or more frequently if requested by the agency, information regarding facility staff-to-resident ratios, staff turnover, and staff stability, including information regarding certified nursing assistants, licensed nurses, the director of nursing, and the facility administrator. For purposes of this reporting:

(a) Staff-to-resident ratios must be reported in the categories specified in s. 400.23(3)(a) and applicable rules. The ratio must be reported as an average for the most recent calendar quarter.

(b) Staff turnover must be reported for the most recent 12-month period ending on the last workday of the most recent calendar quarter prior to the date the information is submitted. The turnover rate must be computed quarterly, with the annual rate being the cumulative sum of the quarterly rates. The turnover rate is the total number of terminations or separations experienced during the quarter, excluding any employee terminated during a probationary period of 3 months or less, divided by the total number of staff employed at the end of the period for which the rate is computed, and expressed as a percentage.

(c) The formula for determining staff stability is the total number of employees that have been employed for more than 12 months, divided by the total number of employees

employed at the end of the most recent calendar quarter, and expressed as a percentage.

(d) A nursing facility that has failed to comply with state minimum-staffing requirements for 2 consecutive days is prohibited from accepting new admissions until the facility has achieved the minimum-staffing requirements for a period of 6 consecutive days. For the purposes of this paragraph, any person who was a resident of the facility and was absent from the facility for the purpose of receiving medical care at a separate location or was on a leave of absence is not considered a new admission. Failure to impose such an admissions moratorium constitutes a class II deficiency.

(e) A nursing facility which does not have a conditional license may be cited for failure to comply with the standards in s. 400.23(3)(a) only if it has failed to meet those standards on 2 consecutive days or if it has failed to meet at least 97 percent of those standards on any one day.

(f) A facility which has a conditional license must be in compliance with the standards in s. 400.23(3)(a) at all times.

Nothing in this section shall limit the agency's ability to impose a deficiency or take other actions if a facility does not have enough staff to meet the residents' needs.

(16) Report monthly the number of vacant beds in the facility which are available for resident occupancy on the day the information is reported.

(17) Notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to

such dementia or impairment. The notification must occur within 30 days after the acknowledgment of the ~~such~~ signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition.

(18) If the facility implements a dining and hospitality attendant program, ensure that the program is developed and implemented under the supervision of the facility director of nursing. A licensed nurse, licensed speech or occupational therapist, or a registered dietitian must conduct training of dining and hospitality attendants. A person employed by a facility as a dining and hospitality attendant must perform tasks under the direct supervision of a licensed nurse.

(19) Report to the agency any filing for bankruptcy protection by the facility or its parent corporation, divestiture or spin-off of its assets, or corporate reorganization within 30 days after the completion of the ~~such~~ activity.

(20) Effective October 1, 2005, maintain general and professional liability insurance coverage, written through admitted carriers, surplus carriers, or offshore captives, in an amount not less than $2,500 per licensed nursing home bed ~~that is in force at all times. In lieu of general and professional liability insurance coverage, a state-designated teaching nursing home and its affiliated assisted living facilities created under s. 430.80 may demonstrate proof of financial responsibility as provided in s. 430.80(3)(h); the exception provided in this paragraph shall expire July 1,~~

~~2005~~.The professional liability insurance coverage shall not allow for wasting of the policy with costs and attorney fees.

(21)(a) Effective October 1, 2005, in lieu of general and professional liability insurance coverage, demonstrate proof of financial responsibility in one of the following ways:

1. Establishing an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52 in an annual amount not less than $2,500 per licensed nursing home bed, to be funded in 12 monthly installments at the inception of the escrow account; or

2. Obtaining an unexpired, irrevocable letter of credit, established under chapter 675, in an annual amount not less than $2,500 per licensed nursing home bed. The letter of credit shall be payable to the facility as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the facility or upon presentment of a settlement agreement signed by all parties to the agreement when the final judgment or settlement is a result of a liability claim against the facility. The letter of credit shall be nonassignable and nontransferable. The letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States which has its principal place of business in this state or has a branch office that is authorized under the laws of this state or of the United States to receive deposits in this state.

(b) In lieu of general and professional liability insurance coverage, a state-designated teaching nursing home and its affiliated assisted living facilities created under s.

430.80 may demonstrate proof of financial responsibility as provided in s. 430.80(3)(h).

(c) The required amount of general and professional liability insurance or financial responsibility shall be recalculated beginning January 1, 2007, and continue each January 1, by the rate of inflation for the preceding year, using the Consumer Price Index Urban B All Items, as published by the United States Bureau of Labor Statistics.

