

Task Force on Availability and Affordability of Long Term Care

Meeting Agendas and Minutes

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February 16, 2001

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Task Force on Availability and Affordability of Long-Term Care

Lt. Governor Frank T. Brogan, Chairperson

Secretary Gema Hernandez, Dr. P.A., Department of Elder Affairs

Bob Sharpe, Agency for Health Care Administration

Philip Freidin, The Florida Bar

Larry Sherberg, Florida Assisted Living Association

David Grofic, Florida Association of Homes for the Aging

Walter Liptak, Insurance Industry

Rene Rodriguez, DOEA Appointee for HUD

Raymond Noga, Investment Banking Representative

Jeff Dwyer, Ph.D., State University System

Jesse Lipnick, M.D., Florida Medical Association

Cherryl Chmielewski, Long-Term Care Provider/AARP Member

Kenneth Connor, JD, Attorney General Appointee

Joy Calkin, Ph.D., Florida Health Care Association

Ed Boyer, Long-Term Care Ombudsman Program

Robert Miller, Senate Consumer Appointee

Victoria Fierro, House of Representatives Consumer Appointee

Hon. John McKay, State Senator

Hon. Nancy Argenziano, State Representative

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AGENDA

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

July 17, 2000, 9:00 a.m. -12:00 noon

Knott Building, Room 412, 400 South Monroe Street The Capitol, Tallahassee

Note: This meeting will be tape-recorded and transcribed for the public record.

8:30 Continental Breakfast

9:00 Welcome Lt. Governor Frank Brogan, Chairperson

Welcome from the Legislature Senator John McKay
Representative Durell Peaden, M.D., J.D.

Introductions Task Force Members

Task Force Charge and Direction Lt. Governor Frank Brogan, Chairperson

10:30 Break

10:45 Task Force Logistics Kathryn Hyer, Task Force Liaison
Upcoming Meeting Dates & Locations (Kathryn Hyer)
Travel Reimbursement (Pam Stobaugh)
Public Testimony Procedures (Kathryn Hyer)
Sunshine Laws (Greg Munson)
External Communication

Research Approach Larry Polivka, Director
Florida Policy Exchange Center on Aging

Response to Research Approach Task Force Members

Priorities and Changes to Research Approach Task Force Members

12:00 Adjourn

MINUTES
Task Force on Availability and Affordability of Long-Term Care
July 17, 2000
Knott Building, Room 412, The Capitol, Tallahassee, Florida

Present: The Honorable Frank Brogan, Dr. Gema Hernandez, Mr. Gary Crayton, Mr. Philip Freidin, Mr. Larry Sherberg, Mr. David Grofic, Mr. Walter Liptak, Mr. Rene Rodriguez, Dr. Jeff Dwyer, Dr. Jesse Lipnick, Ms. Cheryl Chmielewski, Mr. Kenneth Connor, Mr. Robert Miller, Ms. Victoria Fierro, The Honorable John McKay, and The Honorable Nancy Argenziano.

Absent: Mr. Raymond Noga, Dr. Joy Calkin, and Mr. Ed Boyer.

Guests present: The Honorable Durell Peaden, Mr. William Phelan (non-voting, non-speaking stand-in for Dr. Joy Calkin), Dr. Larry Polivka, Jennifer R. Salmon, Dr. Kathryn Hyer, Ms. Pam Stobaugh.

The Chairman, The Honorable Frank T. Brogan, Lieutenant Governor, called the meeting to order on or about 9 a.m. and welcomed the Task Force members and public to the first meeting of the Task Force on Availability and Affordability of Long-Term Care.

Task Force members introduced themselves and described their background as it related to the task force and, in some cases, the areas in HB 1993 that most concerned them.

Dr. Larry Polivka, Florida Policy Exchange Center on Aging, introduced his staff.

The Chairman introduced The Honorable Anna Cowan and The Honorable Charlie Cleary from the Florida Senate and Pete Buigas from the Agency for Health Care Administration.

The Chairman noted the importance of this Task Force. The urgency borne out of the current crises in our long-term care system will make this initiative different from the previous Commission on Long-Term Care and other initiatives like it. We have to address all aspects of the legislation and in long-term care beginning with the dollars and cents but also looking at quality of care, the importance of litigation, alternatives to nursing home and assisted living facility care. The Florida Legislature took a courageous first step in passing this legislation.

President-elect John McKay welcomed the other Task Force members and stated that as President-elect of the Senate his agenda is to address the programs that are just below the surface of our attention. This panel is not about liability insurance or lawsuits but about appropriate housing and care. We must be a good steward of the public's trust and provide quality care. The cost of nursing home care is the bear that will eat the budget's lunch. It is time to bring common sense to our approach for housing our elder citizens. Each of the members represents a vested interest and bring a unique point of view but we must not get bogged down in a narrow agenda or we won't serve the purpose that has been given to you. We are seeking to find a policy that will find appropriate housing for our elders. We've asked you to come up with a piece of legislation which is unusual for a Task Force. It is also unusual that a Task Force is chaired by the Lieutenant Governor. His presence is a commitment to resolution. The President-elect is also committed to resolution of this crisis.

Representative Peaden, welcomed the Task Force members on behalf of the House of Representatives. Long-term care is one of the most expensive and complex programs in the state. In his experience as a physician, the acuity level of nursing home residents today is what used to be cared for in acute care hospitals in the past. The increases in longevity need to be matched by increases in quality of life. The issues that are important are: quality of care, reimbursement for care, the cost of pharmaceuticals, certificate of need and regulation, manpower shortages, educating young people to plan for long-term care, and the need for a standard of care. Liability is a small part. The cost of long-term care will be more than the cost of prisons or acute care.

The Chairman noted that in addition to the Governor's support, the President-elect's support, the Speaker-elect Tom Feeney is also committed to changes in our long-term care system. The charge to this Task Force from the HB 1993 is to create a piece of legislation. We may actually create more than one piece. We will need to familiarize ourselves with current legislation. Our timeline is short; there isn't time for meandering or fretting. There is an urgency here for us to move. We need to keep all our agendas on the table but remember that it is about our constituents. He then reviewed the agenda, the upcoming meetings and public testimony hearing dates.

Secretary Hernandez stated that we need to gather all the legislation in Florida related to eligibility and service availability for the full continuum of long-term care.

Mr. Freidin asked which of the meetings would include votes. The Chairman said that there may be procedural votes at any meeting but most likely voting on the final set of resolutions would be reached near the end of the Task Force at the December 4 meeting.

Mr. Sherberg asked for a copy of the Kizer Commission on Long-Term Care report to be sent to all Task Force members.

The Chairman noted that all members should identify important materials that could help Task Force members understand the issues and forward copies to FPECA for distribution.

Secretary Hernandez asked how accurate were the projections in the Kizer Commission report and that any future use of the model take into account the degree of frailty, the cost of care, and the appropriate level of care.

Representative Argenziano expressed concern that there be sufficient time at each public testimony hearing for the public to speak and that help be provided to citizens who need assistance to attend.

The Chairman stated the importance of advertising and spreading the word to achieve the greatest amount of input and fairness to all at the hearings.

Mr. Connor noted that in Paragraph 4 of HB 1993, members of the Task Force may not delegate their attendance or voting power to designees and asked about the Chairman's decision to allow Mr. Phelan to stand-in for Dr. Calkin. He suggested that the language in HB 1993 provided an incentive for the members to attend each meeting. The Chairman said that due to the extenuating circumstances of Dr. Calkin's absence, he accepted Mr. Phelan's request to stand-in as a non-speaking and non-voting participant.

Dr. Hyer, Task Force Liaison at FPECA, addressed the Task Force regarding the dates and times for the remaining six meetings. The Miami meeting will be held only on September 18th. The meetings are scheduled for: Friday, August 25 (Tampa); Monday, September 18 (Miami); October 16 (Pensacola); October 30 (Tallahassee); December 4 and 18 (Tallahassee). The next four meetings will be divided between mornings for Task Force business and afternoon/early evening for Public Testimony. The draft rules for the Public Testimony hearings were reviewed: Hearings are held 2-6 p.m. to accommodate the public's work schedules; speakers will have 3 minutes that may be followed with questions from the Task Force; written testimony may be submitted; oral testimony will be taped and transcribed.

Ms. Stobaugh, Meeting and Reimbursement Coordinator at FPECA, addressed the Task Force regarding reimbursements and referred members to the General Travel Information in their notebooks. Travel expenses will be reimbursed within the limits of Florida Statutes and with original receipts. Reimbursement forms will be brought to each meeting for Task Force members to sign. Members were also asked to make corrections on the Task Force Member Information form and send a brief biographical sketch to FPECA by the end of the week.

The Chairperson reiterated the importance of planning for the public testimony hearings and being reasonable about the time allotted to each speaker. Task Force members can ask followup questions to clarify the speakers' comments.

Representative Argenziano expressed concern that elders in rural areas were not provided easy access to hearings and offered to hold one meeting in Citrus county. The Chairperson suggested that one of the Tallahassee meetings could be rescheduled for another location.

Secretary Hernandez stated that interpreters would need to be available in Tampa (Spanish) and Miami (Spanish and Creole).

BREAK

The Chairman reconvened the meeting on or about 11 a.m.

Greg Munson, legal counsel to the Executive Office of the Governor, addressed the Task Force regarding Florida's Sunshine Law. By virtue of accepting the appointment to the Task Force, all members must abide by the Sunshine law which covers public records and public meetings. Public records are anything that is written, recorded, created (visual aids), photographed, or e-mailed. Drafts circulated among Task Force members are included. Work done for the Task Force at home or in one's business office is covered. All of these records can be requested through a freedom of information request and must be provided by all members. A fee for copying or undue burden in providing the public documents may be charged.

Public meetings must be 1) truly open to the public (e.g., at a convenient time and location), 2) provide reasonable public notice, and 3) have written minutes or audiotape recording of the proceedings (that does not have to be transcribed). Subgroups of any size meeting about the Task Force to strategize or make decisions must follow the public meeting rules. Staff meetings are not included under the public meeting rules unless they are being used to discuss possible Task Force actions. It is appropriate to talk about what you are thinking about in a private meeting but if the discussion is about planning the direction of the Task Force, it must follow the public meeting rules. In addition, Task Force members should not use staff to convey direction or strategy to other Task Force members.

Representative Argenziano reiterated the importance of the Sunshine Law and that the purpose is to prevent backdoor deals.

Mr. Sherberg asked if it was appropriate to contact FPECA staff for clarification regarding materials sent to Task Force members and Mr. Munson stated that it was.

The Chairman addressed external communication. All members have the right to speak to the media or citizenry. It is up to each member to decide whether or not to be interviewed. The media may also be directed to the Lieutenant Governor's office for official comment. In addition, the staff at FPECA may be used to respond to technical information about the Task Force (e.g., background information on long-term care issues). No one has to answer every question that is posed by the media. Official external communication regarding upcoming meetings and group decisions will be coordinated between the Lieutenant Governor's office and FPECA.

Dr. Polivka, director of the Florida Policy Exchange Center on Aging, addressed the Task Force regarding the approach that the Center will take to provide research and analysis on the 16 questions outlined in HB 1993. He stated that FPECA will be mailing them a draft background paper, Long-Term Care in the 21st Century, produced by FPECA staff, for their comment and review at the August 25th meeting. He then focused on the four major tasks as FPECA staff have grouped them: Availability of Long-Term Care Alternatives; Financing Long-Term Care; Factors that Affect Nursing Home Quality; and Liability and Long-Term Care: Impact on Nursing Homes and Assisted Living Facility Viability. He focused attention on several of the underlying research questions identified by his staff and the approach they propose to use in order to answer the questions (see handout: *Proposed Approach to H.B. 1993 Questions for the Task Force on Availability and Affordability of Long-Term Care*).

Mr. Rodriguez asked if the task force will be considering federal legislation that affects availability and affordability of housing and service options.

The Chairman said that not only can we make recommendations to the Florida legislature but we could also consider pursuing federal changes.

Representative Argenziano asked Dr. Polivka to discuss the home health issue.

Dr. Polivka said that Florida was first or second in the nation in its use of the Medicare home health benefit to support long-term care at home. The Balanced Budget Amendment of 1997 returned that benefit to its original acute care purpose and as a result home health declined 49% in the state.

Representative Peaden asked if the task force would consider the use of technology and telemedicine to improve the monitoring of home care.

Dr. Polivka described recent initiatives with the University of Central Florida to look at “smart homes” and the use of both low tech assistive devices and high tech telemedicine devices to improve the quality of care and quality of life for elders at home.

Representative Argenziano said that we need to think about a simple program just to recycle durable medical equipment like wheelchairs to individuals in need.

Mr. Connor asked if the staff would address the fraud and abuse issues that were behind the 1997 Balance Budget Amendment and how it impacts on the availability and affordability of alternatives to nursing home care?

Secretary Hernandez asked about how “unmet need” would be measured. She noted that it should be tied to actual level of need and frailty. Most clients will say they need more services but the acuity of the need should be considered. In addition, the loss of \$12 million in Older Americans Act funds to Florida has affected ability for the State to meet needs in the community. Also, some counties (e.g. West Palm Beach) have special district funding mechanisms that would be worth investigating. Finally, she recommended that the task force show the eligibility requirements and services for county, state, and federal programs.

Mr. Sherberg asked if eligibility requirements were limited to financial eligibility. He also asked the staff to look at the problem of communication between public agencies and lack of access to client records across agencies due to confidentiality laws.

Dr. Polivka said that eligibility to publicly supported programs are usually based on financial, functional, physical, and cognitive need.

Mr. Conner asked again for clarification of whether or not fraud is addressed in the legislation?

Dr. Polivka said that the legislation does not specifically ask the Task Force to address this issue.

The Chairperson said that it could be addressed within the scope of potential problems with financing long-term care.

Mr. Liptak said the long-term care model needs to take into consideration technological advances and make long-term projections.

Dr. Polivka agreed that we cannot be trapped in the short-term but need to look broadly and comprehensively at our long-term care system.

Representative Argenziano asked what is the state doing now in terms of fraud? She also said that HB 1971 authorized a panel on reimbursement issues and that the task force should be aware of its findings.

The Chairman asked all task force members to read the proposed approach to the four general tasks and to forward all comments to the staff in the next few weeks [by August 4, 2000 to: jsalmon@admin.usf.edu or FAX to: 813-974-5788 attn: Jennifer Salmon]..

