SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: Health Care Committee

BILL: SB 2390

SPONSOR: Senator Campbell

SUBJECT: Nursing Home Facilities

DATE: April 19, 2005 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Harkey	Wilson	HE	**Pre-meeting**
2.			BI	
3.			JU	
4.			HA	
5.				
6.				

I. Summary:

Liability of Nursing Home Nurses

The bill provides that a nursing home licensee is liable for resident's rights violations or acts of negligence by a nurse practicing under the direction of the licensee.

Nursing Home Litigation

The bill puts in place a plan for prompt resolution of nursing home claims. The plan includes mandatory presuit investigation and voluntary binding arbitration of claims of violations of resident's rights and negligence involving "nursing home services."

Nursing Home Insurance Coverage

The bill requires that, effective July 1, 2005, every nursing home must maintain general and professional liability insurance coverage in an amount not less than $2,500 per licensed bed. This amount is to be adjusted for inflation each year beginning January 1, 2007. The bill creates alternatives to obtaining coverage from an insurance carrier through the establishment of an escrow account or through an irrevocable letter of credit. The bill provides for the owners of Continuing Care Retirement Communities (CCRC) or corporations that offer both nursing home services and other long term care services to use the liability insurance or financial responsibility that is in effect for the CCRC or the same corporate entity or holding company respectively as long as the minimum coverage amount of $2,500 per nursing home bed is provided.

The bill requires the Agency for Health Care Administration (AHCA) to amend the Medicaid State Plan effective October 1, 2005, to recognize a pass-through for the cost of professional liability insurance in an amount that does not exceed $2,500 per bed.

Binding Arbitration Clauses in Nursing Home Contracts
The bill provides criteria relating to disclosure and comprehensibility of binding arbitration clauses in nursing home contracts.

Chronically Poor-Performing Nursing Homes
The bill requires that AHCA not renew a Medicaid provider agreement with a chronically poor-performing nursing home facility. AHCA is directed to consult with the Florida Health Care Association, the Florida Association of Homes for the Aging, and the American Association of Retired Persons to identify and improve poor-performing nursing homes. The bill requires AHCA to prepare a report on the Medicaid "Up or Out" Program.

Assessments
The bill requires each nursing home facility to pay an annual assessment of $10 per licensed nursing home bed per day, with an annual inflationary increase. The funds generated from this assessment may not be used to supplement existing program funding but rather must enhance services provided by current funding. The quality assurance assessment on all licensed nursing homes is to be used as a provider contribution, with the federal matching funds, for making Medicaid nursing home reimbursements.

Report to the Legislature
The bill requires a study on AHCA's use of certain procedures against nursing homes, its survey process, and all federal and state enforcement sanctions and remedies available to the agency to use with nursing home facilities. The report is to be presented to the Governor and Legislature by February 1, 2006.

Nonseverability
The bill provides that if any portion of the act is determined to be unconstitutional, the entire act is null and void.

This bill amends ss. 400.021, 400.023, 400.0233, 400.0234, 400.141, 400.147, 400.151, 409.907, 409.908, and 430.80, F.S. The bill creates ss. 400.02342, 400.02343, 400.02344, 400.02345, 400.02347, and 400.02348, F.S., and 5 unnumbered sections of law.

II. Present Situation:

Nursing Home Reform

The 2001 Florida Legislature enacted landmark legislation, CS/CS/CS/SB 1202 (hereafter SB 1202), to deal with quality of care, tort reform, and insurance coverage in the nursing home industry. The bill required an increase in staffing in nursing homes over a three-year period, strengthened regulatory enforcement and quality oversight, established risk management and adverse incident reporting in nursing homes, required Medicaid reimbursement rebasing and full funding of direct patient care, provided significant tort reform, required nursing homes to maintain liability insurance coverage at all times, and required AHCA to seek a federal Medicaid waiver to use Medicaid funds to create and operate a long-term care risk-retention group for self-insurance purposes. The Legislature appropriated more than $70 million in new funding to implement the provisions of SB 1202.

In February 2002, the Speaker of the House of Representatives appointed the House Select Committee on Liability Insurance for Long-Term Care Facilities, in response to concerns of representatives of the long-term care industry regarding the high costs and unavailability of the required liability insurance coverage. The Select Committee concluded that there was no consensus among the various organizations and interest groups participating in the debate over the existence or nature of a specific crisis in the nursing home industry. In December 2002, the Speaker of the House of Representatives and the President of the Senate appointed a Joint Select Committee on Nursing Homes to address the continuing crisis facing Florida's nursing homes in both obtaining and maintaining adequate insurance coverage. The Committee made a number of recommendations which were not adopted by the 2003 Legislature.