(d) General and professional liability coverage or financial responsibility must be demonstrated at the time of initial licensure and at the time of relicensure and in order to maintain the license.

(e) Notwithstanding any provision to the contrary, a nursing home facility that is part of a continuing care facility certified under chapter 651 and owned by the same corporation may use the liability insurance or financial responsibility that is in effect for the continuing care facility as proof of compliance if the total amount of coverage or financial responsibility is no less than the minimum amount required for its nursing home facility based on $2,500 per licensed nursing home bed under the requirements of this section and as adjusted for inflation as provided in paragraph (c).

(f) A corporation that owns a nursing home facility and offers other long-term care or housing services under the same corporate entity or a holding company through which nursing home care and other services are offered, including, but not limited to, assisted living, home health, apartments or units for independent living, or any combination thereof, may use the liability insurance or financial responsibility in effect for the corporation or holding company as proof of

compliance if the amount of coverage or financial responsibility is no less than the minimum amount required for its nursing home facility based on $2,500 per licensed nursing home bed under the requirements of this section and as adjusted for inflation as provided in paragraph (c).

(22)~~(21)~~ Maintain in the medical record for each resident a daily chart of certified nursing assistant services provided to the resident. The certified nursing assistant who is caring for the resident must complete this record by the end of his or her shift. This record must indicate assistance with activities of daily living, assistance with eating, and assistance with drinking, and must record each offering of nutrition and hydration for those residents whose plan of care or assessment indicates a risk for malnutrition or dehydration.

(23)~~(22)~~ Before November 30 of each year, subject to the availability of an adequate supply of the necessary vaccine, provide for immunizations against influenza viruses to all its consenting residents in accordance with the recommendations of the United States Centers for Disease Control and Prevention, subject to exemptions for medical contraindications and religious or personal beliefs. Subject to these exemptions, any consenting person who becomes a resident of the facility after November 30 but before March 31 of the following year must be immunized within 5 working days after becoming a resident. Immunization shall not be provided to any resident who provides documentation that he or she has been immunized as required by this subsection. This subsection does not prohibit a resident from receiving the immunization from his or her personal physician if he or she so chooses. A resident who chooses to receive the immunization from his or

her personal physician shall provide proof of immunization to the facility. The agency may adopt and enforce any rules necessary to comply with or implement this subsection.

(24)~~(23)~~ Assess all residents for eligibility for pneumococcal polysaccharide vaccination (PPV) and vaccinate residents when indicated within 60 days after the effective date of this act in accordance with the recommendations of the United States Centers for Disease Control and Prevention, subject to exemptions for medical contraindications and religious or personal beliefs. Residents admitted after the effective date of this act shall be assessed within 5 working days of admission and, when indicated, vaccinated within 60 days in accordance with the recommendations of the United States Centers for Disease Control and Prevention, subject to exemptions for medical contraindications and religious or personal beliefs. Immunization shall not be provided to any resident who provides documentation that he or she has been immunized as required by this subsection. This subsection does not prohibit a resident from receiving the immunization from his or her personal physician if he or she so chooses. A resident who chooses to receive the immunization from his or her personal physician shall provide proof of immunization to the facility. The agency may adopt and enforce any rules necessary to comply with or implement this subsection.

(25)~~(24)~~ Annually encourage and promote to its employees the benefits associated with immunizations against influenza viruses in accordance with the recommendations of the United States Centers for Disease Control and Prevention. The agency may adopt and enforce any rules necessary to comply with or implement this subsection.

Facilities that have been awarded a Gold Seal under the program established in s. 400.235 may develop a plan to provide certified nursing assistant training as prescribed by federal regulations and state rules and may apply to the agency for approval of their program.

Section 12. Subsection (3) is added to section 400.151, Florida Statutes, to read:

400.151 Contracts.--

(3) If a contract to which this section applies contains a provision that provides for binding arbitration of any dispute that may arise under, or is related to, the duties, obligations, or services set forth in the contract, the binding-arbitration provision must comply with the following criteria:

(a) The provision may not be contrary to this chapter.

(b) The provision must be distinguishable from the remainder of the contract by using uppercase and bold typeface to denominate the provision as one providing for "DISPUTE RESOLUTION" or alternatively, "ARBITRATION." The provision must also use uppercase and bold typeface to notify the resident that signing the contract means that the party agrees to waive any right to a jury trial and consents to engage in voluntary binding arbitration.