Dr. Polivka then described the changes that occurred in Florida's long-term care system since the 1970s when its Community Care for the Elderly (CCE), Home Care for the Elderly (HCE), and Alzheimer's Disease Initiative (ADI, which began in 1985) were considered model programs for the nation. But in 2000, the state is more dependent on nursing home care than it was 15 years ago. Several states provide model home and community based programs including: California, Oregon, Washington, Michigan, Massachusetts, Wisconsin, Arkansas, North Carolina (assisted living facilities), and New York. There is research in each of these states that we can learn from.

Senator McKay asked the staff to identify which states could be replicated and to develop ideas for pilot projects in Florida. He stated his intense desire that the 2001 legislature pass legislation. It won't be a single silver bullet but a universal program.

Representative Argenziano agreed that the State depends too much on nursing home care although nursing homes do an important job. Physicians are limited in where they can refer patients because of the cost of alternatives and the availability of Medicaid dollars to support nursing home care. She asked the staff to look at how these model states (or other states) work with nursing homes.

Dr. Polivka said that Oregon integrates its long-term care system completely and even as it has reduced reliance on nursing homes, has worked to improve the quality of care in nursing homes.

Representative Argenziano suggested looking at how New York and other states license its nursing homes.

The Chairman wrapped up the discussion, saying that we don't have all the answers at this time or we wouldn't need a task force but that we clearly have a good beginning.

The meeting was adjourned at 12 noon.

Respectfully submitted,
Jennifer R. Salmon
Task Force Coordinator, Florida Policy Exchange Center on Aging

Approved August 25, 2000

AGENDA

Task Force on the Availability and Affordability of Long-Term Care
Embassy Suites Hotel Ballroom on the Campus of the University of South Florida
3705 Spectrum Blvd., Tampa, Florida, (813) 977-7066

BUSINESS MEETING

August 25, 2000, 9:00 a.m. – 12:30 p.m

This meeting will be tape-recorded for the public record.

9:00 Welcome to the University of South Florida

Dr. David Stamps, Provost and Dr. Judy L. Genshaft, President
University of South Florida

9:15 Business Meeting

Lt. Governor Frank T. Brogan, Chairperson

Introduce Members

Accept or amend minutes of July 17, 2000 meeting

PANEL ONE

9:30 Profile of Older Floridians

Dr. Sandra Reynolds, Associate Professor
Department of Gerontology, University of South Florida

9:45 Long-Term Care in Florida: Past, Present, and Future

Dr. Larry Polivka, Director
Florida Policy Exchange Center on Aging

10:00 Discuss Presentations; Preliminary Recommendations

Task Force Members

10:45 BREAK

PANEL TWO

11:00 Update on Fraud and Abuse Initiatives at AHCA

John Owens, Chief

Managed Care and Health Quality Assurance, Agency for Health Care Administration

11:15 Plan for Collecting Data on Lawsuits

Mary Oakley, Leader

Task #4: Liability and Long-Term Care

11:30 Measuring Quality in Nursing Homes: Current and New Models

Pete Buigas, Deputy Director

Managed Care and Health Quality Assurance, Agency for Health Care Administration

Dr. Kathryn Hyer, Leader

Task #3: Factors that Affect Nursing Home Quality

12:00 Discuss Presentations; Preliminary Recommendations

Task Force Members

12:30 Adjourn Business Meeting

MINUTES
Task Force on Availability and Affordability of Long-Term Care
August 25, 2000
Embassy Suites Hotel, Tampa, Florida

Present: The Honorable Frank Brogan (Chairman), Dr. Gema Hernandez, Mr. Gary Crayton, Mr. Larry Sherberg, Mr. David Grofic, Mr. Walter Liptak, Mr. Rene Rodriguez, Mr. Raymond Noga, Dr. Jeff Dwyer, Dr. Jesse Lipnick, Ms. Cheryl Chmielewski, Mr. Kenneth Connor, Dr. Joy Calkin, Mr. Ed Boyer, Mr. Robert Miller, Ms. Victoria Fierro, and The Honorable Nancy Argenziano.

Absent: The Honorable John McKay and Mr. Philip Freidin,

Guests and staff present: Dr. Sandra Reynolds, Dr. Larry Polivka, Mr. John Owens, Ms. Mary Oakley, Mr. Pete Buigas, and Dr. Kathryn Hyer

The Chairman thanked all the members of the Task Force for their service and described the purpose of the Task Force: to make recommendations about long-term care including liability, insurance, standard of care, and alternatives to nursing home care. Need to meet in public hearings around the state. Stated that we are facing a number of challenges so that we have adequate long-term health care: that is accessible, affordable and high quality. Members introduced themselves.

Dr. Larry Polivka introduced Dr. David Stamps, interim vice provost at USF and former Dean of the College of Liberal Arts and Sciences

Vice-Provost Stamps welcomed the Commission members and audience to USF and introduced President Judy Genshaft.

President Genshaft welcomed Commission members and described the importance of the Commission and how pleased she was that the meeting today was held at USF.

The Chairman asked for a motion to pass the minutes from the July 17th meeting which was made, seconded, and passed by voice vote.

The Chairman explained that today's agenda was to address only part of the issues in HB 1993.

Panel 1

Dr. Sandra Reynolds, Associate Professor, Department of Gerontology, USF provided a profile of older Floridians. Using the Asset and Health Dynamics of the Oldest Old (AHEAD) representative sample of age 70 and older Floridians compared to older adults in US. Numbers of persons in parentheses are based on 1998 estimates of the 70+ population.

- Older Floridians are very similar to older Americans in terms of age and gender.
- Older Floridians were more likely to be married (less likely to be widowed), Hispanic, and have higher education
- Five oldest counties in Florida (1990) are: Charlotte; Pasco; Citrus; Hernando, and Sarasota.

- 35% of older Floridians live alone (690,000); 35% have a child nearby (694,000); 51% do not have a relative available if they should need assistance (over 1 million elders). They are more likely to have a spouse helping (in nation: it is a child). 14% get help from a spouse (274,000); 2% from a child (41, 000); 1.2% other household member (24,000) and 5.6% from other person/organization (110,500).
- Median income for Older Floridians is very similar to rest of nation (\$22,676; US: \$22,000). 26% live on less than \$9,600. Another 25% live on between \$9,600-\$16,000—300% of the poverty level.
- 33% consider their health fair/poor (650,000). Prevalence of major chronic conditions ranged from 11% who had stroke (217,000) to 43% who had chronic conditions (848,000). For ADL impairments (bathing, dressing, eating), 26% have at least one impairment (513,000 persons). For IADL impairment (higher level activities like managing money, shopping for groceries), 36% have at least one impairment (718,000) and one-third tested to have cognitive impairment (647,000).
- 347,000 older Floridians who need help are getting insufficient or no help at all. This ranges from .6% (11,800) who need help with eating and get no help at all to 5.5% who do not get sufficient help with walking (109,000). Over all ADLs, 6% (118,000) receive insufficient or no help at all. (Remember, this includes the 70+ population).
- In summary, Older Floridians are very similar to older Americans in terms of health, income, assets, and unmet need for assistance. Much of long-term care policy in Florida has been based on the perception that people are younger, healthier, wealthier, and explains our relatively low rate of nursing home beds per 65+ adult and cut back in funding for community-based care. In addition, the plateauing of the population that is happening in other parts of the country, is not happening here because of the in-migration of retirees. There is a significant level of need. Of older adults 70+, over 1 million have no relative to help with care; 347,000 have current unmet need for ADL care; nearly 1 million live at or below 300% of the poverty level; ½million live on less than \$9,600 income. And nearly 1.5 million have no insurance for nursing home or other long-term care.

Dr. Larry Polivka, Director, Florida Policy Exchange Center on Aging, University of South Florida described the highlights of the paper that was sent to the Task Force in advance of the meeting (Long-Term Care in Florida: Past, Present, and Future). Based on a projections model developed in the last Commission for long-term care which will be updated by Dr. Sandra Reynolds for this Task Force.

- From 1995-2010, the need for long-term care will grow 42% from 281,489 to 400,978 frail elders age 65+.
- 180,000 will be eligible for publicly-supported services (3+ ADL and 150% of federal poverty level).
- At that time, if the state continued with the nursing home dominated long-term care policy, the budget would increase to \$3 billion. This will probably be less because there have been some shifts in policy and budget since that time.
- Approximately 86% of all public spending on long-term care in Florida is for nursing home care. Only 12-14% of public spending on long-term care is for home and community-based services. In 1983, only 77% of this spending was for nursing homes and 23% for HCBS. Per capita spending for all the major in-home programs declined between 1990-1999 except for Alzheimer's program and the new HCBS and Assisted

living waiver programs (uses Medicaid money that would go to nursing homes for in-home and community-residential programs), while nursing home per capita spending increased. Florida spends \$60 per capita for HCBS and the US spends \$243 per capita. Florida spends 25% of the national average for HCBS. Florida has one of the lowest ratios for nursing home beds per 65+ population but it has been growing since 1995. It grew faster than the national average (72% or 34,000 new beds).

- Based on research in 90s, most of the states, including Florida, have learned how to make home and community based services cost-effective alternatives. We are serving a substantial number of impaired people in community programs (even though there are much higher percentage of very impaired people in nursing homes). There is great variation around state: SE Florida developed a great HCBS program and they have a low nursing home bed ratio. In areas of the state where you have a higher than average concentration of Medicaid NH beds, you have a diminishing use of alternatives. If you have a higher number of beds and a high number of alternatives, you still have a high nursing home utilization rate. Need to contain the growth of nursing home beds while increasing the HCBS capacity. If you build a bed, somebody will fill it before placing someone in an alternative.
- Recommendations to help frame the conversation: 1) legislation mandate for a more balanced long-term care system (states that have done this, have moved in this direction more successfully); 2) increase the percentage of people who are at risk of nursing home placement to be supported in HCBS to 50%). Right now it is 52,000 in nursing homes and 20,000 in HCBS; 3) impose a 5-year moratorium on construction of new nursing home beds in areas of the state where occupancy rate is below 95% (average is 86% now); and 4) plan for the severity level of residents in nursing homes increasing with the changes mentioned above so will need increase reimbursement rates.
- Fiscal strategies: 1) moratorium on nursing home beds and shift funding to in-home and community-residential programs; 2) develop a tiered system of reimbursement for all programs (currently there is great variation in reimbursement levels depending on the program) and increasing the level in HCBS and assisted living (important because people will require a higher level of care in the community). This has been proven in other states: Arizona, California, Oregon, Washington, Wisconsin. 3) focus on consumer-directed care (pay caregivers for this service—for eligible individuals—way of the future) and 4) adult family care home programs/ adult foster care (small program—350 people; used to be 1,000 people; in Oregon, they serve over 10,000 foster care beds). Monitoring for abuse and neglect has shown it occur in about 1% of cases in Oregon.
- Policy goals: 1) contain future long-term care costs (can't really talk about cutting the cost because of the 45% growth projected over the next 10 years); and 2) give consumers access to alternative care they prefer.

Representative Argenziano asked questions regarding disability levels and problems with adult foster care. Dr. Polivka said that impairment rates have actually declined in the older population according to some studies and the increasing imbalance since 1983 reflects public policy, especially the CCE and HCE programs. Foster care didn't have problems with abuse and neglect but just slipped off the policy agenda.

Representative Argenziano stated that new regulations for licensing assisted living facilities are moving away from the small facilities; if we move back, we'll have to have stringent oversight.

She also expressed concern over the potential high cost of 24-hour care at home. Dr. Polivka suggested that someone who required 24-hour care should probably be in a nursing home.

Mr. Crayton said that Medicaid HCBS waiver programs require that spending be less than for nursing home care so those who need that 24-hour care would probably be served better in a nursing home. Dr. Polivka stated that assisted living facilities may also be appropriate.

Representative Argenziano stated that people with cognitive impairments will need to be safeguarded if we expect them to make more decisions about choosing their caregivers.

The Chairman stated that we will probably need to increase the level of case management with more community-based care: someone who understands the capability of the elder, the family, and is able to draw on public dollars and community services.

Mr. Grofic asked for information about the costs per client for home-based services based on urban/rural; county; and for age 65+. He also stated that with the largest increases being in the age 85+ population (to increase 89.6% from 1995 to 2010), perhaps we may not be able to simply move money for nursing homes to home based programs. He stated that he was a proponent of home based services. Dr. Polivka said that even with the increases in the 85+ population, we need to develop the capacity for a more balanced long-term care system which can happen best by holding the line on nursing home bed growth. Mr. Grofic also asked for how different states fund their in-home programs.

Mr. Rodriguez asked for numbers of current nursing home residents who could be served at home or with alternatives and at what cost. In addition, how many people are in nursing homes because they have no other choices. May want to consider a tiered payment system but due to the diversity of populations in regions of the state use Block grants for local funding. Asked if there was a relationship between unmet need and legal status. Stated that insurance companies need to make a commitment to providing long-term care.

Ms. Chmielewski stated that staffing will be a concern if we increase home and residential care options.

Dr. Calkin stated that in Canada first experienced need for more direct care providers which the US is now experiencing. The combination of shortages in providers and loss of women at home has led to fewer caregivers. She asked: with the increases in need and the decreases in staffing, what other data do we need to solve the staffing problems? She also asked for more information about caregivers [not available on the AHEAD survey]. Dr. Reynolds suggested that there are other data sources that can provide these data. Dr. Polivka said that we have a contract with University of Florida faculty (on another project) to better understand these labor issues.

Mr. Sherberg stated that if 51% of older Floridians are without a caregiver, then there is a definite need for long-term care services. In addition, we need to support aging in place and let the consumer choose where he/she wants to live. The problem is that people don't have the finances and rely on the state so we need to redirect Medicaid dollars to support them. We need more information on eligibility levels across all programs and the lack of parity. Reiterated the Chairman's idea of increasing case management. Dr. Polivka stated that he believed the dollars should be under the control of the frail consumer.

Mr. Owens, Agency for Health Care Administration, presented on Medicaid Fraud and Abuse Initiatives.

