The Florida Senate

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Committee on Health, Aging and Long-Term Care Senator Saunders, Chairman

LONG-TERM CARE AFFORDABILITY AND AVAILABILITY

SUMMARY

Florida has grappled with issues surrounding the provision of long-term care for many years. Substantial problems remain. The state does not have a comprehensive strategy for economically and efficiently meeting the needs of an increasingly elderly population. There continue to be concerns about the quality of the care being provided in long-term care facilities. Public spending for nursing home care is increasing. Long-term care facilities are sued much more frequently in Florida than in the rest of the nation, and liability insurance for nursing homes is becoming more difficult to obtain and is much more expensive.

This report provides recommendations in three areas: developing a coordinated planning structure for the long-term care system, improving the quality of care in long-term care facilities and developing ways to make liability insurance more affordable for long-term care facilities.

BACKGROUND

Most states are facing an increasingly aged and disabled population in need of long-term, supportive services at the same time as demands on resources in other areas increases. Florida's elderly population is currently 2.9 million individuals, 18.3% of the state's population. "Baby boomers" will add 600,000 to that number by 2010. While the majority of Florida's elders live independent and healthy lives, the number of frail elders in need of long-term care services in nursing homes, assisted living facilities and formal home care programs is expected to increase over the next ten years. Florida's challenge is the result of years of state policy decisions about the structure and funding of its long-term care services, the rapid growth in the number of frail elders and disabled people in our state, and significant changes in society's ability to sustain and prolong life.

Long-term Care

Long-term care generally means care that is provided on a continual basis to persons with chronic disabilities. This care is often supportive, rather than curative in nature, and is provided in institutions, home-like institutional settings and to persons living in their own residence. Long-term care may be care provided in a nursing home, in a residential setting such as an assisted living facility, in an adult day care center, or may be delivered to a person as home care. Long-term care in nursing homes is more medically oriented and is often provided by licensed and certified personnel to people with severe limitations and severe cognitive disorders. Much of long-term care provided in the home is supportive in nature, such as assistance with the activities of daily living of eating, toileting, and dressing.

Since the late 1960's there has been an on-going process of "downward substitution" of care from highly institutional settings to less expensive, less institutional and more home-like settings for people with many types of disabilities. In the case of elderly individuals, this trend was significantly accelerated with passage of the federal Omnibus Budget Reconciliation Act of 1989 which created financial incentives for hospitals to discharge Medicare patients earlier, with the result that many nursing home residents are more acutely ill and disabled than in prior years.

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

In the late 1970's Florida implemented the Community Care for the Elderly program to assist frail older people to remain in their homes. In 1980, the federal government began granting waivers to allow states to use Medicaid funds for the purpose of assisting disabled individuals to remain in their homes as an alternative to institutionalization. Florida was one of the first states to implement such a waiver program.

For many years elder advocates have hypothesized that increased levels of less expensive state-supported home care could replace more expensive nursing home care. There has been considerable skepticism about the cost-effectiveness of this notion due to the difficulty of choosing recipients to ensure that services are provided to the same people who would otherwise be served in nursing homes, the loss of economies of scale incurred in bringing into people's homes the intensive services required by very frail individuals, and the tendency of case managers to over-prescribe services in an effort to meet patient desires and preferences.

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

Responsibility for long-term care programs is split between state agencies in Florida. The Agency for Health Care Administration Medicaid program finances nursing home care for Medicaid recipients. The Agency also determines how many nursing home beds are constructed, licenses nursing facilities, and regulates the quality of their care. Medicaid directly funds programs providing home care services. The Department of Elder Affairs operates the state's aging/disabled waiver program, the General Revenue- funded Community Care for the Elderly program and federally-funded Older American's Act programs.

The Department of Elder Affairs was created by the 1990 Legislature in response to a 1988 general election constitutional referendum calling for a state agency focused specifically on the needs and concerns of elders. Chapter 430, F.S., assigns the department lead responsibility for administering human services programs for the elderly and for developing policy recommendations for long-term care.