In November 2003, the Speaker of the House of Representatives and the President of the Senate re-appointed the Joint Select Committee on Nursing Homes (Joint Select Committee). The Speaker and the President asked the Committee to reconsider issues regarding the continuing liability insurance and lawsuit crisis facing Florida's long-term care facilities and to assess the impact of the reforms contained in SB 1202. After hearing testimony, the members of the Joint Select Committee agreed that:

- The Legislature should consider only comprehensive reform which provides access to courts while revitalizing the insurance market and ensuring access to quality and affordable nursing home care. For instance, to ensure access to courts and in order to make compensation available to victims of nursing home abuse and neglect, nursing homes need an incentive to carry professional liability insurance at a higher level. In order to provide such incentive for nursing homes to carry a specified minimum amount of liability insurance coverage, based on a per bed calculation, the Legislature could allow those nursing homes which carry a specified minimum amount of general and professional liability insurance to utilize a voluntary binding arbitration process with caps on non-economic damages. Such an option would provide at least a specified amount of financial assets to be available to the victim, which is not currently the case.

- The data collected by the state regarding lawsuits and recovery is insufficient, thus making it difficult for the Legislature to objectively determine whether the number of lawsuits against nursing homes is increasing or decreasing, or whether the costs of liability claims to the nursing home industry are going up or down.

- Nursing homes continue to be impacted by a combination of increasing liability insurance costs, competing demand for labor, with the consequent increase in labor costs, and limitations on state Medicaid reimbursement.

- At the [Joint Select] Committee's request, the Office of Insurance Regulation reevaluated the liability insurance market and reported that there has been no appreciable change in the availability of private liability insurance over the past year.

- General and professional liability insurance, with actual transfer-of-risk, is virtually unavailable in Florida. "Bare-bones" policies designed to provide minimal compliance with the statutory insurance requirement are available; however, the cost often exceeds the face

value of the coverage offered in the policy. This situation is a crisis which threatens the continued existence of long-term care facilities in Florida.

- There is growing concern that the combination of minimal compliance liability policies and changes in nursing home corporate structures designed to limit liability have the potential of producing a situation in which an injured resident may have no hope of recovery of a legitimate claim.

- It is important that the state be able to take action against chronically poor-performing nursing homes, and that nursing homes which provide chronically deficient care should be closed; however, there is no general agreement as to the criteria that should be used to determine which facilities should be closed.

- Continuing Care Retirement Communities are in a unique situation. These facilities, on the whole, seem to have better quality of care; however, residents, as private purchasers of care, are forced to absorb increases in operating costs due to escalating insurance costs.

Nursing Home Litigation

Part II of chapter 400, F.S., provides a civil cause of action for nursing home resident rights violations. AHCA is required to collect limited information regarding notices of intent to litigate and complaints filed with the clerks of court for such actions. AHCA publishes this statistical information in its Semi-Annual Report on Nursing Homes. However, the information reported is only as accurate as the information received; AHCA has reported that the agency does not always receive copies of the complaints filed with the clerks of court, as is required by law.

Binding Arbitration Clauses in Nursing Home Contracts

Section 400.151, F.S., requires that each resident in a nursing home be covered by a contract executed by the licensee or his or her representative at the time of admission or prior thereto. Each contract must set forth the services and accommodations to be provided by the licensee, the rates or charges, and the policy for bed reservations and refunds. Each party to the contract is entitled to a copy, and the licensee must keep on file all contracts it has with residents.

Nursing home licensure regulations do not address arbitration agreements between nursing homes and residents; however, some nursing homes request that residents sign arbitration agreements prior to admission to the facility. These agreements cannot violate existing regulations. The current nursing home licensure law addresses civil disputes only as they relate to nursing home resident rights violations and does not distinguish types of violations.

Nursing Home Insurance Coverage

All nursing homes must maintain general and professional liability insurance coverage at all times. However, there is an exception for a state-designated teaching nursing home, which may demonstrate proof of financial responsibility as provided in s. 430.80(3)(h), F.S., as an alternative to maintaining the required insurance; this exception expires July 1, 2005.