- Claims payment analyses: are claims spiking or above established thresholds (can suspend checks before they go out).
- Provider surety bonds/background checks: first for physicians and home health agencies; has been expanded.
- On-site provider visits to verify the existence of provider (Providers can no longer have just P.O. boxes).
- Level I and II background checks and Federal background checks required for owners of corporations that are applying for Medicaid provider numbers.
- Medicaid Management Information system expanded to catch improper billing at 10,000 points in the system.
- Improved inter-agency coordination between Attorney General's Medicaid Fraud Control unit, Florida Department of Law Enforcement; Statewide Prosecutor's office; and Operation Restore Trust.
- The Pharmacy Audit Program is run by an outside firm that performs on-site audits and home-site audits.
- Pharmacy lock-in program allows us to lock-in on recipients who are abusing the system to a single pharmacy.
- We are adding pharmacies to the requirement for a \$50,000 surety bond.
- Our goal is to combat fraud and abuse up front: prevent payment from going out. We have been very successful and the GAO has said we are a leader in the nation.
- For long-term care, we have per diem rates that are subject to provider specific and class ceiling targets (since 1983 with minor changes). A facility's rate is established on their initial cost report. We reimburse only at this rate within a prescribed rate of growth.
- Cost reports are submitted annually from all nursing homes that participate in Medicaid. These are inspected for flagrant errors. Costs are audited by outside CPA firms.
- Costs reports are reviewed for misclassification of costs.
- Recent rate increase in April 2000 was targeted specifically to increasing CAN salaries. Nursing homes have to report back that these dollars were actually used as they were intended and will be subject to audit.
- National issues regarding Medicare fraud and abuse—recently settled with a chain for \$170 million. These overpayments for Medicare claims were based on a reimbursement system that was in place prior to the Balanced Budget Act of 1997 when they were operating under a cost reimbursement system. We have a prospective payment system in Florida.
- Nursing home cost reports are reviewed to identify a potential pattern of fraud or abuse. AHCA doesn't pursue fraud (transferred to Attorney General's office).

Ms. Mary Oakley, Florida Policy Exchange Center on Aging, presented the plan for collecting data on lawsuits and liability insurance.

- Primary research objectives are to describe the nature, extent, and effect of lawsuits on Florida's nursing home industry, in comparison with other states.
- What is the distribution of lawsuits within the industry for last 5 years.
- What types of lawsuits are filed: what is the nature of the allegations; the cost of the lawsuits; and the effect on the nursing home industry.

- Interested in the expense of lawsuit settlements and jury verdicts and also the impact at the facility and corporate levels.
- Two primary data collection efforts: 1) in-depth regional analysis of all lawsuit activity against nursing homes in Hillsborough County, 1990-current. Cases will be counted and categorized; 2) standardized information request to corporations that have numerous facilities in Florida (not finalized). The questionnaire is quite extensive and asks for sensitive information that companies will be reluctant to release without assurances that the information would be confidential. We are seeking legal advice regarding our role as a research center in protecting this confidentiality under Florida Statutes [FS 240.241].
- Key informant interviews are underway with Plaintiff and Defense attorneys; providers; and medical practitioners.
- Ancillary research and literature reviews will be used to put our findings in context (e.g., other providers: home care, hospitals). The American Health Care Association and Florida Health Care Association are conducting an analysis of state statutes which we will use.
- Liability insurance will be largely provided by the Department of Insurance's study of liability insurance.
- Although the in-depth analysis of one County will provide a wealth of historical information, there may be reason to believe that Hillsborough County is at the high end of lawsuit activity.
- The multi-facility corporations information request will help us to understand the degree that Hillsborough is different from other counties in Florida.
- The focus in the information request is on for-profit corporations (the largest sector of the industry). We are also working with Florida Association of Homes for the Aging to get information from its not-for-profit members. In addition, the in-depth study will include both for-profit and not-for-profit homes.
- We are focusing on nursing homes more than assisted living facilities due to both the short timeframe and the fact that nursing homes are being impacted at a higher rate than ALF. We may be able to include the large ALF corporations. There are over 2000 ALF compared to 700 nursing homes. This makes it even harder to adequately survey them in a short time.

Mr. Pete Buigas, Agency for Health Care Administration presented on quality initiatives in Florida nursing homes.

- The regulatory environment affects quality: The Balanced Budget Amendment of 1997 dramatically reduced spending by nursing homes. Medicare reimbursements to nursing homes had a 11% growth over 20 years. In 1999, for the first time, expenses were lower from the previous year, catching the health care sector off-guard. The impact was huge in Florida: first for home health agencies (over 210 closed); nursing homes (146 out of 678 are in Chapter 11 (22%) which accounts for 23% of all beds in the State.
- The Balance Budget Refinement Act of 1999 was to correct for the losses caused by BBA of 1997. This is in process. Does not mean money is being returned but delays some of the provisions that were planned; additional relief may be provided as more data on the effect of BBA 1997 are known.
- Florida statistics: highest percentage of people 65+. There are 678 nursing homes; 83,000 beds; occupancy rates are between 84-87.5%; of occupants, 63.5% are on Medicaid. State of Florida is a major payor for Medicaid's long-term care program.
- In Florida 80% of nursing homes are for-profit (20% not-for-profit). Florida ranks 3rd for bankruptcies (behind Texas and California). We also have 2,400 assisted living facilities and

adult family care homes and 1,100 home health agencies. There is a tight labor market and a horrendous shortage of nurses.

- Legal costs per bed are 5 times greater than any other state. There are 8 companies writing insurance (12 have left the state) and liability costs are 8 times greater in this state than the national average. The companies that are writing insurance are for old business and not new business. Nursing home companies are trying to enter the market here and are having trouble getting insurance. The issue is that liability insurance is not accessible or affordable at the provider level. Companies are going without insurance. The State does not require by statute that nursing homes have liability insurance, although it is typically a mandate of financial institutions. Assisted living facilities are required to have liability insurance (by the state). If an ALF went bare a regulator would have to shut it down. USF staff should be looking at liability as a long-term care issue, not just a nursing home issue.
- Quality is often described as the absence of evil; regulators define it as the absence of deficient practices and adverse outcomes.
- Quality is ensured through survey process (minimum data set) which is outcome driven and looks for the most vulnerable residents. Surveyors are divided into functional groups (nursing home, hospital, assisted living) so that they don't survey one type of facility with the biases of the other types.
- Quality is ensured through proactive enforcement using financial auditing. With 22% of facilities in bankruptcy, AHCA can't wait for something (bad) to happen. Surveyors are at these facilities frequently to make sure that care is not compromised. This has increased workload; last year there were 1,000 financial visits.
- Quality assurance teams are trained in current practice.
- Communication with adult protective services and local law enforcement has increased.
- House Bill 1971 (sponsored by Argenziano) provides AHCA with more tools to improve quality: Quality monitors (over 800 visits so far) are 13 senior nurses who visit facilities on the watch list or have a history of chronic performance problems and work with the facilities to improve compliance (rather than punitively); The Gold Seal program is chaired by our Secretary Ruben King-Shaw and is defining quality and how to reward it; medical director qualifications are being redefined; and publishing a Nursing Home Guide for consumers which provides information on: regulatory track history; areas where they are good or bad; and resident and family satisfaction
- The Procurement Quality Program: as the major purchasers of long-term care in the state, we have a responsibility both to tax payers and to residents: that they are getting the best care. We will be able to pay for Medicaid care in homes that are providing the best care and not the ones who are chronically poor performers.

Dr. Kathryn Hyer, Florida Policy Exchange Center on Aging, presented on studying quality of care in nursing homes.

- Currently quality is measured through citations through the state survey process by AHCA; complaints which are monitored by both AHCA and DOEA and come through the State's Ombudsman program; and lawsuits.
- Regulatory indicators of quality are not sufficient; they are at a minimum level; a "gotcha" system.
- Residents and families want to know what is good care.
- We're not certain of: what produces good care; what information consumers need; how information about quality actually changes provider performance; and how to regulate it.

- We do know that certain factors affect citations and complaints: recruitment and retention of staff; adequate staffing; training; turnover; and length of service; quality of medical and nursing care; and, even, resident choice.
- Proposal to respond to HB 1993 questions: 1) what is the relationship between number, severity, and types of citations, to facility characteristics (size, chains, affiliations, profit/not-for-profit; who pays for service, and occupancy by payor type); and 2) what is the relationship of complaints to these same facility characteristics.
- Will suggest measures of quality of life and meaning from the consumer perspective so that facilities can achieve the top standard (such as in the Gold Seal program).
- Will suggest a way to conduct these measures but reduce duplicative and redundant surveying of providers.

Mr. Connor, referring to Florida Statute 400.061 which states that the rules of the State are not ensuring the rights, safety, health, and welfare of the residents, asked how the charts he subpoenas for cases of abuse and neglect of nursing home residents could have the following errors: charting on non-existent days (February 30th, etc.); charting when the resident is out of the facility; charting after the resident has died; charting prior to being admitted to the facility. In addition there are time cards of staff who are supposed to have charted on days when they were not at work. With all of this, the State has never asked for its money back when care wasn't actually given. Sometimes the facilities get a superior rating and were surveyed during the same dates where these charting errors happened. He asked: what is the responsibility of regulators to prevent these problems so that the lawsuits and the corresponding increases in insurance rates don't happen. Mr. Buigas stated that regulators and caregivers both have a responsibility. Suggested that we improve the standard quality protocols to include the things that are being missed; improve the reimbursement procedure; and look at the tort issue.

The Chairman suggested that the lapses in charting should be tracked back to individual regulators and how well they are doing their job of oversight and hold them responsible. Mr. Buigas suggested that the new Quality Assurance Team is doing this. It re-inspects a facility after a surveyor is there.

Mr. Liptak stated that audits are useful in measuring quality of care but asked if there were plans to ask customers about their satisfaction? Dr. Hyer said that some states look at consumer satisfaction; some chains release data on consumer satisfaction; and the new Gold Seal program is supposed to address this. Mr. Buigas said that HB 1971 which required the Nursing Home Guide will include a consumer survey.

Mr. Crayton provided information about a Legislative request to AHCA to study the cost of liability insurance in nursing homes. These data can be available for staff in their analysis.

Dr. Lipnick I haven't heard any discussion about the level of function of residents as a measure of quality. This is the highest measure of medical success. Is there a way currently that surveyors are measuring changes in function? Dr. Hyer stated that under the Minimum Data Set, using the Resident Assessment Instrument, we are looking at long-stay nursing home residents by definition. Still, the MDS does measure a lot of detail including changes in function. Because of patient confidentiality, we do not have access to these data at that level. We can look at citations given for not accurately reporting a significant change in functional status. Dr. Lipnick expressed concern that function be an overall goal, not just measuring the lack of

functional progress. Dr. Hyer stated that under the regulations, the goal is to achieve the highest functional standard. Dr. Polivka stated that the point of the presentations here is that by shifting resources to provide more options for places where people with many chronic conditions can receive care, helps people to maximize their ability under a range of impairments and functional capacities. Dr. Lipnick explained that as a rehab physician, he cares for people in acute care settings that didn't need that level of care and were moved to a lower level of care because of insurance pressures and also that the medical provider felt it was possible. As a result, the patients who could achieve a higher level of functioning are mixed in with more impaired patients. The rehab group could have their level of function increased.

Representative Argenziano described the questions she wants answered in the liability study: what are the common conditions that are regarded as preventable? Are there people in nursing homes as part of the dying process who could go home? And are there really facilities going with coverage due to the high cost or unavailability of insurance and why would they do this? Do ALFs have to have liability insurance and nursing homes do not? Mr. Buigas: yes (ALFs do and nursing homes do not). Rep. Argenziano: if in the State of Florida you are making no money, the reimbursement rates are low, you can't hire CNAs, litigation rates are high, and insurance premiums are high, how are you still here? Are you making that much profit to keep you here? Other questions: has legal action contributed the most to bankruptcy? What percentage of lawsuits are frivolous? How are they categorized? Finally, I can't believe that there are administrators who go out to provide poor care yet for those chronic poor performers have to leave the State of Florida.

Dr. Calkin asked about the correlation between MDS quality indicators and those that have been documented in the literature and tested on large samples. I have asked the MDS researchers for the underlying data and they have refused to provide it. For example, in terms of pressure sores, other agencies have documented that 30% of patients in hospitals with hip fractures develop pressure sores; nationally, 2 percent of nursing home residents have pressure sores. We may need a comparative measure across the health system.

Mr. Rodriguez asked how much is lost to fraud annually? Mr. Buigas said that the GAO reports nationally 10% of expenditures; it has recently been reduced to 8% of expenditures; information on Florida specifically wasn't available. Mr. Rodriguez suggested that this could help provide a savings to the State and should be looked into.

Mr. Sherberg commented on the fact that when a resident doesn't return to his (assisted living) facility from a hospital it is because they don't get proper care (ambulation) and so they can't walk and therefore must be discharged to a nursing home for rehabilitation. They often return with pressure sores from the lack of walking. It might be better for them to get more physical therapy in the hospital before they are discharged so they wouldn't have to go to the nursing home in the first place. People are coming out (of the hospital because of) managed care and other reasons before their time and not in the condition we used to get them.

The Chairman asked about Florida ranking 3rd in the number of SNF bankruptcies (146) behind Texas (271) and California (170). New York was zero. How come? Mr. Buigas said that NY does not allow large national publicly traded chains to do business and many of the bankruptcies are in this group. In NY SNFs are mostly owned by small independent operators.

The Chairman announced a break in the meeting for lunch to be reconvened 15 minutes prior to the public testimony hearing.

The Chairman reconvened the meeting to go over the upcoming schedule proposed by FPECA staff. Asked about the East coast representation in the meetings. Ms. Salmon reported that the October 30th meeting in Tallahassee will be available via teleconference to downlink sites in most communities (Community Colleges and schools). The Chairman asked about the rest of the dates and the content.

Secretary Hernández asked for a profile of residents in nursing homes vs. clients in community-based settings (resources, educational level, family patterns, income, spend down) and access to Medicaid. I want to be able to compare the nursing home profile with our profiles of our clients. Also, let's look at the infrastructure that is in place for community care models, beginning with Senior Centers, adult day care, Community Care for the Elderly, and network of providers that we have.

Mr. Connor expressed concern regarding the first come, first served basis for signing up for public testimony. There is criticism about interest groups who stack the line in one way or another; we may want to consider a list that segments the interests of consumers, providers, medical, nursing to ensure a balanced representation of presentations.

The Chairman agreed that we break out the sign up into several topics to get a broader balance.