In 1994, the Legislature created the Commission on Long-term Care, chaired by former Senator Curtis Kiser. In 1995 the Commission developed recommendations for long-term care system reform, to be implemented by the Department of Elder Affairs, the Agency for Health Care Administration and the Department of Children and Family Services. The Commission's primary recommendation was that the state should begin planning to meet its residents= long-term care needs in order to ensure that the state=s long-term care dollars are spent on the most appropriate and cost-effective mix of institutional, residential and community services. The report also recommended the development of alternative systems of care, including transitioning the state=s entire long-term care delivery system from an institutional to a community and risk-based managed care model integrating acute and long-term care services by the year 2000, and establishing a long-term care planning and coordination advisory body.

Lawsuits Against Nursing Homes and Assisted Living Facilities

There is a growing concern among long-term care policy experts that lawsuits against nursing homes and assisted living facilities in Florida are growing at a disproportionate rate compared to the rest of the country. The purported cause of these suits is reported to be Florida's unique statutory scheme of liability which combines a broad residents' rights civil liability cause of action with unlimited compensatory and punitive damages, combined with the lure of add-on attorney's fees. The long-term care industry perspective is that this has created an atmosphere in which nursing homes are an easy and lucrative target for litigation, and that conditions produced by the normal process of aging and frailty at the end of life are responsible for a substantial portion of the lawsuits.

Availability of Liability Insurance

The effect of the increase in suits and judgments is that nursing homes and assisted living facilities are experiencing large insurance premium increases and are increasingly unable to secure liability insurance coverage from regulated carriers. Liability insurance which is available is increasingly expensive, with the result that 9% of Florida's nursing homes do not have liability coverage. Nursing homes are not required to have liability insurance. Assisted living facilities are required, as a condition of licensure, to maintain liability insurance.

Financial Viability of the Nursing Home Industry

Approximately 20% of Florida nursing homes are currently under Chapter 11 bankruptcy protection. Other nursing homes are reported to be teetering on the brink of bankruptcy. The causes of this situation are variously described as a change in Medicare reimbursements to nursing homes, bad business decisions on the part of nursing home companies, reimbursements to government programs for revenues generated through

fraudulent billing, Medicaid reimbursement which does not cover the rapidly increasing cost of providing care to residents, lawsuits, and increasing liability insurance premiums.

Adequacy of Government Payments

Nursing homes have stated that Florida Medicaid payment rates are inadequate to reimburse their costs. Nursing homes were able to stay in business by subsidizing costs associated with these residents from revenues received from the Medicare program and private pay residents. The Balanced Budget Act of 1997, however, was implemented for the purpose of eliminating perceived inappropriate charges by nursing homes to the Medicare system. The Balanced Budget Act of 1997 modified the Medicare reimbursement scheme to ensure that the federal government reimbursed only for care necessary to meet the needs of patients.

Quality of Care in Nursing Homes

Nursing homes have long been seen as care settings for the elderly of last resort, both because they were seen as institutions where the elderly went to die, and because of perceptions of indifferent, callous and uncaring treatment by nursing home staff. Patient advocates, family members of people in nursing homes and attorneys representing nursing home residents often have taken the position that the state system for assuring quality and humane care in nursing homes has failed and that recourse to the courts is the method of last resort to force nursing homes to provide quality care and to punish those who do not.

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

> The report described health hazards and deficiencies in patient care that allegedly have been allowed to continue for years. Of the 38 Dade County nursing homes surveyed by the Grand Jury, 60 percent provided either generally unacceptable or consistently very poor care. The Jury found that sanctions against homes are invoked 'rarely, timidly, and ineffectively,' and that once a deficiency is identified, on-site follow-up visits are too infrequent to ensure correction. [p. 1, *Senate Staff Analysis and Economic Impact Statement*, June 10, 1980]

The 1987 Omnibus Budget Reconciliation Act (OBRA-87) was the most sweeping set of reforms to nursing home regulations enacted by Congress since the passage of Medicare and Medicaid. These reforms were passed in response to consumer complaints and a host of state and federal reports criticizing both nursing home quality and government regulatory efforts. They also responded to a congressionally mandated study by the Institute of Medicine on how to improve nursing home quality, and they embodied most of the Institute's recommendations. The reforms were endorsed by a substantial bipartisan majority in Congress and enjoyed widespread support from nursing home residents, families, organizations representing the elderly, and a host of long-term care providers, including nursing home owners, administrators, nurses, social workers, therapists, and physicians.