(c) The provision must include a short, easily understandable explanation of the arbitration process and what claims are subject to arbitration. The provision must clearly inform the resident, or the resident's designee, that he or she has the right to consult an attorney and have the agreement reviewed by an attorney of his or her choice. A representative of the licensee must read the provision to the resident and answer any questions asked by the resident. If a

resident requires special accommodations for reading or hearing the provision, the licensee must ensure that appropriate accommodations are made.

(d) The provision must comply with chapter 682, including, but not limited to, the right of the parties to participate in discovery, the right to counsel, the right to present evidence, the right to cross-examine witnesses, and present expert testimony.

(e) The contract's provision may not limit the amount of the damages, if any, which may be awarded by the arbitrator other than to state that the limitations set forth in section 400.023(1) apply to the contract. If a claimant seeks to assert a claim for punitive damages, ss. 400.0237 and 400.0238 apply when determining whether such a claim may be brought and the amount of damages, if any, which may be awarded.

(f) The provision must state that the laws of this state apply to any legal issue presented to the arbitration panel and must state that the arbitration will be held in the county where the nursing home facility is located.

(g) The provision does not limit the resident from bringing a claim in the arbitration based upon an alleged deprivation of his or her resident rights as set forth in s. 400.022, and in accordance with the standards set forth in s. 400.023(2)-(5).

(h) The resident, or, if the resident is unable to sign the contract due to any physical or mental impairment, the resident's health care surrogate, health care proxy, spouse, or other person holding a power of attorney or durable family power of attorney has 14 calendar days following the date of signing the contract, excluding state-recognized holidays, in which to rescind the arbitration provision, and

the rescission does not affect the other duties and obligations set forth in the agreement by and between the parties.

(i) The page on which the dispute-resolution or arbitration provision appears must include a signature line or other area where the resident, or resident's designee, can sign or initial that they have read the page and that the contents of the page have been explained to them.

(j) The provision may not require the resident or the resident's designee to incur any initiation fees for the binding-arbitration process which would be greater than the filing fee applicable to the initiation of a civil action in the circuit where the claim could be brought.

(k) This subsection applies only to contracts having arbitration provisions signed on or after July 1, 2005. This subsection does not apply to continuing care contracts governed under chapter 651.

Section 13. Subsection (13) is added to section 409.907, Florida Statutes, to read:

409.907 Medicaid provider agreements.--The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.

(13)(a) Effective January 1, 2007, and notwithstanding s. 409.905(8), the agency may not renew a Medicaid provider

agreement with a chronically poor-performing nursing home facility.

(b) Effective January 1, 2007, any nursing home facility determined to be chronically poor-performing may not participate in the voluntary binding arbitration provisions set forth in part II of chapter 400.

Section 14. Subsection (2) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.--Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent

or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(2)(a)1. Reimbursement to nursing homes licensed under part II of chapter 400 and state-owned-and-operated intermediate care facilities for the developmentally disabled licensed under chapter 393 must be made prospectively.

2. Unless otherwise limited or directed in the General Appropriations Act, reimbursement to hospitals licensed under part I of chapter 395 for the provision of swing-bed nursing home services must be made on the basis of the average statewide nursing home payment, and reimbursement to a hospital licensed under part I of chapter 395 for the provision of skilled nursing services must be made on the basis of the average nursing home payment for those services in the county in which the hospital is located. When a hospital is located in a county that does not have any community nursing homes, reimbursement must be determined by averaging the nursing home payments, in counties that surround the county in which the hospital is located. Reimbursement to hospitals, including Medicaid payment of Medicare copayments, for skilled nursing services shall be limited to 30 days, unless a prior authorization has been obtained from the agency. Medicaid reimbursement may be extended by the agency beyond 30 days, and approval must be based upon verification by the patient's physician that the patient requires short-term rehabilitative and recuperative services only, in which case an extension of no more than 15 days may be

approved. Reimbursement to a hospital licensed under part I of chapter 395 for the temporary provision of skilled nursing services to nursing home residents who have been displaced as the result of a natural disaster or other emergency may not exceed the average county nursing home payment for those services in the county in which the hospital is located and is limited to the period of time which the agency considers necessary for continued placement of the nursing home residents in the hospital.