Ms. Fierro said that the cost of prescription drugs needs to be addressed especially as it affects the overall Medicaid budget.

The meeting adjourned around 2:00 p.m.

Respectfully submitted,
Jennifer R. Salmon
Project Coordinator
Florida Policy Exchange Center on Aging

Amended October 16, 2000. Minutes passed by voice vote, October 16, 2000.

AGENDA

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

October 16th and 17th, 2000

University of West Florida, 11000 University Park Way, Building 22, Pensacola, Florida

BUSINESS MEETING OCTOBER 16, 2000

University Conference Center

This meeting will be tape-recorded and transcribed for the public record.

Interpreted for the Hearing Impaired

8:00 Welcome to University of West Florida and the Panhandle

Dr. Morris Marx, President, University of West Florida

Rep. Durell Peaden, Jr., District 5 State Representative

Old Business

Lt. Governor Frank T. Brogan, Chairperson

Accept or amend minutes of August 25, 2000 meeting

8:15 In-Home Models (Q&A after each presentation)

Department of Elder Affairs (DOEA) and the Continuum of Care, Secretary Gema Hernández
Area Agencies on Aging, Dottie Peoples, Executive Director, Northwest Florida Area
Agency on Aging

Long-term care providers, John Clark, Secretary, Florida Association of Aging Service
Providers and Executive Director, Escambia Council on Aging

Community Care for the Elderly, Kathy Arrant, President, CCE Lead Agency Coalition and
Director, Eldercare Services, Tallahassee

Consumer Directed Care, Sharlene Davis, Contract Management Administrator, Department
of Elder Affairs

9:45 BREAK

10:00 In-Home Models (Continued; Q&A after each presentation)

Managed Long-Term Care, Marti Osborne, Director, Health and Home Connection, Orlando
(DOEA/AHCA Cooperative Agreement)

Channeling Project, Karen Wells, Miami Jewish Home (AHCA Contract)

10:30 Community-Residential Models (Q&A after each presentation)

Affordable housing and assisted living conversion projects, Jane Johnson, Director of
Housing, Florida Association of Homes for the Aging

Optional State Supplement for Assisted Living Facilities, Paul Williams, Executive Director,
Florida Assisted Living Association

Medicaid Assisted Living for the Elderly Waiver, Bob Schemel, Heritage Park Retirement
Community

11:15 Task Force Members: Discussion

12:00 Adjourn Business Meeting (Task Force Members Provided Box Lunch)

1:00 Public Testimony Hearing (there will be one 15-minute break at 3:00 p.m.)

5:00 Adjourn

AGENDA

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

October 16th and 17th, 2000

University of West Florida, 11000 University Park Way, Building 22, Pensacola, Florida

BUSINESS MEETING OCTOBER 17, 2000

University Commons Auditorium

This meeting will be tape-recorded and transcribed for the public record.

Interpreted for the Hearing Impaired

8:30 Expert panel: Family and consumer perspectives

Bentley Lipscomb, State Director, Florida AARP

Annette Kelly, Executive Director, Greater Orlando Chapter, Alzheimer's Association

Anna M. Spinella, Chairman, Area 6 and State Council on Health and Human Services,
Silver-Haired Legislature

9:15 Long-Term Care Insurance

Robert Glowacki, Vice President, Government Relations, AEGON

9:30 BREAK

9:45 Task Force Members: Discussion

In-Home Programs

Managed Care Programs

Community Residential Programs

Family Caregiver Programs

Long-Term Care Insurance

12:00 Adjourn

MINUTES
BUSINESS MEETING

Task Force on Availability and Affordability of Long-Term Care
October 16-17, 2000
University of West Florida, Pensacola, Florida

October 16, 2000

Present: The Honorable Frank Brogan (Chairman), Dr. Gema Hernandez, Mr. Bob Sharpe, Mr. Philip Freidin, Mr. Larry Sherberg, Mr. David Grofic, Mr. Walter Liptak, Mr. Raymond Noga, Dr. Jeff Dwyer, Dr. Jesse Lipnick, Ms. Cheryl Chmielewski, Dr. Joy Calkin, Mr. Ed Boyer, Mr. Robert Miller, Ms. Victoria Fierro, and The Honorable Nancy Argenziano.

Absent: Mr. Kenneth Connor, The Honorable John McKay, and Rene Rodriguez

Staff present: Dr. Larry Polivka, Dr. Kathryn Hyer, Ms. Jennifer R. Salmon

Dr. Michael Beechem welcomed the Task Force members on behalf of the University of West Florida and the Center on Aging. He thanked the student volunteers of the Student Gerontology Club.

Rep. Durrell Peaden welcomed the Task Force members and noted that the task force is important because of its complexity and its expense. He stated that if we don't do it right, we'll bankrupt the state. It affects seniors and also younger adults with disabilities. The acuity level in nursing homes is what we had in hospitals 20 years ago. The goal is to keep people out of nursing homes and living independently because the outcomes will be better. He stated that we need to adequately fund the quality bedside care—which is more important than tort reform. He ended by saying that the upcoming legislature will spend many hours on this issue.

The Chairman noted that in one of his two recent visits to nursing homes he met a 109 year old woman which demonstrates that the longevity issue is important and will expand.

Task Force members introduced themselves.

Dr. Morris Marx, UWF President, welcomed Task Force members to University of West Florida.

The minutes were presented and amended. Ms. Fierro stated that she asked for information on prescription drugs and how it affects the overall Medicaid budget. Mr. Grofic asked that wording in two statements made by him be amended. These amendments were noted and the minutes were passed by voice vote (Dr. Calkin moved; Mr. Miller seconded).

PANEL ONE

Dr. Gema Hernandez described the continuum of care in Florida where 89% of all elders are still in the community and need only support for self care and positive aging. Senior Centers serve 2.8% of elders; public and affordable housing serves 2.2%; assisted living facilities serve 1.9%; in-home services serve 1.6%; hospice serves .2%; and family care homes serve less than .1% of elders. Nursing homes are an important option for the 2.1% of elders aged 65+ who need a higher level of care. Through the CARES intake process, the Department is diverting 15% of frail elders to home and community based programs rather than nursing homes. It has helped to reduce the occupancy rate from 92% to 88%.

The following problems need to be addressed:

- How to serve the 79,000 elders in HUD housing.
- Problem of fragmentation and the need to integrate services in all areas.
- Shortage of CNAs (need to think about programs that require high intensity of CNA staffing vs. low intensity need for CNA staffing).

She suggested the following recommendations:

- Universal assessment tool
- Allow the funding to follow the consumer
- Support the public guardian program
- Long-term care ombudsmen should be advocates not surveyors
- Quality of care and choices.
- Work within finite resources: need to provide the right package of services based on the frailty level of the elder and in the right place for the individual.
- Case workers (case managers, social workers, Public Guardians, Ombudsmen) have an important role in simplifying the system for clients. One case worker should follow the client.

The cost per person per year and typical length of time services are provided to an average elder consumer were listed as:

- 10 years using seniors centers; congregate meals at \$1300/year
- 6 years using public housing at \$12,000/year
- 1.5 years using in-home services at \$3,000/year
- Home Health Agency use at \$11,000/year
- Adult Day Care use at \$13,000/year
- Adult Group Foster Care Home at \$8,000/year
- 26 months in an Assisted Living Facility at \$14,600/year
- 1.5 years in a nursing home at \$37,000/year
- 40-50 days in Hospice at \$4,600/year

The packet also includes Table 1: Customer Profiles by Assessment Level. Level 5 profile is a person who would be nursing home eligible but potentially could be diverted to home and community based programs.

Dr. Hernandez referred Task Force members to a letter dated September 13, 2000 in the Department of Elder Affairs packet that described her personal experience with caring for both her parents.

Ms. Dottie Peoples explained how Area Agencies on Aging are part of the integrated network of providers that begins with the Federal Administration on Aging and moves through the State Department of Elder Affairs and then to the 670 nationwide AAAs to the service providers. The goal is to improve the quality of life for older persons by enabling them to stay at home and in the community. There are 11 AAAs in Florida. The Northwest Florida AAA serves 4 counties in the Panhandle and was established in 1979. This AAA took charge of a lead agency that had been the provider for the area in 1999 when it closed. As an experiment, they found that they could offer one stop shopping. It was also an example of separating case management and services. Ms. Peoples' handed out the recommendations of the Florida Association of Area Agencies on Aging:

- The responsibility for long-term care policy and planning in Florida remain consolidated within the DOEA with the Department being further empowered to reach the under 60+ age group, especially younger caregivers in the “sand wich generation” through on-going programs addressing preventive health care, retirement planning, and long-term care insurance information.
- The design by the Department of an effective single-point-of-entry system for older consumers which would 1) determining eligibility; 2) register the consumer for services; and 3) direct the consumer to the appropriate community agency, a case management agency, a service vendor, CARES unit or to Adult Protective Services, as circumstances warrant, with authorization of AAAs by the Department to implement and manage the system.
- The up-grading of the case management system to include required minimum credentials; standard statewide training materials, guidelines, and certification; and mandatory technology and equipment to enable them to function as professionals.
- The consideration of the Department's pilot project here in Santa Rosa County which supports the successful separation of case management and supportive services, as a model for service delivery statewide.

John Clark, representing the Florida Association of Service Providers addressed the significant role of community-based options to delay institutionalization. Membership in FASP includes: senior centers, nutrition providers, adult day care centers, Community Care for the Elderly). For example, in Escambia County, the Council on Aging has been the lead agency for 20 years and is a private non-profit organization that serves the greater Pensacola area. They offer: nutrition programs, two small senior centers, adult care center, foster grandparenting and companion programs, in-home services such as personal care and homemakers, respite, CARES program, and others (home repair, yardwork). Expressed concern over the [Policy Center] report that indicated that Florida in the past 10 years was spending 25% of the national average on home and community based care. Suggested that not paying for these services now will mean a “giant balloon payment later.” Recommends that:

- Senior centers can be a natural point of entry and can be places for prevention and early intervention activities. They are also a place where the young old help the older old. And places where families can learn information early on.
- Meals on wheels is indispensable element between home and institutionalization

- Adult day care provides a safe and secure environment and respite to family members.
- Need to encourage private sector to offer retirement information programs well before retirement age, and to provide long-term care insurance for employees.

Kathy Arrant spoke on behalf of the CCE Lead Agency Coalition. Community Care for the Elderly Lead Agencies are nonprofit organizations locally-based that know their customers and have been around for 30 years. They leverage their resources with volunteers (social entrepreneurship). For-profit home and community based service providers come and go; they are responsible to their shareholders while the nonprofits are responsible to their clients.

Recommends:

- Continuing the CCE Lead Agency model, because of the existing strong network and their ability to adopt to the local community, but help them to become more creative.
- Better utilize the case management component of CCE—the person is often the first contact for the elder or family member.
- Use tobacco funds to support more services; families are not prepared to pay for these services.
- Need capital outlay of funds to build more adult day care centers.
- Need to consider the cost of serving a few high acuity level persons or more lower acuity level persons. For example, a priority 5 person could cost \$10,000 whereas 3 priority 3 persons would be served for the same amount.

Sharlene Davis described the origins of consumer directed care: to preserve choice and autonomy, consumer satisfaction, and to control costs. It can occur in all settings: nursing home residents can have more choices with roommates; consumers at home can choose their providers and when the services are provided. In some cases, consumers will need someone to manage their choices.

Home Care for the Elderly (HCE) was one of the original consumer-directed care programs in the state and began in 1981. It is a small program because of federal restrictions on direct payments to families, so it is entirely funded through General Revenues. Basic subsidy is \$106/month for support and maintenance. A special subsidy reimburses for supplies, medications, and respite care. Case management provides for assessment and care plan development. Eligibility is the same as for Medicaid: 60+ years, income $\leq$ \$1336/month, assets $\leq$ \$2,000, at risk of nursing home placement, has a capable caregiver available. The average age is 82 years old; 45% have 6 ADL impairments; 72% have 8 IADL impairments; 86% have dementia. Average annual expenditures are \$2,222/person. Current funding is \$13 million and it serves 9,378 elders.

Robert Wood Johnson Foundation Consumer Directed Care Demonstration Research Project was initiated in 1996. Participants receive a cash stipend which provides an incentive to make cost-effective purchases (get more care for less dollars). The project uses consultants rather than case managers. It is available for all age groups in the 19 county region where it is implemented but targeted to: frail elders, adults with disabilities, developmentally disabled adults and children, and those with brain and spinal cord injuries. It is statewide for children. The consultant's role is to provide training, technical assistance, information & referral, answer questions, oversight, and an annual assessment. The purchasing plan averages \$5,291/year and can be saved month to month to pay for costly items. There are bookkeepers available. It is a research project so there

is a control group that is not getting the cash stipend (though July 2001). Continuation is guaranteed for 2 years after that.

Mr. Liptak asked if there were financial models that existed that looked at savings from diverting individuals from institutional to in-home care.

Dr. Hernandez responded that by diverting 20% of their clients from nursing homes, we can save x amount of dollars (see projections in packet). There are a variety of models based on several service packages.

Mr. Sherberg asked about the Department of Children and Families (DCF) financial eligibility requirements which have used COLA increases for the income requirement but continues to keep the asset test at \$2,000.

Dr. Hernandez responded that programs are fragmented because aspects are under the umbrella of other organizations. The asset test should be increased.

Rep. Argenziano stated that everyone agrees people should remain at home but wondered if the 20% who are in nursing homes could be transferred to home had been identified. She also asked if people in the nursing home can really be diverted back home care; if the people who are using senior centers at \$1300/year would be going to nursing homes if this service wasn't used. She commented that prior to 5-7 years ago, nursing home residents included people who could be at home but it is no longer true. Would savings from diverting people from nursing homes, take away resources from nursing homes who are serving people at a more critical level of care. She stated that we need to add additional resources for these programs to keep them out of nursing homes but not advocating to take away dollars from nursing homes for those who need to be there.

Dr. Hernandez clarified that the 20% are new people that would be new to the system and after the assessment, they can be diverted from nursing home placement. The dollars associated with each level of the continuum is for clients when they are at that level of need. Each level of the continuum needs to be fully supported. There are people going to the nursing home from public housing that don't belong in the nursing home. There needs to be a way to prevent eviction of these people. This happens because of existing HUD rules [e.g. keeping apartment clean] and the fact that Service Coordinators in HUD housing are not working with DOEHA. Service coordinators know about nursing homes and need to be educated about other options.