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

Residents' bill of rights suits

Section 400.023, F.S., creates a statutory cause of action against nursing homes who deprive or infringe upon the rights of residents specified in s. 400.022, F.S. Sections 400.428 and 400.429, F.S., contain similar provisions for assisted living facilities. Prevailing plaintiffs may be entitled to recover reasonable attorney's fees, and costs of the action, along with actual and punitive damages. Prevailing defendants may be entitled to receive attorney's fees. The statutes require that attorney's fees be based on a number of factors including time and labor involved, difficulty of the case and other similar factors.

Suits may be brought by the resident, his guardian, a person or organization acting on behalf of the resident, or the personal representative of the estate of a deceased resident. If the suit alleges a deprivation of the right to receive adequate health care which results in injury or

death, claimants are required to conduct an investigation which includes a review of the case by a physician or registered nurse familiar with standards of care for nursing home residents, and a statement that the deprivation of the right occurred during the resident's stay in the nursing home.

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

Medical Malpractice Suits

Medical malpractice actions are the subject of ch. 766, F.S. In medical malpractice actions, the burden is on the claimant to prove by a greater weight of the evidence that the actions of a health care provider represented a breach of the prevailing professional standard of care for that provider. Claimants must notify defendants of their intent to sue, and defendants' insurers must conduct a review to determine the liability of the defendant. The defendant may admit liability and offer to arbitrate the amount of damages. Alternatively, the court may, upon motion of any party, require the parties to submit to non-binding arbitration. Chapter 766 also provides a third method of voluntary binding arbitration. In this scheme, the defendant does not admit liability, but does agree to arbitrate the amount of damages. Economic damages are limited to past and future medical expenses, and 80% of lost earning capacity, reduced by collateral payments. The statute provides for the settlement to be reduced by the amounts of payments made to or on behalf of the claimant, and that future damages be reduced to present value. Non-economic damages are limited to $250,000 per incident, calculated on a percentage basis with respect to capacity to enjoy life. Punitive damages are not allowed. Defendants shall pay attorneys fees for claimants, limited to 15% of the award, reduced to present value. If a defendant refuses binding arbitration, there is no cap on damages at trial, and attorney's fees are recoverable up to 25% of the award. If a claimant rejects binding arbitration, damages at trial are limited to net economic damages and $350,000 in non-economic damages. Malpractice suits may be brought by the injured patient or, if the patient dies, the personal representative of the patient's estate.

Wrongful Death Suits

Wrongful death is the subject of ss. 768.16-768.27, F.S. Suits for wrongful death may be brought by the decedent's personal representative on behalf of survivors and the decedent's estate. Personal injury suits abate when a personal injury results in death. Survivors may recover the value of lost support and services, spouses may recover for loss of companionship and mental pain and suffering, minor children (or all children if there is no spouse) may recover for lost companionship, guidance and mental pain and suffering, and parents may recover for mental pain and suffering. The Wrongful Death Act prohibits adult children from recovering damages for mental pain and suffering when their parent dies as a result of medical malpractice. Additionally, parents of an adult child who dies as a result of medical malpractice may not recover damages for pain and suffering. The decedent's estate may recover damages for lost earnings from the date of injury to the date of death, loss of prospective net accumulations, and medical and funeral bills.