(b) Subject to any limitations or directions provided for in the General Appropriations Act, the agency shall establish and implement a Florida Title XIX Long-Term Care Reimbursement Plan (Medicaid) for nursing home care in order to provide care and services in conformance with the applicable state and federal laws, rules, regulations, and quality and safety standards and to ensure that individuals eligible for medical assistance have reasonable geographic access to such care.

1. Changes of ownership or of licensed operator do not qualify for increases in reimbursement rates associated with the change of ownership or of licensed operator. The agency shall amend the Title XIX Long Term Care Reimbursement Plan to provide that the initial nursing home reimbursement rates, for the operating, patient care, and MAR components, associated with related and unrelated party changes of ownership or licensed operator filed on or after September 1, 2001, are equivalent to the previous owner's reimbursement rate.

2. The agency shall amend the long-term care reimbursement plan and cost reporting system to create direct care and indirect care subcomponents of the patient care component of the per diem rate. These two subcomponents

together shall equal the patient care component of the per diem rate. Separate cost-based ceilings shall be calculated for each patient care subcomponent. The direct care subcomponent of the per diem rate shall be limited by the cost-based class ceiling, and the indirect care subcomponent shall be limited by the lower of the cost-based class ceiling, by the target rate class ceiling, or by the individual provider target. ~~The agency shall adjust the patient care component effective January 1, 2002. The cost to adjust the direct care subcomponent shall be net of the total funds previously allocated for the case mix add-on. The agency shall make the required changes to the nursing home cost reporting forms to implement this requirement effective January 1, 2002.~~

3. The direct care subcomponent shall include salaries and benefits of direct care staff providing nursing services including registered nurses, licensed practical nurses, and certified nursing assistants who deliver care directly to residents in the nursing home facility. This excludes nursing administration, MDS, and care plan coordinators, staff development, and staffing coordinator.

4. All other patient care costs shall be included in the indirect care cost subcomponent of the patient care per diem rate. There shall be no costs directly or indirectly allocated to the direct care subcomponent from a home office or management company.

5. On July 1 of each year, the agency shall report to the Legislature direct and indirect care costs, including average direct and indirect care costs per resident per facility and direct care and indirect care salaries and benefits per category of staff member per facility.

6. In order to offset the cost of general and professional liability insurance, the agency shall amend the plan to allow for interim rate adjustments to reflect increases in the cost of general or professional liability insurance for nursing homes. This provision shall be implemented to the extent existing appropriations are available.

7. Effective October 1, 2005, the agency shall amend the plan to recognize increases in professional liability insurance costs incurred by a nursing home facility. The agency shall provide a pass-through of professional liability insurance, including contributions establishing financial responsibility under s. 400.141(20), in an amount that does not exceed $2,500 per licensed nursing home bed. Any portion of the costs of professional liability insurance which exceed $2,500 per bed is recognized as an operating cost and is subject to the operating-cost ceiling and target.

8. The agency may impose a quality assurance assessment on all nursing home facilities licensed under part II of chapter 400 as a provider contribution for making payments, including federal matching funds, through the methodologies for Medicaid nursing home reimbursement. Funds received for this purpose must be accounted for separately and may not be commingled with other state or local funds in any manner.

It is the intent of the Legislature that the reimbursement plan achieve the goal of providing access to health care for nursing home residents who require large amounts of care while encouraging diversion services as an alternative to nursing home care for residents who can be served within the

community. The agency shall base the establishment of any maximum rate of payment, whether overall or component, on the available moneys as provided for in the General Appropriations Act. The agency may base the maximum rate of payment on the results of scientifically valid analysis and conclusions derived from objective statistical data pertinent to the particular maximum rate of payment.

Section 15. Subsection (9) of section 400.147, Florida Statutes, is amended to read:

400.147 Internal risk management and quality assurance program.--

(9) By the 10th of each month, each facility subject to this section shall report any notice received under s. 400.0233(1) ~~pursuant to s. 400.0233(2)~~ and each initial complaint that was filed with the clerk of the court and served on the facility during the previous month by a resident or a resident's family member, guardian, conservator, or personal legal representative. The report must include the name of the resident, the resident's date of birth and social security number, the Medicaid identification number for Medicaid-eligible persons, the date or dates of the incident leading to the claim or dates of residency, if applicable, and the type of injury or violation of rights alleged to have occurred. Each facility shall also submit a copy of the notices received under s. 400.0233(1) ~~pursuant to s. 400.0233(2)~~ and complaints filed with the clerk of the court. This report is confidential as provided by law and is not discoverable or admissible in any civil or administrative action, except in ~~such~~ actions brought by the agency to enforce ~~the provisions of~~ this part.