Nursing home licensees provide proof of their licensee's general and professional liability insurance to AHCA upon initial licensure and annually at license renewal. AHCA reviews the submitted documentation of general and professional liability insurance in conjunction with Florida's insurance laws. There is no minimum amount of coverage specified in the current law. No licenses have been denied by Final Order of the Agency for failure to supply proof of general and professional liability insurance.

"Chronically Poor-Performing Nursing Homes"

AHCA conducts inspections of nursing homes for the purposes of state licensure and Medicare and Medicaid certification every 12 months on average. If during an inspection, a nursing home provider is found to be out of compliance with federal regulations, the provider may be terminated from both Medicare and Medicaid if they do not achieve compliance within six months. This termination period may be shortened under certain circumstances. Other federal sanctions may apply including the imposition of fines and denial of payment for new Medicare and/or Medicaid recipients for failure to correct deficiencies within required timeframes. Medicaid nursing home provider agreements are currently issued for a three-year period.

The Medicaid Up-or-Out Program is authorized in s. 400.148, F.S. The program, which required the Agency to coordinate monitoring and oversight activities in certain nursing homes, is no longer funded and has been inoperable since December 2003. A final report was issued by AHCA at that time.

Report to the Legislature

AHCA produces a Semi-Annual Report on Nursing Homes; an annual report on Nursing Home and Assisted Living Facility: Adverse Incidents & Notices of Intent Filed; and the Nursing Home Guide and Nursing Home Watch List every quarter. These reports contain information regarding facility-specific and aggregate nursing home quality as well as other information.

The Medicaid Program

The Medicaid program is jointly funded by the federal, state, and county governments to provide medical care to eligible individuals. Medicaid is the largest program providing medical and health-related services to the nation's poorest citizens. Within broad national guidelines, which the federal government establishes, each of the states:

- Establishes its own eligibility standards;
- Determines the type, amount, duration, and scope of services;
- Sets the rate of payment for services; and
- Administers its own program.

AHCA is the single state agency responsible for the Florida Medicaid Program. The Florida statutory provisions for the Medicaid program appear in ss. 409.901 through 409.9205, F.S. The federal Medicaid provisions are in Title XIX of the Social Security Act.

Medicaid Nursing Home Reimbursement

Nursing homes that participate in the Florida Medicaid Program are reimbursed in accordance with The Florida Title XIX Long-Term Care Reimbursement Plan (the Plan). The Plan is incorporated by reference into Chapter 59G of the Florida Administrative Code (FAC) and details the methods and standards by which facilities are reimbursed.

The Plan is often referred to as a cost based prospective reimbursement plan. It is cost based because it utilizes historical data from cost reports to establish reimbursement rates. The Plan is prospective because it adjusts historical costs for inflation in establishing reimbursement rates for subsequent rate semesters.

Each nursing home is required to submit an annual cost report to the Agency. Cost reports are due within three calendar months after the end of the facility's cost reporting period. The data within these cost reports is then used to establish reimbursement (per diem) rates in accordance with the Plan.

Per diem rates are established for each facility twice a year, every January 1 and July 1, based on the latest cost reports received by September 30 and March 31, respectively. The January 1 – June 30 and July 1 – December 31 periods are referred to as rate periods or rate semesters. Each semester, a single per diem rate is established for each facility that is paid for all Medicaid patient days.

Nursing home per diem rates are facility specific and are an aggregate of four components:

- Operating,
- Patient care (which is the sum of direct and indirect patient care subcomponents),
- Property, and
- Return on equity (ROE) for money invested and used in providing patient care.

The operating component includes administration, laundry and linen, plant operations, house keeping expenses, and liability insurance costs. It may also include Medicaid bad debt expenses. The patient care component includes nursing, dietary, other patient care (social services and medical records) and ancillary expenses. The property component includes interest, depreciation, insurance, property taxes and equipment rental expenses. The return on equity component is a calculation based on the equity in the facility. Each of these components is calculated independently and is then combined to determine the per diem rate.

Voluntary Binding Arbitration under Chapter 766, Florida Statutes

In 1988, the Legislature enacted sweeping medical malpractice reforms. Sections 48-59 of chapter 88-1, Laws of Florida, currently located in ss. 766.201-766.212, F.S., created additional presuit requirements and voluntary binding arbitration of medical negligence claims. The Legislature expressed its intent that arbitration provide:

- Substantial incentives for both claimants and defendants to submit their cases to binding arbitration, thus reducing attorney's fees, litigation costs, and delay;

- 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 damages 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.