Civil Damages

Damages are the subject of ss. 768.71-768.81, F.S. A claim for punitive damages is not permitted unless there is a reasonable showing by evidence that there is a reasonable basis for recovery of such damages. Punitive damages are awarded only after a determination, based on clear and convincing evidence that the defendant was personally guilty of intentional misconduct or gross negligence. Intentional misconduct is defined as the defendant knowing the wrongfulness of the conduct and the high probability that injury would result, and still intentionally pursuing the course of the conduct, resulting in the damage. Gross negligence means that the conduct was so reckless or wanting in care such that it constituted a conscious disregard or indifference to the life, safety, or rights of persons exposed to such conduct.

Punitive damages may be imposed on a corporation or employer only if the above criteria are met and the corporation knowingly participated in the conduct, condoned or consented to the conduct or the corporation engaged in conduct which was grossly negligent and contributed to the loss suffered. Punitive damages are limited to three times compensatory damages, or $500,000, whichever is greater. If the defendant's conduct was motivated solely by financial gain, then punitive damages may not exceed the greater of four times compensatory damages or $2,000,000. There is no cap on punitive damages if the defendant had a specific

intent to harm the claimant.

As noted earlier, these damage standards do not apply to ch. 400 suits, in which case punitive damages are limited to three times compensatory damages unless the claimant demonstrates to the court by clear and convincing evidence that an award in excess of the limitation is not excessive in light of the facts and circumstances that were presented.

Senior Housing

A sizable percentage of the more than 80,000 senior residents in Florida's rent subsidized housing facilities are having trouble living independently. This group tends to be women living alone, members of ethnic and racial minorities, and those reliant on Medicaid benefits. They often experience health problems and declines in physical and mental functioning. There is little coordination between state-funded community care programs and public housing providers.

Medicaid Nursing Home Budget

Florida's Medicaid nursing home expenditures will increase by nearly $100 million between FY 1999-2000 and FY 2000-2001. Florida has a relatively low number of nursing home beds per 1,000 aged 65+, at 30.1. Over the past two decades, however, the growth in the number of nursing home beds (129%) in Florida was more than double the increase in the state's 65+ population (63%). The result is the ratio of nursing home beds in Florida increased from 21 to 30 beds per 1,000 persons aged 65+ from 1980 to 1998. Despite the fact that this is a relatively low bed rate compared to the rest of the country, Florida continues to experience substantial growth, and a high percentage increase in nursing home utilization, as measured by total days of care and nursing home expenditures. Medicaid pays for approximately two-thirds of the patient days in nursing homes in Florida.

The Task Force on the Availability and Affordability of Long-Term Care

The Legislature created, in the 2000 Session, the Task Force on the Availability and Affordability of Long-Term Care. The purpose of the task force was to assess the current long-term care system in terms of the availability of alternatives to nursing homes, the quality of care in nursing homes and the impact of lawsuits against nursing homes and other long-term care facilities on the costs of care and the financial stability of the long-term care industry. The task force was chaired by the Lieutenant Governor and received staff support from the Florida Policy Exchange Center on Aging, which prepared a comprehensive report based on a wide range of research materials, public testimony and the contributions of task force members. On December 18, 2000, the members of Task Force determined that they would not reach consensus on recommendations and decided not to submit recommendations to the Legislature.

METHODOLOGY

To complete this report Senate staff reviewed both national and Florida literature regarding long-term care, met with staff of the Florida Policy Exchange Center on Aging at the University of South Florida, the Department of Elderly Affairs, The Agency for Health Care Administration, and the nursing home and assisted living facility industries. Staff attended meetings of the Task Force on the Availability and Affordability of Long-term Care in Tallahassee, Tampa, Pensacola, Miami and Jacksonville.

FINDINGS

Lawsuits

One of the tasks assigned the Task Force was to determine "the kinds of incidents which lead to the filing of lawsuits and the extent to which frivolous lawsuits are filed." In an attempt to determine the merits and costs of nursing home lawsuits the task force performed several separate analyses of lawsuits in Florida. Staff of the Task Force reviewed all ch. 400 nursing home lawsuits filed in Hillsborough County since 1990, reviewed all jury-tried nursing home lawsuits statewide since 1990, analyzed the relationship between Agency for Health Care Administration survey data and lawsuits, and reviewed all lawsuit settlement data which was publicly available. In addition the Task Force reviewed a study of the costs and frequency of lawsuits submitted by Aon Actuarial Services under contract with the Florida Health Care Association (FHCA). Significant findings were:

1. Since 1990, 256 nursing home care resident suits had been filed in Hillsborough County. Eighty percent of the nursing homes in Hillsborough County had at least one lawsuit, with most (51%) having fewer than five suits.