Mr. Sherberg asked why service coordinators don't refer to assisted living facilities?

Dr. Hernandez said that in some cases, they do meet the level of care requirement because of confusion; in other cases, they don't but because of financial concerns, the assessment worker will make it work so individuals can qualify for nursing homes [since they are covered by Medicaid.]

Mr. Boyer asked the panelists for information on individuals who are not served by the various programs but would benefit from them. What would it cost to serve them? Also, recent reports by AARP and Senate Hearings suggest that the cost savings from 20 million family caregivers amounts to \$45-\$75 million. How many people are waiting for Medicaid Waiver programs?

Ms. Davis responded that there are individuals who do not receive HCE but are being served through other HCBS programs. The large number of caregivers are the people that DOEA is trying to target to provide more support with programs such as Alzheimer's Disease Initiative, Community Care for the Elderly, Medicaid Waiver programs. About 10-13,000 individuals are interested in Medicaid Waiver programs.

Ms. Arrant said that it is difficult to measure something you don't have. CCE lead agencies estimate that they are able to meet 20% of the estimated need.

Dr. Hernandez described a new care plan method that went into effect 2 months ago that tries to capture the total cost of care, including family contributions. In 6 months, we will have better data on the true cost of care.

Mr. Grofic asked about the success of the 15% of people who are diverted from nursing homes. He also asked about the source of funding and how unmet need is figured into projections.

Dr. Hernandez said that a report exists and can be provided. The age, family situation, impairment level are all used to identify the candidates for diversion. She also stated that it costs the state \$62 million more to support elders who are tobacco dependent than those who are not dependent on tobacco. Costs are projected based on the frailty level of each client and then projected out 5 years.

Dr. Calkin expressed enthusiasm for consumer directed care and asked for current research on outcomes. She also suggested that there is a need to define coordination of services versus integration of services and it appears there is more coordination than integration in the current system. The total costs of long-term care need to include the economic impact of family caregiving.

Dr. Lipnick suggested that the task force is talking about two sets of people: those with the potential to achieve higher functional levels and those who cross a threshold where community living is no longer possible. The strategies for serving these two populations must be different. There is a lot of untreated depression. People who are at home may not be doing the things to improve their function. Rehabilitation can be used to maintain community living. It would help to know what number of individuals at home could benefit from these services.

Dr. Hernandez stated that a comprehensive universal assessment tool would capture the need for rehab services. This would be linked to a care plan that is tailored to the individual needs and including their own coping skills.

Mr. Clark stated that by the time a person enters the long-term care system, it is too late for many. They have problems with personal care. Senior Centers can work as an early intervention to promote healthier aging.

Ms. Arrant stated that there are several programs designed to combat depression through active engagement: retired senior volunteers, foster grandparents, and senior companion programs.

Dr. Dwyer commented on the huge load on families to provide long-term care and stated that he supported diversion of potential new entries into nursing homes into the community. We need to acknowledge that these people are a lot more impaired with complex medical needs than we saw 10-15 years ago. \$2,000/year spent on the HCE program may take care of some direct services but it doesn't nearly cover all the costs: family members quit jobs, suffer from depression and other conditions. As these more impaired people are diverted, we need to plan for training caregivers. He also asked about how Hospice can be expanded to the period of life prior to the time they qualify for services.

Dr. Hernandez responded that consumer directed care includes a family caregiver training component—to teach them how to bathe, provide hydration and medications. The HCE program is general revenue funded and does not take into account these other caregiver costs. But the CDC program can pay caregivers and pay social security for them. DOEA has a Task Force on Palliative Care.

BREAK

The Chairman reminded Task Force members that there will be time for discussion on these issues tomorrow.

Marti Osborne provided information about a nursing home diversion project called Health and Home Connection in the Orlando area. The program:

- Began December 1998 and serves Orange, Osceola, and Seminole Counties.
- Based on United Health Care's Eldercare program in Miami
- Similar to two other diversion programs in West Palm Beach
- Reimbursed on a capitated basis
- Provide case management of community and medical services

Clients served by this program compared to nursing home residents, on average:

- Have higher rates of cognitive impairment (29% vs. 22%)
- Have the same level of ADL impairment (need help in 4 personal care areas) and many more IADL impairments (8 vs. 3). [Note by Jennifer Salmon: IADLs are help with finances, shopping, housekeeping; areas that are often not assessed accurately in nursing homes since they are provided as part of the care.]
- Have higher proportion of Hispanics (28% vs. 6%) and other racial groups represented (37% vs. 28%).
- Are just as likely to be female (76%).

Clients receive an average of 35 hours of assistance a week for the following services: personal care, homemaker, home delivered meals, pharmacy, durable medical equipment/supplies, emergency monitor, environmental adaptation, companion, escort, adult day care, \$10 monthly OTC medication benefit, respite care (in-home or in a facility), chore services, financial counseling, assisted living, and nursing home custodial care.

The program grew from 10 people in December 1998 to 433 in September 2000. The allocation from Medicaid has been expended so no new enrollees can be accepted unless there are people who disenroll. They project that by June 2001, the waiting list will be almost as large as the number of enrollees unless new funds are provided.

The potential savings to the overall long-term care budget assuming a \$125/day Medicaid rate for nursing home care (\$3,750/month) amounts to \$45,000/year per person. For 750 slots (the projected need by next June), this would cost the Medicaid program \$33,750,000. In contrast at a \$2432/month/person rate, these same 750 people could be served for \$21,078,000. A savings of \$12,672,000.

One of many success stories for this program was an older woman admitted with a stroke, hypertension, Alzheimer's disease, four open wounds on sacrum, urinary tract infection, catheter, respiratory infection, and skin cancer on her forehead. She was not expected to live very long. Ten months later, wounds healed, daughter has relief from 24-hour care, and the client is still living at home.

Recommendations include:

- Provide additional funding to allow expansion of program locally and to other areas of the state.
- Develop a community continuum of care: identify enrollment criteria for each program and progress clients to next level of program when needed.

Karen Wells described the Channeling program which started in 1981 at Miami Jewish Home and Hospital for the Aged at Douglas Gardens as one of 10 sites around the nation that participated in a Medicare research and demonstration project to look at case management and alternatives to nursing home care. The program converted to a AHCA-sponsored project using a Medicaid Waiver in 1985. It is offered in Dade and Broward counties.

Eligibility requirements are:

- 65+ years old
- Medicaid eligible (ICP level established by Department of Children and Families; \$1536/month) but can transfer assets to a spouse
- Nursing home eligible (level of care) as determined by CARES
- Have two unmet service needs and two ADL deficiencies (average=4)

Program services:

- Capitated rate of \$25.28/day that client is receiving care in the community (not reimbursed when the client is hospitalized or out of the area). They still provide oversight but are not reimbursed during these times.
- Contract with 76 providers in a closed provider network (competitive bid process to become a provider) which keeps costs down (e.g. 95% of clients get personal care at \$11.50/hour as opposed to the state paying \$11-\$21/hour for nurse aides).
- Provide 19 services: case management, adult day health, adult companions, chore service/pest control, environmental accessibility adaptations, family training, financial education and protection, home health aide, in-home counseling, occupational therapy, personal care services, personal emergency system, physical therapy, respite up to 24 hours, drug and nutritional assessments, home delivered meals, medical equipment, medical supplies, speech therapy.
- Serves 1607 individuals a year.
- Only direct service is case management; rest is contracted. Case managers have 55-60 clients each.

- Nurse consultants have 300 clients each.
- Rehab is not included but ought to be.

Reimbursement is:

- \$760/month if client is in the community the entire month
- nursing home costs of \$4140/month (\$138/day)

Costs are on average:

- \$650/month (\$400-\$2,200/month)

Client characteristics in Broward vs. Dade counties are:

- 23% vs. 69% on SSI.
- 71% vs. 81% female
- 34% vs. 94% nonwhite
- 37% vs. 49% are age 85+
- 15% vs. 27% live alone

Disenrollment occurs for the following reasons:

- 53% die
- <1% hospitalized
- 19% go to nursing home
- 4% move out of the area
- <1% become ineligible, not LOC eligible, or noncompliant
- 12% withdraw voluntarily
- 6% move to an ALF
- 4% other reason

Recommendations:

- Provide support to caregivers
- HCE at \$106/month is insufficient
- Explore different models of ALF
- Oversight is important
- Review FS 415 that eliminated the abuse registry

The Chairman recognized Senator Charlie Clary who addressed the group briefly.

PANEL TWO

Jane Johnson addressed the issues of affordable housing and assisted living conversion projects on behalf of the Florida Association of Homes for the Aging (FAHA). FAHA represents 270 long-term care facilities that range from affordable housing to HUD financed housing for low income seniors aged 62 and older, to nursing homes, assisted living facilities, and continuing care retirement communities; mostly nonprofit, faith-based programs. Together, they care for over 70,000 individuals. There are more elders in HUD housing (80,000) than are in nursing homes in Florida.

Characteristics of elders in HUD housing:

- Average age of 82
- Female
- Live alone
- Without family, they will be primary candidates for Medicaid funded nursing home care based on their income status alone; it will be the only option for them.

Service Coordinators were funded by HUD in 1999 to be social workers, service coordinators, case managers, and activity planners (see job description that was handed out). A total of 5 were funded in Florida last year. There is no formal link between the Service Coordinators and DOEA. In fact, several different homemakers come to the building to provide services to individuals when a permanent assignment of one person would be more efficient and cut down on homemaker travel and other expenses.

Recommendations:

- Formalize relationship between affordable housing facilities and local aging services networks.
- Assign caseworkers, homemakers, home health aides to facilities (HUD apartment buildings) rather than to individuals.
- Allow HUD Service Coordinators to complete assessment forms and submit referrals.
- Establish state program to fund additional service coordinators in all HUD housing.
- Create incentives for rent-subsidized facilities to provide services to assist older tenants to age in place.

Affordable assisted living is not available to most seniors who earn more than \$25,000/year. The average market rate of ALFs is \$2,000/month. In addition, providers are seeing huge increases in their liability insurance rates for facilities with ECC license.

Recommendations:

- Convert nursing homes that are going out of use to affordable assisted living facilities.
- Convert HUD housing to affordable assisted living facilities.
- Consider changing the rules for ALE Medicaid Waivers so for facilities that provide affordable ALF. Facility would not have to have an ECC license which has costly physical plant requirements (either for a renovation of an old nursing home or HUD building or for a purpose-built building).
- Provide state-funded, low interest mortgage financing for affordable assisted living projects.

Paul Williams described the Optional State Supplementation (OSS) for assisted living facilities. OSS is a means-tested cash assistance program for individuals who receive Supplemental Security Income (SSI) to be used for supportive living arrangements in the community to prevent unnecessary institutionalization. OSS amount is (as of 8/00) based on a \$697/month cost of care plus a \$43 personal needs allowance for a total of \$740. The federal SSI amount is \$512 and the maximum State OSS amount is \$228. The average is \$206/month.

46% of OSS recipients are age 65+. About 23% of Florida's ALFs participate in the program. The 75% who do not participate is due to the very low total reimbursement, and the additional regulatory oversight if you accept OSS recipients, and the number of regulators (Department of Children and Families, Agency for Health Care Administration, Department of Elder Affairs). In addition, ALFs lose up to \$150/month per resident for their medications. In a nursing home, this same resident would have a higher income eligibility level (\$1536/month) and the nursing home would be reimbursed \$3,000/month for care in addition to the cost of medications. The ALE waiver has the same eligibility requirements as nursing homes and reimburses ALFs at a higher rate than OSS.

Finally, there has been a significant deterioration in the cost of liability insurance. Our insurer will not insure the smaller facilities (<16 beds) which represents 2/3 of Florida's facilities. The standard rate was \$65/bed in 1999 and it has increased to \$100-\$1000/bed in 2000 (53% to 1000% increase). They also are not insuring facilities that have an ECC license.

Recommendations:

- Institute a Gatekeeper/CARES Assessment.
- Develop tiered payment system linked to need.
- Establish better communication between agency data systems and provider industry.
- Increase program participation by providing adequate funding.
- Standardize ALF medication eligibility level to nursing home level.
- Maximize State resources by cross-training staff to perform case management and eligibility functions.
- Develop capability to submit client applications online.
- Cover costs of incontinence products, OTC medications, and personal care items.
- Streamline regulations.

Robert Schemel spoke on behalf of the Florida Health Care Association members regarding ALF and the Medicaid Waiver. He is the executive director of a retirement community that serves 500 residents including 200 in two assisted living facilities and a home health agency that serves the outside community as well. He has maximized the use of public funding to make his programs affordable to the residents. But there are problems with the rules that make it hard for a resident or client to access the services she needs (e.g., with the ALE waiver, other services are not available like adult day care). The people in the community are very needy and often just as needy as the people we serve in nursing homes.

It is often a trade off between quality of care (offered in the nursing home) and quality of life (found at home). It isn't possible to duplicate the quality of care in a facility with what can be provided a few hours a day or week at home. To do that, the cost would be phenomenal.

Recommendations:

- Case manager should follow the person.
- Case management should be operated by the State and be independent of providers.
- Recognize that there is a trade off between quality of life quality of care.

He also described the recent increase in liability insurance costs which went from \$80,000 in 1998 to \$120,000 in 1999 and \$240,000 in 2000.

The Chairman thanked the panelists and asked for questions from Task Force members.

Rep. Argenziano explained the changes in FS 415 which ended the abuse registry. It was based on several years of study which showed it wasn't as effective as it should have been. The decision was supported by Florida Department of Law Enforcement and the Elder Law section of the Florida Bar. She then asked if the Health and Home Connection information was misleading because the people they serve in the community are not in nursing homes so the projected savings aren't real.

Ms. Osborne explained that the comparisons to nursing home residents was to show that they were able to care for people who were at a similar level of care need. They don't get the 24-hour supervision from the agency (as they would in a nursing home). Without the program, they would have to be admitted to a nursing home.

Rep. Argenziano asked if the people in nursing homes could be taken out and receive adequate care through this program.

Ms. Osborne stated that they don't provide the same level of care but care for people at the same level of impairment.

Mr. Freidin asked Mr. Schemel for insurance claim history prior to the increase in premiums. He also asked him to reconcile his perhaps arbitrary experience with claims and the increase in premiums and if the insurance company has treated him fairly.