Sections 766.201-766.212, F.S., establish a requirement that must be met before a claimant may file a claim for medical malpractice, establish limits for noneconomic damages, prohibits the awarding of punitive damages, establishes requirements for an arbitration panel, and provides for allocation of responsibility among multiple defendants.

III. Effect of Proposed Changes:

Section 1. Amends s. 400.021, F.S., to add the following definitions:

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, F.S., or an asserted deviation from the applicable standard of care. (This first part of the definition is being moved from s. 400.0233(1)(a), F.S.) The following is being added to the definition. 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.

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.

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, F.S., or s. 400.023, F.S.

Financial responsibility means demonstrating the minimum financial responsibility requirements as provided in s. 400.141(20), F.S.

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

"Insurer" means any self-insurer authorized under s. 627.357, F.S., liability insurance carrier, joint underwriting association, or uninsured prospective defendant. (This definition is being moved from s. 400.0233(1)(b), F.S.).

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, F.S., or s. 400.023, F.S.

Section 2. Amends s. 400.023, F.S., to provide that a licensee is liable for certain violations or negligence by a licensed nurse practicing under the direction of the licensee. The bill requires a resident or a resident's legal representative to include a certificate of compliance with the requirement to serve a copy of any complaint to AHCA when a complaint alleging violation of resident's rights is filed with court.

Section 3. Amends s. 400.0233, F.S., to require that presuit notice of a claim against a nursing home must be given to each prospective defendant. The notice 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 the bill, the time for the defendant to submit a written response 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 pre-suit time period in which to exercise the options described below:

- Rejecting the claim;
- Making a settlement offer; or
- Offer voluntary binding arbitration, in which liability is admitted and binding arbitration is conducted only on the issue of damages.

The bill authorizes parties to stipulate to toll the statute of limitations for 90 days in order to mediate.

The bill deletes definitions of "claim for resident's rights violation or negligence" and "insurer," which are provided in section 1 of the bill.

Section 4. Amends s. 400.0234, F.S., to provide that failure to provide complete copies of a resident's records will constitute failure of that party to comply with good faith discovery requirements and will waive the voluntary binding arbitration and mediation requirements established in the bill.

Section 5. Creates s. 400.02342, F.S., to make voluntary binding arbitration a statutorily defined option in lieu of a jury trial. It 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, F.S. Any party may elect to participate in voluntary binding arbitration, with respect only to a claim

arising out of the rendering of, or the failure to render, nursing home services. Such person may voluntarily submit the issue of damages to binding arbitration and have the issue determined by an arbitration panel. For purposes of arbitration, 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:

- Skin care;
- Mobility and walking assistance;
- Nourishment;
- Hydration;
- Infection prevention;
- Skilled therapy;
- Skilled nursing services; and
- Fall prevention.

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), F.S., 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), F.S., and ch. 90, F.S.

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.

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 (DOAH).

A party participating in arbitration may not use any other forum against a participating defendant during the course of the arbitration. A participating claimant agrees that damages be awarded according to this part, subject to the following limitations:

- 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.
- 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, F.S., or s. 400.023, F.S.
- 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, F.S., or s. 400.023, F.S., are limited to a maximum of $500,000, regardless of the number of individual claimants or defendants.
- Punitive damages may not be awarded.
- The defendant is responsible for the payment of interest on all accrued damages with respect to which interest would be awarded at trial.
- The party requesting binding arbitration shall pay the fees of the arbitrators and the costs of DOAH associated with arbitration, as assessed by DOAH. If DOAH determines that the plaintiff is indigent and unable to pay, the defendant must pay the fees and costs as assessed by DOAH, and the defendant shall have a claim for reimbursement against the estate of the plaintiff.
- A defendant who agrees to particate in arbitration under this section is jointly and severally liable for all damages assessed under this section.
- 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.
- 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.
- 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), F.S. A claimant who rejects a defendant's offer to arbitrate is subject to s. 400.02344(4), F.S.
- 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 AHCA. 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.
- This part does not preclude settlement at any time by mutual agreement of the parties.
- 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.
- Damages and costs that are not paid within 20 days are subject to postjudgment interest.
- This part does not relieve a defendant who voluntarily participates in binding arbitration from timely paying damages and costs awarded by an arbitration panel.

The bill provides 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.

The bill authorizes DOAH to adopt rules to implement this procedure, including a reasonable sanction, except contempt, against a party for violating a rule or failing to comply with an order. DOAH is authorized to charge a fee for conducting the arbitration. The administrative fee may not exceed $1,000. The bill allows parties to employ private arbitrators who must follow the same procedures.