2. No frivolous suits were found. All suits contained serious allegations pertaining to the resident's physical condition and cite the violation of the statutory right to adequate and appropriate health care as the cause of action. These lawsuits are fundamentally about pressure sores, falls, dehydration, and malnutrition or weight loss among nursing home residents.

3. In virtually all the suits, infringement on the right to receive adequate and appropriate health care was the primary cause of action. In many of the suits, an infringement of the right to privacy and dignity were secondary causes of action.

4. Suits were filed by the resident, spouses, sons and daughters and personal representatives in 88% of the cases. Wrongful death was alleged in 89 of the 256 suits.

5. Data from the FHCA/Aon study of losses reported by 12 predominantly multi-facility, for-profit chains in Florida indicated that the average size of claims for these facilities in Florida was $278,637, which is 250% greater that the average claim in other states ($112,351). The average loss per occupied bed in these facilities in Florida in 1999 was $6,283, which is 8 times the average loss in the other 49 states ($809).

6. Add-on attorney fees were not regularly awarded in nursing home lawsuits. In 68% of the Hillsborough cases, each party paid its own attorney's fees.

7. Agency for Health Care Administration survey violations, severity of patient condition, for-profit status and Medicaid patient ratios were not predictive of lawsuits being filed.

8. The number of lawsuits filed per year in Hillsborough County peaked in 1998 with 26 suits being filed. In 1999 17 suits were filed, and 3 had been filed by August 2000. The task force hypothesized that closure or change in ownership of the three nursing homes having the most suits (more than 20 times) had caused the drop in the number of lawsuits filed.

9. The Hillsborough survey identified 16 lawsuits against assisted living facilities since 1990. These suits generally involved charges of failure to provide adequate and appropriate health care.

Other State Resident Bill of Rights and Tort Systems

A review of other state (including Washington D.C. and Puerto Rico) nursing home resident rights laws and tort practices performed by GeneralCologne Reinsurance (*GeneralCologne Re: 50-State Long Term Care and Tort Liability and Survey Information*) indicated that 36 states had a resident's bill of rights. Of these, 31 allowed tort recovery for violation or deprivation of resident's rights. In six states, punitive damages are recoverable for resident's bill of rights violations. In two, punitive damages are recoverable under adult protection or elder abuse statutes. Attorney's fees are recoverable under resident's bills of rights or elder abuse statutes in 15 states. Tort damages are unlimited in 28 states. In 15 states, there is a resident's bill of rights, punitive damages are recoverable under that bill of rights or under common law, and tort damages are unlimited.

Availability of Liability Insurance

The Department of Insurance conducted research to determine the status of the Florida long-term care liability insurance market for nursing homes, assisted living facilities and continuing care retirement communities. The department concluded that the long-term care liability market had shrunk significantly, as it has in the rest of the nation. As of September, 2000, 17 companies were writing coverage in Florida, however, 6 of the 17 insurers wrote only two policies in 2000. Twenty-three other companies, which did provide this coverage in the last three years, no longer provide this type of insurance. Companies which were withdrawing from the long-term care market reported that they are doing so nationally. Of those companies which are still providing this type of coverage, most have tightened underwriting criteria, particularly in Florida and Texas, and raised rates and deductibles, citing high loss ratios, the legal climate, and problems with obtaining reinsurance. Companies withdrawing from selling this type of coverage began initial withdrawals in Florida and California, each of which allows unlimited punitive damage recoveries for resident bill of rights violations and permits unlimited damages in tort actions, and Texas, which excluded elder abuse matters from its tort reform and has been the site of several high nursing home verdicts ($83 million, $65 million, and $28 million in 1997, 1999, and 1998, respectively).