Section 16. For the purpose of incorporating the amendment made to section 400.141, Florida Statutes, in a reference thereto, paragraph (h) of subsection (3) of section 430.80, Florida Statutes, is reenacted to read:

430.80 Implementation of a teaching nursing home pilot project.--

(3) To be designated as a teaching nursing home, a nursing home licensee must, at a minimum:

(h) Maintain insurance coverage pursuant to s. 400.141(20) or proof of financial responsibility in a minimum amount of $750,000. Such proof of financial responsibility may include:

1. Maintaining an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52; or

2. Obtaining and maintaining pursuant to chapter 675 an unexpired, irrevocable, nontransferable and nonassignable letter of credit issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized to receive deposits in this state. The letter of credit shall be used to satisfy the obligation of the facility to the claimant upon presentment of a final judgment indicating liability and awarding damages to be paid by the facility or upon presentment of a settlement agreement signed by all parties to the agreement when such final judgment or settlement is a result of a liability claim against the facility.

Section 17. Adjustment of arbitration limits.--Effective January 1, 2007, the arbitration limits set forth in sections 400.02342(7) and 400.02344(4)(a), Florida

Statutes, shall be adjusted annually for inflation as measured by the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics of the United States Department of Labor.

Section 18. Chronically poor-performing nursing home facilities.--

(1) It is the intent of the Legislature that the Agency for Health Care Administration not renew Medicaid provider agreements with any nursing home facility that has a pattern, over time, of actual harm or immediate jeopardy citations in accordance with state and federal licensure and certification requirements. These facilities, are known as chronically poor-performing nursing home facilities. To abide by the intent of the Legislature, the agency, after consulting with the Florida Health Care Association, the Florida Association of Homes for the Aged, and the American Association of Retired Persons (AARP), shall:

(a) Define a chronically poor-performing nursing facility with a specific period of time for determining a pattern.

(b) Identify, notify, monitor, measure improvement, and, when appropriate, implement nonrenewal of the Medicaid agreements for chronically poor-performing nursing home facilities.

(c) Foster the improvement of chronically poor-performing nursing home facilities by including time limits for demonstrating measurable improvement, including identifying criteria that measure the improvement.

(d) Analyze and prepare a report regarding the existing Medicaid Up-or-Out Program authorized in section 400.148, Florida Statutes, including the progress of

participating nursing home facilities, benefits of the program, and success in achieving the intended goals.

(e) Review all administrative procedures and barriers relating to identifying and eliminating chronically poor-performing nursing home facilities and make recommendations for necessary statutory changes to eliminate barriers.

(2) It is the intent of the Legislature that a study be conducted of all federal and state enforcement sanctions and remedies available to the Agency for Health Care Administration for use with nursing home facilities. The study must include, but need not be limited to, a review and evaluation of the agency's use over the past 5 years of receivership, civil money penalties, and denial of payment for new admissions. The study must also evaluate the state survey process, including statewide consistency in survey findings by state area office, the systemic costs for survey appeals, the effectiveness and objectivity of the informal dispute-resolution process in resolving disputes, and recent experiences of reversals of final orders of the agency and modifications of the state's administrative actions concerning surveys and ratings. The results of the study shall be presented to the Governor, the President of the Senate, and the Speaker of the House of Representatives by February 1, 2006.

Section 19. The Agency for Health Care Administration must establish a health care quality improvement system for nursing home facilities licensed in this state. The system shall include, but need not be limited to, the following:

(1) Guidelines for internal quality assurance programs, including standards for:

(a) Written quality assurance program descriptions.

(b) Responsibilities of the governing body for monitoring, evaluating, and improving care.

(c) An active quality assurance committee.

(d) Quality assurance program supervision.

(e) Requiring the program to have adequate resources to effectively carry out its specified activities.

(f) Provider participation in the quality assurance program.

(g) Delegation of quality assurance program activities.

(h) Credentialing and recredentialing.

(i) Enrollee rights and responsibilities.

(j) Availability and accessibility to services and care.

(k) Accessibility and availability of medical records, as well as proper recordkeeping and process for record review.

(l) Utilization review.

(m) A continuity of care system.

(n) Quality assurance program documentation.

(o) Coordination of quality assurance activity with other management activity.

(2) Guidelines requiring the entities to conduct quality-of-care studies that:

(a) Target specific conditions and specific health service delivery issues for focused monitoring and evaluation.