Section 6. Creates s. 400.02343, F.S., to establish procedures concerning apportionment of financial responsibility among multiple defendants who agree to arbitrate. 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. The apportionment proceeding must be conducted before a panel of three arbitrators, including the administrative law judge who presided in the arbitration proceeding and two nursing home arbitrators appointed by the defendants. The apportionment panel must be convened no later than 65 days after the arbitration panel issues a damage award.

The apportionment panel must 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 are responsible to one another for their proportionate share of the damage award, attorney’s fees, and costs awarded by the arbitration panel.

The bill provides that 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 and extinguishes the defendant's liability for contribution to any defendant who did not participate in arbitration. A defendant paying damages has a cause of action for contribution against any defendant whose negligence contributed to the injury.

Section 7. Creates s. 400.02344, F.S., to provide that if neither party requests or agrees to voluntary binding arbitration, the claim will proceed to trial or to any available legal alternative such as offer of, and demand for, judgment under s. 768.79, F.S., or offer of settlement under s. 45.061, F.S.

If a defendant rejects a claimant's offer to participate in voluntary binding arbitration, the claim will proceed to trial 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.

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

- Damages are limited to net economic damages and noneconomic damages of no more than $750,000 per claim, regardless of the number of individual claimants or defendants.
- Attorney's fees may not be awarded.
- 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.
- Punitive damages may be awarded under ss. 400.0237 and 400.0238, F.S.

Section 8. Creates s. 400.02345, F.S., to provide procedures for determining if a specific claim is subject to binding arbitration. A court of competent jurisdiction must determine if a claim is subject to voluntary arbitration under ss. 400.02342 and 400.02348, F.S., 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 a plaintiff amends a complaint to allege facts that render the claim subject to binding

arbitration under ss. 400.02342 and 400.02348, F.S., the parties must decide whether to participate in binding arbitration no later than 30 days after the plaintiff files the amended complaint.

Section 9. Creates s. 400.02347, F.S. to require a defendant to pay a damage award within a specified time period. No later than 20 days after the arbitration panel makes a finding of damages, a defendant must:

- Pay the arbitration award to the claimant; and
- Submit any dispute among multiple defendants to arbitration.

Beginning 20 days after a damage award is issued by the arbitration panel; the award will begin to accrue interest at the rate of 18 percent per year.

Section 10. Creates s. 400.02348, F.S., to provide that an arbitration award and an apportionment of financial responsibility are final agency action for purposes of s. 120.68, F.S. An appeal must be taken to the district court of appeal for the district in which the arbitration or apportionment took place. An appeal does 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), F.S. A party to an arbitration proceeding may enforce an award or apportionment of financial responsibility by filing a petition in the circuit court.

Section 11. Amends s. 400.141, F.S., effective October 1, 2005, to require nursing homes to maintain general and professional liability insurance with admitted carriers, surplus carriers, or offshore captives in an amount not less than $2,500 per licensed nursing home bed. The policy may not allow for wasting of the policy with costs and attorney fees.

Effective October 1, 2005, in lieu of general and professional liability insurance coverage, nursing homes may demonstrate proof of financial responsibility in one of the following ways:

- Establishing an escrow account 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
- Obtaining an unexpired, irrevocable letter of credit in an annual amount not less than $2,500 per licensed nursing home bed.

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

The required amount of general and professional liability insurance or financial responsibility must be recalculated beginning January 1, 2007, and continue each January 1, by the rate of inflation for the preceding year. 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.

The bill provides that a nursing home facility that is part of a continuing care facility certified under chapter 651, F.S., 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.

Section 12. Amends s. 400.151, F.S., to provide criteria for resident's contracts, signed on or after July 1, 2005, that include arbitration or dispute-resolution provisions. The contract must give prominent notice of arbitration provisions using uppercase and bold typeface. The contract must explain the arbitration process and give notice of which claims are subject to arbitration. The contract may not limit the amount of damages other than to state the limitations set forth in this bill. These requirements do not apply to continuing care contracts which are governed by chapter 651, F.S.

Section 13. Amends s. 409.907, F.S., to prohibit AHCA from renewing a Medicaid provider agreement with a chronically poor-performing nursing home after January 1, 2007. Also after that date, a chronically poor performing nursing home may not participate in voluntary binding arbitration proceedings.