According to testimony from an insurance underwriter who testified before the task force, his company, the last admitted (regulated) carrier writing policies in Florida will stop renewing policies effective February, 2001, forcing facilities to purchase coverage from unregulated excess and surplus lines companies. Representatives from insurance agents reported that some excess and surplus lines companies were also planning to withdraw from the market for reasons similar to the admitted carriers.

Risk Pooling

During Task Force deliberations and in public testimony, considerable concern was expressed by and about nursing facilities which had experienced no suits but nevertheless were unable to purchase liability insurance or which had been forced to pay extremely high premiums in order to obtain coverage. Many of these were faith-based or non-profit facilities. Some public

testimony suggested establishing separate risk pools for facilities with no quality of care difficulties as a possible solution.

Insurance representatives explained that their practice is to set rates based on the entire universe of facilities in a single risk pool providing a given type of care. Assisted living facilities, for-profit and non-profit facilities, since they provide the same type of care, are included in the same risk pool. Once rate levels are established at base limits, the prospective client is evaluated for discounting by review of claims history, financial condition, risk management practices, staff skills and subjective factors. Separating facilities into good and bad risk pools would, in the insurance industry's opinion, create a group of facilities which was uninsurable since it would be impossible to spread the costs of the losses for these facilities to those which had fewer losses.

Financial Viability of the Nursing Home Industry

A number of major nursing home chains (Vencor, Mariner, Genesis Health Ventures, Sun Healthcare, and Integrated Health Services) are currently in bankruptcy proceedings. In Florida, 21 percent of nursing home beds (17,000) are in facilities which have filed for Chapter 11 bankruptcy protection. The precarious condition of many nursing homes appears to be due to a variety of factors including changes made to the Medicare reimbursement system in the Balanced Budget Act of 1997, business decisions made and debt burdens acquired based on a belief that Medicare payment would continue to increase, decreased revenues due to efforts to fight fraud and waste in the health care industry, and litigation and insurance costs.

Changes to the Medicare reimbursement system stemmed in part from a GAO report in 1995 which found that nursing homes were engaging in widespread overcharges, inflated markups, and exploitation of regulatory weakness in the Medicare system. The GAO described the problem as "national in scope and growing." Abusive billing practices in the nursing home industry were characterized as pervasive. The GAO cited complaints from Medicare patients of nursing homes billing for unnecessary and unprovided services, concluding that lax Medicare rules invited abuse. The result of this system was a rise in ancillary costs at a rate of 19% per year while routine costs rose at 6% per year. The GAO noted that the rise in ancillary costs was "not explained by increase in beneficiary health needs."

Of the seven largest chains, most had higher than average costs. In two, capital costs are substantially higher than the national average and a third reported a four-fold increase in rent due to renting from its own subsidiary. Most of the chains in bankruptcy had invested heavily in selling ancillary services to themselves and others.

The BBA of 1997 closed loopholes by gradually phasing out the system which allowed for unlimited cost based reimbursement and gradually phasing in a system in which payment was a per day amount based on severity of patient health care need. The average Medicare per diem declined by about 9% between FY 1998 and 1999, reaching the same average rate as in 1996. The GAO found this noteworthy, because payment rates in 1996 were believed to be excessive given that they reflected 6 years of growth at more than 12% per year at a time when prices for goods and services purchased by nursing homes were rising about 3% each year.

According to the GAO, the Balanced Budget Reconciliation act of 1999 restored some of the funding to facilities which had been hurt by the BBA 1997 changes by increasing payments across the board by 4% for 2001 and 2002, adding an estimated $200 million to Medicare nursing home spending in FY 2000. The GAO estimated that if the increases were allowed to remain in place for five years, total Medicare nursing home spending would increase by $1.4 billion nationwide. In December, 2000, the Congress added an additional $1.6 billion to Medicare payments to nursing homes.