(b) Use clinical care standards or practice guidelines to objectively evaluate the care the entity delivers or fails to deliver for the targeted clinical conditions and health services delivery issues.

(c) Use quality indicators derived from the clinical care standards or practice guidelines to screen and monitor care and services delivered.

(3) Guidelines for external quality review of each contractor which require: focused studies of patterns of care; individual care review in specific situations; and followup activities on previous pattern-of-care study findings and individual-care-review findings. In designing the external quality review function and determining how it is to operate as part of the state's overall quality improvement system, the agency shall construct its external quality review organization and entity contracts to address each of the following:

(a) Delineating the role of the external quality review organization.

(b) Length of the external quality review organization contract with the state.

(c) Participation of the contracting entities in designing external quality review organization review activities.

(d) Potential variation in the type of clinical conditions and health services delivery issues to be studied at each plan.

(e) Determining the number of focused pattern-of-care studies to be conducted for each plan.

(f) Methods for implementing focused studies.

(g) Individual care review.

(9) Followup activities.

Section 20. Assessments of nursing home facilities.--

(1) Effective October 1, 2005, each nursing home facility licensed under chapter 400, Florida Statutes, shall

pay an annual assessment for each licensed bed in the facility. The funds raised by the assessment are intended to ensure access to nursing home services by the state's elderly population. The funds raised by the assessment shall be used as provided in this section.

(2) The amount of the annual assessment shall be determined in the following manner:

(a) The initial annual assessment shall be $10 per bed per day. Thereafter, the assessment shall be adjusted annually for inflation as measured by the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics of the United States Department of Labor.

(b) The initial assessment shall be determined by the Agency for Health Care Administration and shall be based on the agency's determination of the needs that will be paid for by the assessment and the ability of nursing home service providers to pay the assessment.

(3)(a) It is the intent of the Legislature that funds derived from the assessment may not be used to supplement existing funding of programs providing nursing home services, but rather to enhance the services provided by the current funding.

(b) All funds collected from the assessment must be used to meet the minimum certified nursing assistant staffing of 2.9 hours of direct care per resident per day as required by section 400.23(3), Florida Statutes.

Section 21. If any portion of this act, including this section, is found to be unconstitutional, the entire act shall be null, void, and of no effect.

Section 22. Except as otherwise expressly provided in this act, this act shall take effect October 1, 2005.

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SENATE SUMMARY

Provides legislative findings and intent relating to liability insurance for nursing home facilities. Requires a resident or the resident's legal representative to include a certificate of compliance when a complaint alleging a violation of a resident's rights is filed with the clerk of court. Requires that the presuit notice be given to each prospective defendant. Requires that certain specified information be included with the notice. Provides that any party may elect to participate in voluntary binding arbitration. Provides the procedures to initiate and conduct a voluntary binding arbitration. Permits the parties to use private arbitrators. Requires multiple defendants to a binding arbitration proceeding to apportion a damage award amongst themselves through a second arbitration proceeding. Providing that a participating defendant has a cause of action for contribution from other defendants. Provides consequences for a claimant or defendant that fails to participate in binding arbitration. Creates procedures to determine if a specific claim is subject to binding arbitration. Requires a defendant to pay a damage award within a specified time period. Provides for an appeal of an arbitration or apportionment award. Authorizes a party to an arbitration or apportionment proceeding to enforce an arbitration award or an apportionment of financial responsibility. Requires a nursing home facility to maintain general and professional liability insurance with specified insurance carriers. Provides alternative methods to establish financial responsibility for claims filed against the nursing home. Provides criteria for a resident's contract which include arbitration or dispute resolution provisions. Directs the Agency for Health Care Administration not to renew a Medicaid provider agreement with a chronically poor-performing nursing home facility. Requires the agency to recognize increases in professional liability insurance costs by providing a pass-through of professional liability insurance in a specified amount. Requires that arbitration limits be adjusted annually for inflation. Directs the agency to consult with certain specified private organizations to identify and improve poor-performing nursing homes. Requires the agency to prepare a report of the Medicaid "Up-or-Out Program." Provides legislative intent that a study be conducted of all federal and state enforcement sanctions and remedies available to the agency to use with nursing home facilities. Requires a report of the findings of the study to be submitted by a specified date. Requires each nursing home facility to pay an annual assessment on each licensed bed after a specified date. Provides for the use of the funds collected. Provides a method by which the assessment will be determined. (See bill for details.)