Section 14. Amends s. 409.908, F.S., to delete obsolete provisions and, effective October 1, 2005, to amend the Medicaid nursing home reimbursement plan to add a pass-through of professional liability insurance, including contributions establishing financial responsibility under s. 400.141(20), F.S., in an amount not to exceed $2,500 per licensed nursing home bed. The bill also authorizes AHCA to impose an assessment fee on nursing homes for quality assurance. The assessments will be matched with federal funds through Medicaid.

Section 15. Amends s. 400.147, F.S., to correct cross-references.

Section 16. Reenacts s. 430.80(3)(h), F.S., to incorporate the amendment to s. 400.141, F.S.

Section 17. Requires an annual adjustment of arbitration limits for inflation beginning January 1, 2007.

Section 18. Prohibits AHCA from renewing Medicaid provider agreements with a nursing home that has a pattern over time of actual harm or immediate jeopardy citations and provides that such facilities will be known as "chronically poor-performing nursing home facilities." AHCA must consult with the Florida Health Care Association, the Florida Association of Homes for the Aged (sic), and the American Association of Retired Persons to identify and improve poor-performing nursing homes and to analyze and prepare a report on the Medicaid Up-or-Out Program.

The bill expresses the intent of the Legislature that a study be conducted of all federal and state enforcement sanctions and remedies available to AHCA for use with nursing homes. The study must include a review of AHCA's use of receivership, civil monetary penalties, and denial of payment for new admissions. The results of the study must be presented to the Governor and Legislature by February 1, 2006.

Section 19. Requires AHCA to establish a health care quality improvement system for nursing homes to include guidelines for internal quality assurance, guidelines requiring the entities to conduct quality of care studies, and guidelines for external quality review.

Section 20. Effective October 1, 2005, each licensed nursing home must pay an initial annual assessment of $10 per bed per day for each licensed bed. Thereafter the assessment will be adjusted annually for inflation. The assessment will be used to enhance services, specifically to meet the minimum staffing ratios of 2.9 hours of direct care per resident per day.

Section 21. Prohibits a court form severing the provisions of the act in the event that a portion of the bill is found to be unconstitutional. The bill provides that the entire act will be null and void if any portion is found to be unconstitutional.

Section 22. Provides that the bill will take effect October 1, 2005, except as otherwise expressly provided in the bill.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

D. Other Constitutional Issues:

The bill limits the recovery that a claimant may receive if the claimant rejects a defendant's offer to enter into voluntary binding arbitration. This limitation raises questions about possible infringements on the right of access to the courts. Section 21, Art I of the State Constitution provides that the courts shall be open to all for redress for an injury. To impose a barrier or limitation on litigants right to file certain actions it would have to meet the test announced by the Florida Supreme Court in Kluger v. White[1]. Under the constitutional test established by the Florida Supreme Court in *Kluger v. White*, the Legislature would have to: (1) provide a reasonable alternative remedy or commensurate benefit, or (2) make a legislative showing of overpowering public necessity for the abolishment of the right and no alternative method of meeting such public necessity.

[1] See *Kluger v. White*, 281 So.2d 1 (Fla. 1973).

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

Nursing home providers will be assessed $10 per bed per day which must be paid annually. This amount will be adjusted for inflation. AHCA has not provided an estimate of a total annual amount for this fee.

B. Private Sector Impact:

Nursing home providers will be assessed $10 per bed per day which must be paid annually. This amount will be adjusted for inflation. The cost likely will be passed along to those residents who pay privately for nursing home care. AHCA has not provided an estimate of a total annual amount for this fee.

Nursing home providers are expected to pay higher rates for insurance coverage; however, Medicaid will reimburse providers for the costs of required insurance amounts.

C. Government Sector Impact:

According to AHCA, a minimum of four full time positions (FTEs) are necessary to carry out the prescribed programs and tasks provided in this bill at a cost of an estimated $276,779 the first year and $264,939 annually thereafter. Although the bill does not specifically provide a funding source for these positions, it may be the intent that the quality assessment fees in the bill will fund these costs. However the bill as currently written does not provide this authority.

VI. Technical Deficiencies:

On page 12, line 21, the number (2) should be inserted before (b).

On page 50, line 16, the bill misstates the name of the Florida Association of Homes for the Aging by using the word “Aged” in place of “Aging.”

On page 53, line 28, the number (9) should be replaced with (h).

VII. Related Issues:

The bill requires AHCA to study the Medicaid Up-or-Out Program. The program is no longer funded and has been inoperable since December 2003. A final report was issued by AHCA at that time.

VIII. Summary of Amendments:

None.