Industry analysts and government officials expect that most public chains currently operating in bankruptcy will recover. In states where a large number of nursing homes are operating in bankruptcy, however, it is important that contingency plans be developed to address the closure of some bankrupt facilities.

Adequacy of Government Payments

Florida Medicaid pays nursing homes a facility-specific per diem rate based on the facility's reported costs. The per diem is the aggregate of costs in four specific domains: operating expenses, patient care, property costs and return on equity. The operating component includes administration, laundry, plant operations and housekeeping. The patient care component includes nursing, dietary, social services, and ancillary expenses. The property component includes interest, depreciation, insurance, property taxes, and equipment rental. Each of these components is calculated separately and the components are combined to determine the per diem. Reimbursement ceilings limit the level of increase in facility per diem rates. According to the Medicaid program, per diem rates as of July 1, 2000, are reimbursing 89% of facility Medicaid costs.

House bill 1971, passed during the 1999 Legislative session, created the Panel on Medicaid Reimbursement to study the state's Medicaid reimbursement plan and recommend changes. The panel was housed at and staffed by the Agency for Health Care Administration. The panel determined that quality of care to nursing home residents was likely to be negatively affected by the increasing difficulty providers are experiencing in hiring and retaining direct caregiver staff and the lack of current incentives for nursing homes to renovate and update physical plants. The panel recommended rebasing the patient care component and gave options to modify the Fair Rental Value System in the property component.

Nursing Home Staffing

Currently, according to the Institute of Medicine, the key indicators by which quality is monitored and measured in the nursing home environment are: (1) pain, (2) use of physical and chemical restraints, (3) pressure sores, (4) malnutrition, (5) continence care, and (6) aspects of care related to quality of life. The quality of services provided in nursing homes is increasingly dependent on the personnel available. This dependence is based on the reality that most nursing home residents are sicker than nursing home residents being admitted just a few years ago.

In January 2000 the University of California released the results of a study funded by the Health Care Financing Administration entitled *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1992 Through 1998*, by Charlene Harrington, Ph.D., et al. The report provides several statistical findings relating to nursing homes throughout the United States, presented in a state-by-state format. In Table 30 of the study, statistics cited for Florida show that the state's nursing homes, for each of the focus years, slightly exceeded the national average in staffing as computed using payroll hours per resident day rather than actual hours of care delivered directly to residents. These data were reported by each facility for the two weeks prior to the facility survey. Despite the fact that on average, Florida facilities had higher staffing ratios, Florida facilities were cited more often than the national average on a number of key indicators.

Percent of Nursing Homes Cited for Top Ten Deficiencies

Indicator	% Nat'l	% Fl
Food Sanitation	23.7	30.5
Dignity	14.1	24.7
Quality of Care	17.2	20.3
Pressure Sores	17.1	20.5
Comp.Care Plans	15.2	24.8
Comp. Assessments	15.1	17.7
Physical Restraints	12.7	15.5
Accident Prevention	14.7	10.0
Accidents	18.0	10.8
Housekeeping	14.4	13.3

Source: U. Cal report, 2000

Two trends, relating to staffing, detected from data presented in the report are particularly noteworthy. First, the study illustrates that while facilities in Florida, on average, exceeded the national average in staffing ratios, the percentage of nursing homes in Florida cited for nutrition deficiencies, from 1992 through 1998, exceeded the national average, and were more than double or almost double the national average for several years.

Percent of Nursing Homes Cited for Nutrition Deficiencies

	1995	1996	1997	1998
National Average	8.1%	8.1%	8.3%	8.1%
Florida Average	16.2%	16.6%	15.5%	13.2%

Source: U. Cal report, 2000

In addition, Florida has seen a steady increase in the percentage of facilities with deficiency citations issued for insufficient staffing, while the national average which has stayed within a narrow range of variation for most of the study's focus years

Percent of Nursing Homes Cited for Staffing Deficiencies

Year	% Nat'l	% FL
1992	6.0	4.8
1993	6.2	5.6
1994	7.0	7.1
1995	5.7	9.3
1996	4.2	10.9
1997	3.8	10.8
1998	4.6	13.9