Mr. Schemel said there was one claim in past three years, a lawsuit against the retirement center which is under litigation. No claims against our nursing home, two ALFs, or home health agencies. He stated that the insurance companies are not being arbitrary. He has been an expert witness on a number of other lawsuits and most of the time the negotiation is over attorney's fees. He asked "what attorney wouldn't want to take on a case for 1/3 of \$5 million dollars?" The incidents are usually for minor injuries. [Insurance companies] are negotiating for hundreds of thousands of dollars before going to trial, not for pain and suffering, but to lowering attorneys' fees. He said that he felt the insurance company treated him fairly because of his vulnerability [to potential lawsuits].

Mr. Freidin asked if attorney fees were restricted, would that solve the problem. He went on to ask if most of the suits are health care related or civil rights related?

Mr. Schemel said that restrictions would help but that cases were often both health care and civil rights related (e.g., improper supervision could mean someone falls or is hurt in some way).

Mr. Boyer said that he looked forward to data at the next meeting to support Mr. Schemel's claims. He also provided support for FS 415 changes. It allowed Adult Protective Services to protect people and not be pulled into investigating and prosecuting cases. It goes a long way towards protecting people. He then asked about the eligibility for ALE Medicaid Waiver for someone who does not meet all three criteria for Institutional Care Program (ICP) level of care such as in the case of Mr. H. in the presentation.

Mr. Williams said that individuals in this scenario (who do have insufficient funds for medications) are absolutely moved to nursing homes.

Mr. Sherberg stated that in his own facility, financial eligibility alone can place you in a nursing home regardless of the other criteria.

Business Meeting ended at approximately 12:15.

October 17, 2000

Present: The Honorable Frank Brogan (Chairman), Dr. Gema Hernandez, Mr. Larry Sherberg, Mr. David Grofic, Mr. Walter Liptak, Mr. Raymond Noga, Dr. Jeff Dwyer, Ms. Cheryl Chmielewski, Mr. Kenneth Connor, Dr. Joy Calkin, Mr. Ed Boyer, Mr. Robert Miller, Ms. Victoria Fierro, and The Honorable Nancy Argenziano.

Absent: Mr. Bob Sharpe, Mr. Philip Freidin, Dr. Jesse Lipnick, The Honorable John McKay and Rene Rodriguez

Staff present: Dr. Larry Polivka, Dr. Kathryn Hyer, Ms. Jennifer R. Salmon

The Chairman reconvened the business meeting and introduced the agenda for the day.

Task Force members introduced themselves to the audience.

Lyn Bodiford spoke on behalf of AARP. The long-term care system needs to provide access that is focused on the client who needs resources regardless of finances or eligibility. Need to look beyond the people who are funded by the state. Families need information to improve access to information and level of expertise they receive that is appropriate to their needs. Families need respite. People who are nursing home eligible and receive care at home will move to the nursing home because the caregiver wears out not because the person's physical health or condition changes. The aging network is not a system. There are lots of pieces that exist but they need to be coordinated or integrated. There needs to be a common language. There is no one way to serve all consumers and family members but with consumer direction, care coordinators, and heavy case management we can serve them better. We need to target our resources and to think about when it is better to focus resources on the less frail or more frail and make good use of resources for prevention. The system should coordinate acute and long-term care needs rather than separate them (e.g. the Health and Home Project in Orlando). Need to decide when to pool funds and when to maximize each source. Families need to know that there is quality care. AARP supports the decision by the State to close poor performing nursing homes.

Annette Kelly spoke on behalf of the Alzheimer's Association. The policy goals for the Task Force should be:

- Alternatives to care that are the least restrictive
- Access to sufficient resources, information, and referral
- Appropriate training, pay, and benefits for care providers
- Affordable insurance

- Assurance of quality of care and autonomy
- Alleviation of stress on the family caregiver

The Alzheimer's Association recommends the following:

- Increase state-funded home and community-based care programs like in-home health care, adult day care, and respite care. Seek state support to improve the availability and increase the duration of respite care for family members.
- Expand HCBS Waivers: increase the number of recipients overall, and include services such as adult day care, assisted living and adult family care homes.
- Expand Medicaid reimbursement to include alternative care
- Develop a clearinghouse service or single point of entry (like NJ or MA) with capable and qualified consumer advocates and case managers to help seniors through the maze of services from the first phone call to the last.
- Serve ethnic minorities and rural areas by funding mobile services that will bring education services to the caregiver; training for health care professionals; and enhance the ability of families to care for their loved ones.
- Support on-going dementia-specific training standards for personnel who provide services for the elderly, including but not limited to: community-based agency staff, nursing facilities, assisted living facilities, students in nursing, social work, gerontology, medical schools, and other related fields.
- Expand the Alzheimer's Association Safe Return program state-wide and promote dementia specific training for law enforcement, emergency response personnel, and appropriate volunteer crime watch programs.
- Increase wages and benefits for dementia care staff to a reasonable standard of living.
- Establish specific standards for staff to patient ratios in specialized care units for people with dementia, and for those providers offering community-and home-based care.
- Work with Department of Insurance to ensure quality and viability of long-term care insurance products in Florida. Benefits to include in-home care options and community options like adult day care.
- Explore the feasibility of implementing long-term care public/private partnerships.
- Assist insurance industry in writing affordable long-term care policies in order to ease the burden and alleviate the strain on nursing home costs.
- Promote state-sponsored long-term care insurance for government employees.
- Work with Florida employers to offer employees long-term care insurance as an optional benefit.
- Mount a public awareness campaign to stress the importance of planning and saving for long-term care and retirement.
- Require state agency to more effectively monitor and enforce regulation in licensed facilities.
- Increase the number of surveyors, provide sufficient funding, and assure that they are properly trained.
- Provide adequate funding for state ombudsman staffing and assure that staff is appropriately trained and responsive to complaints.
- Consolidate and coordinate multi-agency regulatory functions and develop a regulatory process that is increasingly focused on quality improvement and outcomes.

- Through a case management approach, assure that persons are appropriately served at each level in the LTC continuum of care and provide equal access to appropriate levels of care.
- Provide more options that are home and community-based so that stressed caregivers can get relief and maintain their caregiver role longer.

Anna Spinella spoke on behalf of the Silver-Haired Legislature. Her recommendations included:

- Include positive aging and prevention in the continuum of care.
- Expand CCE
- Provide better transportation
- Early identification of elders at risk for nursing home placement (using CARES).
- Create public/private citizen caregiver coalitions to develop a volunteer training program in nursing homes and ALFs.
- Include input from consumer and family in CARES assessment, including their preferences.
- Expand adult day care
- Create a single point of entry into all eldercare programs to avoid the runaround.
- Encourage consumer directed care but be aware that many with Alzheimer's Disease cannot direct their own care.
- Create a 10 year stable trust fund for elder programs using tobacco funds.
- Put all eldercare programs under one umbrella.
- Eliminate the waiting lists to get services.
- Regulate nursing homes to do their job right.
- Don't abandon the people who are currently in nursing homes as the system is changed.
- Increase minimum staffing ratios:
7AM-8 PM: 1 CNA to 6 Residents; 1 RN to 10 residents
8 PM-7 AM: 1 CNA to 10 residents; 1 RN to 15 residents
Alzheimer's units: 1 CNA to 3 residents
- Increase benefits and wages for CNAs
- Beef up monitoring of nursing homes: survey at night and on weekends; include a plan of correction and limit appeals.
- Give ombudsmen more authority.
- Contact the Family Council as part of the survey
- Close seriously deficient nursing homes.

Rep. Argenziano asked why AARP didn't have a state newsletter to inform older Floridians?

Ms. Bodiford responded that AARP is now recognizing that changes will happen at the state level (rather than national level). The State will be more active in public information campaigns.

Mr. Grofic asked for clarification about higher staff ratios for units with residents who have Alzheimer's disease.

Mrs. Spinella explained that the 1:3 ratio was for Adult Day Care (not nursing homes).

Ms. Kelly said that the Alzheimer's Association will provide more information on ratios for Special Care Units in writing.

Dr. Calkin mentioned that University of Wisconsin researchers have addressed the ecological issues of design for dementia units and that the environment can empower residents with Alzheimer's Disease.

Ms. Kelly said that the problem is in how to retrofit existing buildings. In addition, the units design and mission are both important to quality of dementia care.

The Chairman said that just as in schools, there is often no magic ratio of staff to residents if the care is provided in the same poor way. He wouldn't want to see arbitrary ratios.

Mr. Connor said that the recent HCFA study showed that the single biggest indicator for positive outcomes was staffing. The State asks for minimum staff ratios; the Federal agency doesn't set a minimum or maximum but requires that the staffing maximize the care and life of residents.

Ms. Spinella said that many nursing homes don't have special care units for dementia care so Alzheimer's residents are mixed with others and the ratios are inadequate.

The Chairman said that a good nursing home might have to cut back on services they were providing (like PT) in order to comply with higher staff ratios.

Rep. Argenziano stated that CNAs complain that they can't handle the number of residents in their care.

The Chairman said there is a difference between a floor and a ceiling. If we move the floor higher rather than counting on facilities to do the most.

Mr. Sherberg stated that increases in funding won't mean we can do so much more; we're just trying to get back to where we need to be.

Mr. Noga explained that the tobacco money has been securitized to protect against bankruptcy of the tobacco companies. There is a November 2000 deadline for how to use the tobacco money.

The Chairman said that [former] Gov. Chiles had earmarked the money for children. Gov. Bush was adamant about paying for people who had long-term tobacco use. In the last session, the money that was put into biomedical research represented a drop in the bucket for them—it could perhaps be used elsewhere. The tobacco settlement money is supposed to be used to drive down tobacco product use. With less purchasing, the tobacco companies could go bankrupt which is why the trust fund was securitized.

Mr. Connor said that he agreed with Mr. Sherberg that State and Federal government needs to assure that long-term care facilities have adequate funding. When you squeeze reimbursement, the pressure is to cut staff.

Robert Glowacki presented information about Long-term care insurance. Coverage for a typical policy includes: nursing home care, assisted living facilities, home health care, adult day care, respite care, caregiver training, durable medical equipment rental, other incidental services. Policies can come with inflation protection: either a 5% compounded or %%% simple rider or guaranteed purchase option. They also have a nonforfeiture benefit if the insurer should drop coverage. There is protection in the event of a lapse (which can happen if someone becomes forgetful) so that the beneficiary can be reinstated.

State and federal long-term care programs will not solve the long-term care problem. Private insurance is not a solution for everyone. We need to work out a public/private solution. If workers 35+ paid 2% of their income for a policy, there would be \$28 billion in savings to Medicaid and \$63 billion in savings to consumers.

The average LTC Insurance policy holder is 67 years old. 58% have less than \$50,000 in income and 71% have over \$100,000 in assets. The average age is decreasing.

At the federal level, in 1996 they passed the Health Insurance Portability and Accountability Act which allowed for a tax deduction on premiums for health expenses.

October 2000, Congress is considering “above the line” tax deduction for LTC Insurance premiums and federal employees long-term care insurance benefits.

Florida has 10% of all long-term care insurance policies (other big states are: CA, PA, IL, TX).

Recommendations:

- Educate consumers about who pays what for long-term care
- State initiatives: government employee long-term care insurance programs
- Educate government and insurers.

BREAK

The Chairman asked what does long-term care insurance cost and how much it would cost as a federal or state benefit (group purchase).

Mr. Glowacki said that the typical 67 year old for a plan that provides for 5 years of long-term care with 5% protection rider, would pay \$1600/year. A 65 year old would pay \$700/year and a 75 year old would pay thousands. There are three options for group purchasing. They are usually \$1400/year.

Mr. Liptak said that the State of Florida is planning an employee LTC Insurance benefit program. Proposals are due in November.

The Chairman said that if 120,000 employees were covered that would have a long-term savings.

Mr. Glowacki said that the policies are capped at paying up to \$120/day for nursing home care.

Rep. Argenziano asked how will the baby boom not bust LTC Insurance budget? And what happens if you pull out of the business?

Mr. Glowacki said that the insurance industry knows that a certain % will die and never use it. There is more accountability with this product than a hurricane policy.

Mr. Liptak explained that LTC Insurance has a level premium. The price stays the same unless assumptions have to be recalculated. Recipients are prepaying for their insurance.

Ms. Fierro said that in the public testimony, a salesman was told it would cost \$300,000 to purchase LTC Insurance for his wife with Alzheimer's disease. Perhaps there should be education requirements for salesmen and agents.

Mr. Glowacki agreed that continuing education should be required. There are National Association of Insurance Commissioners guidelines and Florida has a booklet on LTC Insurance which he will send to the Task Force along with information about consumer protection statutes in other states.

The Chairperson then asked for general recommendations from Task Force members regarding all the topics over the past 1½days.

Ms. Fierro asked for clarification on what type of structural changes would be needed to adopt a universal assessment instrument (suggested by Secretary Hernandez): state or federal legislation or an interagency agreement.

Dr. Hernandez recommended that the TF define components in a continuum of care and that they would dictate which components would be included in an universal assessment instrument. From this a consensus for appropriate levels of care (e.g. levels 1-5 suggested in her October 16th presentation) would be developed. Would need to change Florida Statutes (e.g. Adult Protective Services and DOEA define "eminent risk" differently). Would also require interagency agreements.

Dr. Calkin stated that other states do have these interagency agreements to create a single point of entry. Often, they require a "neutral party" to do the intake assessment—a party that would not be providing services.

Dr. Hernandez stated that a single point of entry is not a location but a process. For example, a Senior Center or an Adult Day Care center could follow the same protocol but both be points of entry into the entire system. In this way, the point of entry would be culturally appropriate to the citizen who needed to gain access to long-term care.

Mr. Connor suggested that before looking at these details, the TF talk about the underlying principles that would guide decision making. He proposed seven:

1. Providers are entitled to fair compensation.
Tax payers are entitled to full and fair accounting.
Residents are entitled to adequate and appropriate care.
2. Frail elderly need and deserve full protection of the law.
3. Accountability and responsibility work hand in hand.

4. Artificial caps on recoveries are unfair.
5. Expand consumer choice and alternatives to nursing homes.
6. Increase incentives for providers who do a good job to get them into the market—especially the non-profits.
7. If we're going to risk pool; offenders must be driven out of the market.