Source: U. Cal report, 2000

Senior Housing

Administrators of public housing for the elderly judge that 14 to 17% of elder tenants are having trouble remaining responsible for themselves and that 11-17% are confused, abusive, or depressed. Elder tenants themselves reported higher self-estimates of their dependency, and only 37% of them felt that if they were sick or disabled, they could rely on someone to help them as long as needed. The top two services they felt lacking: handrails or grab-bars in their bathroom and transportation to and from a doctor's appointment. Over a third of elder tenants have no idea where they would move if they had to vacate their apartment. In practice, an average of 30% of the tenants who do annually vacate their apartments enter a nursing home.

Finding appropriate and affordable supportive services is stressful and difficult. This is especially the case for seniors who cannot rely on family assistance, who are less educated, have trouble speaking English, or are easily intimidated by bureaucratic ways. State funded community-based service providers compound this problem by either underestimating these elder tenants' needs, identifying them as a lower-priority group, or by offering only overly narrow care. In some cases service providers are simply too over-committed to reach this group.

Many public housing facilities have expressed interest in converting existing public housing to assisted living to meet these needs. The drawbacks of this approach are that these providers often want government to pay for both the conversion and the ongoing services which will be provided to these residents, there are regulatory requirements for assisted living which are not present for public housing, and this strategy creates a deficit in the number of public housing units available to low-income elderly individuals.

In December, 2000 the federal Department of Housing and Urban Development announced that $20 million in federal assistance would be made to convert existing low-income senior housing into assisted living facilities. The grants will cover only construction costs; project owners will be responsible for providing supportive services to individuals residing in the converted facilities. Florida's allocation of these conversion funds is $2.75 million.

RECOMMENDATIONS

1. Florida should develop a plan to build a system of delivering long-term care to elderly residents which provide maximum choice of alternatives so that elderly citizens can receive care in the most cost-effective settings appropriate to their needs.

- The Legislature should establish, in the Executive Office of the Governor, an interagency panel responsible for analyzing Florida's long-term care system, ensuring coordination among the agencies responsible for the long-term care continuum, and making recommendations to executive agencies and the legislature designed to increase quality of care and the use of non-institutional settings to provide care to the elderly.
- The Legislature should require the Department of Elder Affairs and its local contractors to develop formalized linkages to public housing providers, and to increase services to residents of these facilities who are at risk of nursing home placement
- The Agency for Health Care Administration should develop a strategy for insuring that, if the state's inventory of nursing homes is reduced due to closures, care of patients is re-directed to the highest quality facilities or alternative care settings.

2. Florida should take steps increase the quality of care for persons in nursing homes and assisted living facilities.

- The Legislature should increase staffing standards in nursing homes, and ensure that Medicaid reimburses these costs for Medicaid recipient care.
- The Legislature should prohibit renewal of nursing home and assisted living facility licenses if there are unpaid fees or sanctions due to the state.
- The Legislature should require the Agency for Health Care Administration to increase the frequency of on-site visits to long-term care facilities, and increase licensure fees to support this increased oversight.
- The Legislature should require the Agency for Health Care Administration and Department of Elder Affairs to develop contingency plans for mitigating the effects of closure of some of the state's nursing homes.
- The Legislature should increase funding to the Long-Term Care Ombudsman program to expand recruitment, training, and support of volunteers.
- The Legislature should increase funding for public guardians to protect the interests of nursing home residents who need but do not have guardians.

3. The Legislature should attempt to stabilize liability risks for long-term care facilities.

- The Legislature should consider capping attorneys fees and damages in resident rights lawsuits to bring

stability and predictability to the long-term care liability market. Such caps should; however, insure that residents have access to judicial remedies in instances of abuse, neglect and resident's rights violations.

- The Legislature should remove the requirement that assisted living facilities maintain liability insurance as a condition of licensure.

COMMITTEE(S) INVOLVED IN REPORT ***(Contact first committee for more information.)***
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MEMBER OVERSIGHT
Senator McKay