Dr. Hernandez stated that the first principles should be that elders are allowed to age in place with dignity and within an ethic of care.

Dr. Calkin added that caregivers—mostly family members—should be the next priority and that the TF should look at care outcomes regardless of where the care is provided or by whom. Instead of using residents (which assumes institutional or congregate settings), use care receivers and include families as providers.

Dr. Dwyer stated that in consumer directed care, the consumer (especially with dementia) is the elder and caregiver. He also suggested that we followup on the Representative's concern that we accept certain components in the dying process and use palliative care to alleviate suffering in incurable situations.

Mr. Boyer stated that the TF needs to protect people who can't protect themselves (Connor principle #2).

Dr. Calkin stated that there needs to be a fit between the care receiver's needs, the caregiver's skills, and the services provided ("contingent caregiving").

Rep. Argenziano asked how far can we go for very complex care. She also asked what if a consumer chooses nursing home care?

Mr. Sherberg stated that care needs to be need-driven, not service-driven.

The Chairperson suggested that one principle would encompass: consumer-driven within services that are available and funded; to include a continuum of care; and quality outcomes.

Mr. Sherberg asked who should decide on the competency of the consumers to direct care? And how will they be protected at home?

The Chairperson stated that ultimately there will be someone who makes the decision for you if you can't make it yourself. The system will have a: gatekeeper/advocate, the universal assessment instrument, single point of entry, matching services to client within eligibility requirements and ability to pay.

Mr. Sherberg stated that Department of Children and Families and DOEA staff do not talk to each other so it makes it hard to have a single entry point.

Secretary Hernandez agreed that the system is fragmented and there is a need to integrate systems.

Mr. Connor stated that these concerns go back to principle #4.

Mr. Liptak asked for clarification on the purpose of the principles.

The Chairman stated it was to undergird all discussions of recommendations. For example, the legislators will have faith that our decisions were based on a set of principles. He suggested that the top two principles might be:

1. Focus on the client (care receiver, consumer).
2. System that all people can access and that is linked together.

Dr. Calkin stated that principles can be used to explain to the public and also as a way to ask for feedback but principles should not set system limits (since HB 1993 does not set system limits). Other ways to look at it include: 1) start with the budget and then adjust the system; 2) set long-term care objectives and then calculate the funding needed; and 3) look at what we have and then decide how to do it better.

Mr. Sherberg stated that principles need to be flexible so we can react to unanticipated situations (e.g. we didn't anticipate the need for care to individuals affected HIV).

The Chairman agreed that underlying principles should allow the system to evolve; can't be rigid. Summarized again the top three principles:

1. start with client needs
2. services available and choice
3. good quality, accountable, and outcome-related

Mr. Connor suggested that members put principles on the table so they can be distilled.

The Chairman asked that they be sent prior to the next meeting.

Rep. Argenziano stated that the TF needs to look at what's failing in the system and how we can fix it.

The Chairman reorganized Connor Principle #1 and Secretary Hernandez Principles to:

1. System of care that all people can access.
2. Consumers are entitled to adequate and appropriate care.
3. Providers are entitled to appropriate compensation.
4. Taxpayers are entitled to fair and full accounting.

Mr. Liptak suggested that members turn in their principles to staff to be organized for next discussion.

Ms. Salmon (staff) asked for principles to be turned in by Friday, October 20th.

The Chairman asked that the TF apply the principles to the areas in the legislation: alternatives to care, quality of care, etc.

Dr. Calkin asked about the level of services on Secretary Hernandez's continuum that are in place already.

Dr. Polivka (staff) stated that the services are available but are not sufficient and there is a gap between what people want (in-home services) and what is available.

Dr. Hernandez stated that care needs to be integrated and coordinated with acute care.

Dr. Dwyer said that if we are spending 88 cents of every long-term care dollar on nursing home care, we should consider balancing the system.

Rep. Argenziano said that we may not be able to shift funds from one program to another but may need additional funds (e.g., individuals with developmental disabilities are looking at the adequacy of services). In many parts of the state, there are no providers.

Ms. Fierro asked for an inventory by region of the state of all services available. She also stated that individuals should be enabled to be responsible for planning for and paying for care—it isn't all on the taxpayers.

Mr. Sherberg stated that the principles need to look at negotiated risk across the whole spectrum of care.

Dr. Polivka (staff) stated that the Annette Kelly's presentation pointed out how important it is to create a balance between safety and autonomy.

Dr. Dwyer said that research is changing our understanding of what is normal decline. Early interventions in memory loss can keep people sharp and delay the onset of dementia.

Ms. Chmielewski asked that staff review services by County and that some allocations need to be updated (e.g. drug rehab in Sarasota county is overfunded).

The Chairman said that ties into the accountability of the whole system.

Mr. Boyer stated that another early intervention program is the Public Guardian program which estimates that 20,000 individuals need guardianship but cannot afford it and there isn't a public guardian available.

Dr. Polivka (staff) stated that Community Care for the Elderly (CCE) was a general revenue sponsored program that began as an early intervention program for lower acuity consumers. The goal was to maximize the Medicaid Waiver for people who were at risk. But now CCE \$ from General Revenue are being used to provide the state match to these Medicaid Waiver programs. This is still true even with the increases by Governor Bush recently.

Original principles revised (from blackboard):

MISSION: system of care that all people can access system that links services:

1. Care recipients are entitled to adequate and appropriate care.
2. Taxpayers are entitled to fair and full accounting.
3. Providers are entitled to fair and adequate reimbursement.
4. Frail elders need full protection of the law.
5. Expand consumer-driven choices.

6. Accountability and responsibility run hand in hand.
7. Increase incentives to encourage good providers entry to market (not for profits?).
8. If risk pool: repeat offenders must be driven out.

The meeting adjourned around 12:00 noon

Respectfully submitted,
Jennifer R. Salmon
Project Coordinator
Florida Policy Exchange Center on Aging

Amended October 31, 2000. Minutes passed by voice vote, October 31, 2000.

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

BUSINESS MEETING

October 30, 2000

Room 412 Knott Building and Senate Room 37 (overflow)

400 South Monroe Street, The Capitol, Tallahassee

*This meeting will be tape-recorded and transcribed for the public record and telecast on the
Florida Channel Interpreted for the Hearing Impaired*

8:30 Introductions **Lt. Governor Frank T. Brogan**
Old Business: Accept or amend October 16-17 minutes

New Business: Expert Panels on the Causes of Nursing Home Bankruptcies

8:45 Financial:
Business Practices, John Ransom, Raymond James Financial Services
Reimbursement Levels, Carol Shotwell, Regulatory Analyst Supervisor, Agency for
Health Care Administration
Liability Insurance, Dan Sumner, Department of Insurance
Florida's Business Climate for Nursing Homes, Randy Miller, Associated Industries of
Florida

9:35 Quality:
Complaints, Steve Rachin, State Long-Term Care Ombudsman
Nursing Home Quality, Shawn Phelps, Economic Analyst, Agency for Health Care
Administration
Quality Improvement in Nursing Homes, Bruce E. Robinson, MD, MPH, Professor of
Medicine, University of South Florida, Chief of Geriatrics, Sarasota Memorial
Hospital

10:20 BREAK

10:30 Litigation:
Resident Rights, Lauchlin Tench Waldoch, Elder Law Attorney
Right to Cause of Action, Lance Block, President, Academy of Florida Trial Lawyers
Quality and Litigation, Cathy Ates, Director of Clinical Services, Emerald Healthcare
Cost of Litigation on Non-Profit Long-Term Care Facilities, Erwin Bodo, Sr. VP,
Reimbursement, Florida Association of Homes for the Aging
Litigation and Assisted Living Facility Viability, Ron D'addio, Plastridge Insurance Agency
and
Lyn Bentley, Manager, Government Affairs, Marriott Assisted Living Services

11:45 Task Force Discussion (not available for teleconference due to transponder schedule)

12:45 Adjourn Business Meeting (Task Force Members Provided Box Lunch)

1:45 Public Testimony Hearing (there will be one 15-minute break at 3:45 p.m.)

5:45 Adjourn

AGENDA

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

BUSINESS MEETING

October 31, 2000

Room 412, Knott Building

400 South Monroe Street, The Capitol, Tallahassee

This meeting will be tape-recorded and transcribed for the public record.

Interpreted for the Hearing Impaired

9:00 Task Force Discussion:

Principles that undergird Task Force decisions

Home and Community Based Alternatives (continued discussion from October 17th meeting)

10:15 BREAK

10:30 Task Force Discussion:

Nursing Home Bankruptcies

12:00 Adjourn

MINUTES
Task Force on Availability and Affordability of Long-Term Care
October 30-31, 2000
Knott Building, The Capitol, Tallahassee

October 30, 2000

Present: The Honorable Frank Brogan (Chairman), Dr. Gema Hernandez, Mr. Bob Sharpe, Mr. Philip Freidin, Mr. Larry Sherberg, Mr. David Grofic, Mr. Walter Liptak, Mr. Rene Rodriguez, Dr. Jeff Dwyer, Dr. Jesse Lipnick, Ms. Cheryl Chmielewski, Mr. Kenneth Connor, Dr. Joy Calkin, Mr. Ed Boyer, Mr. Robert Miller, Ms. Victoria Fierro, and The Honorable Nancy Argenziano.

Absent: Mr. Ray Noga, The Honorable John McKay

Staff present: Dr. Larry Polivka, Dr. Kathryn Hyer, Ms. Jennifer R. Salmon, Dr. Paul Duncan, Dr. Christopher E. Johnson.

Note: This meeting was made available via satellite teleconference to: Brevard Community College (Cocoa), Florida Atlantic University (Boca Raton), Polk Community College (Winter Haven), and Gulf Coast Community College (Panama City).

The Chairman introduced the mission of the Task Force.

Task Force members introduced themselves.

Ms. Carol Shotwell described the major characteristics of the reimbursement plan, recent nursing home funding issues, and a profile of the July 1, 2000 rate setting seminar.

- Nursing home appropriation is 1.6 billion dollars, the second largest lineitem in the Medicaid budget and 1/5 of the total Medicaid budget of 8.3 billion dollars.
- The Federal share is 56.62% and state share is 43.38%.
- Nursing home per diem rates are facility specific and based on Medicaid costs/Medicaid days.
- Per diem is comprised of: operating costs (administrative, housekeeping, plant operations, laundry), patient care (nursing, dietary, therapies), property (depreciation, interest, taxes, insurance), and Return on Equity (ROE: capital spent to provide patient care).
- Per diem rates are set on January 1 and July 1 based on the most recently submitted cost reports submitted by each facility: uniform cost reporting using standard forms. Rates are either prospective or interim based on budgets.
- New providers/Change of Ownership (CHOW) submit a budget without cost history and so prospective rates are based on historical costs (nursing home market basket index produced by Data Resources Inc.) projected into the future and adjusted for inflation.
- On July 1, 2000, 86% of rates were prospective. Interim rates are adjusted after 9-21 months of cost history.
- Reimbursement ceilings limit increases in per diem rates within adequate and allowable and reasonable costs of efficiently operated nursing homes.

- April 1, 1999, case mix adjustment was added to the patient care component of the per diem rate (to enhance care for residents with a higher acuity level). This increased the nursing home Medicaid budget \$4.4 million.
- January 1, 2000, partial rebasing of the reimbursement ceiling on patient care (for patient care). Increased the budget \$18.1 million
- April 1, 2000, direct care staffing adjustment to patient care component (recruitment and retention of direct care staff: RN, LPN, CNA). Increased budget \$31.7 million.
- July 1, 2000, provided for interim rate requests (IRR) for general and professional liability insurance (for facilities with 65% Medicaid beds and policy cost increases that increase per diem rates by 5%). Increased the budget over \$1 billion.
 - 8 facilities were granted; 18 were denied; 60 are pending.
 - IRR ranged from 30 cents/day to \$5.70/day (average \$3.63).
 - Liability insurance increases cost the facility \$8.48/day (for 8 granted) so the IRR provides 43% of coverage due to class ceilings.
- As of July 1, 2000 nursing home rates are set for 520 for profit and 130 not for profit facilities.
- Medicaid pays approximately 17 million nursing home days/year.
- Average Medicaid utilization is 65%.
- Average Medicaid facility occupancy is 86% (this includes prospective and budgeted rates); Prospective only is 88% occupancy.
- Average per diem is \$116.02 (\$1.9 billion annually, including the direct care staffing adjustment); without the DCSA adjustment, the per diem is \$114.06 which is 89% of the average Medicaid cost for the facility of \$128.18/day.
 - Operating costs: \$26.04 per diem; \$32.55 actual (80% of facility costs); \$426 million annually
 - Patient care costs: \$76.33 per diem; \$80.62 actual (95% of facility costs); \$1.223 billion annually
 - Property costs: \$11.66 per diem; \$15.97 actual (73% of facility costs); \$196 million annually (includes \$15 million annually for ROE).
- Adjustments and add on rates:
 - Medicaid adjustment rate: average 1.71per diem; \$24.1 million annually for 430 facilities
 - Case-mix add on: average \$2.42 per diem; \$40.4 annually for 643 facilities
 - Direct care staff adjustment: average \$1.96 per diem; \$31.7 million annually for 600 facilities

Rep. Argenziano asked for clarification on the direct care staffing adjustment.

Ms. Shotwell said that 600 facilities have taken the DCSA and the minimum amount given was 50 cents/day. An artificial ceiling of a staffing ratio of 5 was set. Followup survey of the 600 facilities is due back by November 30th and will help to provide information on whether or not the purpose of the adjustment as served.

Rep. Argenziano asked if the facilities that needed it the most were getting it based on a formula that included a higher percentage of Medicaid residents.

Ms. Shotwell said that those who received 50 cents/day had a staffing ratio of five or above; those who received the maximum of 2.81/day had a staffing ratio of 2.3 or below the minimum.

Mr. Liptak asked why the reimbursement for property per diem rates was 73% of cost.

Ms. Shotwell said that 93% of providers are on the prospective payment system and not a fair rental value system and 7% are on cost based so when you average it, the statistics can be misleading. Fair rental value system is based on a cost per bed as opposed to the cost of the actual facility..

Mr. Rodriguez asked how Florida's per diem costs compare to other states.

Ms. Shotwell said that there aren't current data available but heard through the VA that Florida's rates had gone up higher than other states in recent years (3 states had increased), so Florida may be making progress in terms of reimbursement.

Mr. Boyer asked if there were other ways (besides the recent survey to facilities) that the direct care staff adjustment was being used for staffing.

Ms. Shotwell said that the current survey was part of the legislative directive and the follow up will be to audit the facilities. The audit looks at all rates and add-ons and look for outliers.

Rep. Argenziano asked for clarification on the VA's comment about Florida being one of 3 states with increases, did it mean they were now higher than most other states.

Ms. Shotwell said that it was the rate of increase not the rank.

Mr. Sherberg asked if the reimbursement rates is for all types of care in the nursing home or does it represent tiers.

Ms. Shotwell said that the only way it was tiered is that there are the four components to the rate. The level of care concept went out with the Gainesville plan in 1983. At that time, reimbursement rates were based on intermediate, intermediate II and skilled nursing care.

Dr. Calkin clarified the previous remarks that Florida is still low in its reimbursement rates compared to other states, it was just the rate of increase that was high.

Mr. Connor asked if Ms. Shotwell agreed with two statements in testimony provided to the Senate Special Committee on Aging by Laura Dummit: *"our analysis indicates that aggregate Medicare payments for covered nursing home services likely cover the cost of care needed by beneficiaries, although some refinements to the payment system are needed. But Medicare policy changes have required many nursing homes to adjust their operations. The adjustments have been particularly disruptive for nursing homes that took advantage of Medicare's previous payment policies to finance inefficient and unnecessary care delivery and those companies that invested heavily in the provision of ancillary services (such as rehabilitation therapies) to nursing homes. The problems experienced by some providers of nursing home and ancillary services are, therefore the result of business decisions made during a period when Medicare exercised too little control over its payments."* (p. 2). Those payment reforms set forth in the

Balanced Budget Act of 1997 were enacted to control rapid spending and growth for Medicare coverage services furnished in nursing homes. The spending was neither sustainable nor readily linked to demonstrated changes and beneficiary needs. The reforms alter the financial incentives inherent in the former cost based system to reward providers for delivery of care efficiently.

Ms. Shotwell stated that prior to BBA97, she agreed with the statements. Certain facilities in a one-year period went up 2000% which is why the federal and state governments stepped in.

Mr. Connor asked if there had been a great weeping and gnashing of teeth in the industry about the cutback in the revenue stream.

Ms. Shotwell said that she believed even the Federal government agrees that they cut back too much and they made one adjustment and will make a second adjustment in Medicare rates. But for Medicaid,:

- 22% of facilities in Florida receive 100% of Medicaid costs; 45.7% receive 95% of their Medicaid costs.
- Within the operating costs, 17.8% receive 100% of their Medicaid costs and 32% receive 95% of their Medicaid costs.
- For patient care, 51.6% received 100% of their Medicaid costs and 67.5% receive 95% of their Medicaid costs; so all of the additional patient care money (\$90 million) is having an effect.

Mr. Connor asked what authority does the Florida legislature have to enhance those reimbursements and by what amount are we able to increase those rates?

Ms. Shotwell said that the legislature decides about Medicaid spending. There are a lot of areas that could use improvement. From the experience of the Medicaid Reimbursement Panel, it would help if new initiatives had specific directives—something measurable that can be tracked—rather than just throwing money at a nursing home and letting them spend it any way they wish.

Dr. Calkin stated that it issued to be that nursing homes had to use Medicare funds to supplement the cost of their Medicaid residents. With the changes in the Medicare reimbursement, that has meant that there is a greater national attention on Medicaid rates.

Ms. Shotwell stated that Medicare did cover the deficiencies in the Medicaid rates but now Medicare should pick up its own slack and we need to improve Medicaid separately.

Mr. John Ransom described the how financial institutions decide to finance or not finance nursing homes and assisted living facilities.

- Referred members to his September 5, 2000 testimony at the Grassley Commission (mailed to Task Force members prior to the meeting).
- Raymond James Financial covers about 60 health care companies; 2 are nursing homes.
- Bankruptcies are due to a combination of Medicare cutting more than they meant to and some public companies over leveraging their balance sheet.

- Need to distinguish between purchase and pooling accounts. Deals were done using a leveraged-buy out type of transactions and swapping debt for equity. Without increasing infrastructure, the industry leveraged \$7 billion in mid 1990s on existing assets.
- With Medicare rates increasing 20% a year, it looked pretty good.
- Sellers were asking for cash and not stock in the industry.
- There are four public companies going bankrupt. The financing/banking industry (the landlords) are in a fight over who is going to lose the least. Vencor was the first and has the most complicated capital structure.
- Next 12 months: industry will emerge from bankruptcy with less debt—perhaps 40-60% less. It will be a skinnier capital structure. The banks and the rates are going to have to eat the losses. The shareholders of nursing home companies, the lenders, and the shareholders of lenders have taken a hit. This affects public stock ownership and banks beefing up their reserves. The end result will be a better financial backdrop than before PPS.
- Companies like Sun Health and HIS and Manorcare will need to shed assets to get their debt down to an even level so they can compete effectively.
- Need to move towards stability in the industry. Medicare spending is not going to grow 20% a year again. We could create community-based nursing home operators. Some increases in Medicare/Medicaid/PPS will probably happen. Need a simpler and more transparent system that will attract capital back.
- Investors and lenders will be scared away from this industry for at least 12-18 months.
- Need some tort reform because of the explosion of litigation costs.
- There will be a definite increase and demand for nursing home beds over next 5-10 years. We aren't building any new hospital beds or assisted living beds because of capital shortage. There is a rising demand and shrinking supply. Public operators are stampeding out of the state and would sell their assets if they could because of the liability costs.
- If the government does not address the reimbursement and liability issues, the government will have to put more money in to the industry to rebuild the infrastructure.
- If we fix the system, attract private capital back in the next 12-18 months and rebuild some capacity, then we can stave off problems in 5 years when there could be a nursing home shortage.
- The industry is in an iron triangle where there's no margin available to make interest payments to repay investors down the road.

Mr. Rodriguez stated that if we restructure the debt service of the existing beds available now based on the growing need, we might be painting ourselves into a corner unless there is a new program such as funding vouchers on the client side or development of facilities on the industry side. Need to also address affordable housing through tax credits. HUD approved the use of vouchers to pay for assisted living facilities, for example.

Mr. Ransom stated that anything the government can do to encourage capacity and the view that there won't be extreme periods where providers make too much money and then we take it back ("beat the heck out of them") will be good for the public interest. In addition, Florida has had a restrictive CON process on the nursing home side. There isn't a development program where providers could reliably get a signed CON. In addition to tax credit for assisted living, we need the CON process to be improved.

Ms. Fierro stated that in Mr. Ransom's recommendations to the Grassley commission did not address improving quality of care which directly affects the liability issues and nothing about the pervasive fraud in the industry and the amount of charges that these corporations have been assessed because of fraud.

Mr. Ransom stated that he didn't know how you can have as many nursing homes and patient days as there are without having some problems in terms of quality. With 4% unemployment, they are having trouble getting good workers, especially at the LPN level. He agreed that you need oversight and accountability but with overleveraged facilities with no margin, it isn't surprising that there will be quality issues. He agreed that there was fraud in the industry. He never agreed with a cost based reimbursement system and no accountability. Hospitals have used DRGs successfully for years. The 20% annual increases were just too tempting to nursing homes. Instead, have a Prospective Payment System whose rate of increase grows at the rate of inflation plus the rate of demand growth and provides enough profit margin to invest in the industry. The current payment system is cut too finely and is too complicated to administer. Managed care systems have 4-6 levels of acuity for reimbursement. The government doesn't need 100s of pages of paperwork which cuts into the industry's profit margin.

Ms. Fierro stated that quality is a key issue to the Task Force as well as affordability of care. While the industry was growing at 20% before the BBA was enacted in 1997, the increased revenues were not going to wage increases and increasing staffing.

Mr. Ransom asked if quality can be legislated any more than it can be legislated in the classroom. Given 4% unemployment, hard to recruit staff especially at the LPN level, and the labor pool and the number of patient days, he isn't surprised that there is a problem with quality/accountability. He agreed there was fraud but does not agree with cost-based reimbursement with no accountability. Hospitals use the DRG process. You could use PPS if the rate of increase includes both inflation and demand. This isn't a hospital type system with 4-6 levels of acuity for reimbursement. If spending on nursing homes increases 5% but staffing requirements increases costs 10%, then it isn't possible to get out of the box of capacity and capital.

Rep. Argenziano stated that given Mr. Ransom's description, why would a financial investor want to invest in nursing homes with not getting good quality people to work which lowers the quality of care, upping the litigation that affect health care costs. Why not invest in non-profits?

Mr. Ransom agreed that investors would not invest given this scenario. They would rather invest in hotels which can charge their own rates, the burden of care is much lower, and you can build new hotels without regulators artificially restricting your supply. He would put his health care investment dollar in the hospital industry and not nursing homes because hospitals have doubled their operating margin and Congress is giving them even more money.

The Chairman summarized the presentation saying that the forecast will continue unless the state, within their capacity to do so, addresses very important issues that when addressed positively may impact the investment capabilities of the industry in the future. In addition, quality and/or accountability is critical to give investors confidence. And liability is having an impact on investment. There is also the alternative care issue and reimbursement.

Mr. Ransom stated that assisted living is a great product but it's at the far end of being unregulated. It is going through a classic Real Estate cycle where it is overbuilt and overleveraged and there will be some short-term dislocation. Longer term, the demand will continue and so will the supply. It is better than the old intermediate care: less costly and more homelike.

In terms of nursing homes, there is a window of opportunity: there is the best budget cycle in 20 years; the facilities are going to emerge from bankruptcy with less debt than three years ago; they will have more operating flexibility; and service burdens are going to be less. He would play poker and let the bankruptcy process flush out and see what kind of capital structures are available. But revenues have to grow at least as fast as expenses. If the state gives 3% increases but expects greater accountability in terms of quality of care which translates to 8-9% increased expenses, nursing homes will be back where they started. What needs to happen is:

- Cap growth of expenses and the best way is through tort reform (liability expenses have grown 5-7 times faster than revenues).
- Interest costs need to decline and will because of bankruptcy process.
- Labor costs are a function of the economic cycle and labor market but Medicare and Medicaid rates need to grow at least 4-5% to keep up with labor costs.
- Make nursing homes easier to manage by making regulations transparent: we don't need 56 levels of DRGs; we don't need facilities so focused on filling out paperwork for the state that they aren't focused on quality of care.

The answer to the quality of care problem is more free enterprise.

Mr. Connor referred to Raymond James Financial's report "Sunshine Burns Long-Term Care Providers" that it stated that you do not guarantee the report is accurate or complete and asked if that applied to the testimony today.

Mr. Ransom stated that every comment put out to investors on any industry has the same disclaimer.

Mr. Connor stated that Mr. Ransom's boss, Tom James, is a member of the governing body of Arbor Health Care.

Mr. Ransom said that Tom's on the board as a friend of Pierre Bourse; he doesn't think that Tom is responsible for quality of care at Arbor Health Care.

Dr. Calkin stated that since she has direct knowledge of Arbor, she knows that Mr. James doesn't have anything to do with it now. Sold out two years ago in 1998.

Mr. Dan Sumner, Department of Insurance, presented on a series of surveys conducted by the DOI with regard to long-term care liability insurance.

- Surveyed all 515 insurers who write commercial multi-peril or other liability insurance in the state.
- Followed up with a refining survey to 79 companies to ask focused questions with regard to long-term care liability: 56 were admitted and 23 were surplus lines. Insurers were included if they wrote 1 or more policies in the past year.

- Admitted insurance companies are licensed by the state of Florida DOI and is subject to the solvency rate and fund requirements of the state. Surplus lines insurers are an alternative market, established by law, that if the insured cannot find insurance through a licensed (admitted) company, they are entitled to obtain coverage through a surplus lines carrier—they do not operate in a regulated environment and there is no rate approval or fund coverage. Example of surplus lines is Lloyd's of London.
- Results are not necessarily scientific but provide a mosaic of the LTC insurance market.

	#Companies		Policies		Beds	
	Admitted	Surplus	Admitted	Surplus	Admitted	Surplus
NH						
1998	24	9	72.2%	27.8%	58.2%	41.8%
1999	24	9	54.0%	46.0%	31.9%	68.1%
2000	11	9	53.4%	46.6%	31.5%	68.5%
ALF						
1998	16	8	35.0%	64.5%	68.5%	31.5%
1999	16	8	38.0%	62.0%	45.2%	54.8%
2000	8	7	32.0%	68.0%	77.6%	22.4%

Withdrawing from market: NH: 8 admitted; 6 surplus; ALF: 4 admitted; 4 surplus.

- For nursing homes, from 1998, admitted companies dropped from 24 to 11; admitted policies dropped from 72% to 53%; and admitted beds dropped from 58% to 32%. The admitted market policies for nursing home beds is stable but the number of companies is reduced from 24 to 11. Concern that the drop may mean that facilities are going bare (no insurance) or other type of coverage outside of the admitted market.
- For assisted living facilities, from 1998, admitted companies dropped from 16 to 8; admitted policies remained stable but are just one-third of the market (surplus ranged from 65% to 68% of the market in the same time period); but the admitted market covered 68.5% of the beds in 1998, 45% in 1999, and 78% in 2000. Concern that although the percentage is high, it may represent a smaller actual number of policies and beds which are now going outside the market.
- Closed claim data (1998 data omitted in minutes for brevity):

NH	Payments	Claims	Total Indemnity Pd	ALEA Pd ¹
1999	0	264	0	979,073
	\$1-\$250K	162	6,774,728	1,764,420
	>\$250K	61	29,341,573	1,902,086
1997	0	199	0	111,793
	\$1-\$250K	161	7,769,264	1,723,595
	>\$250K	36	16,991,001	1,664,069
ALF	Payments	Claims	Total Indemnity Pd	ALEA Pd ¹
1999	0	62	0	133,562
	\$1-\$250K	26	1,581,319	183,786
	>\$250K	4	1,200,000	259,840
1997	0	6	0	680
	\$1-\$250K	24	763,034	114,474
	>\$250K	2	1,150,000	83,667

¹Allocated Loss Adjustment Expenses (the cost of closing a claim)

- In 1999, there were 264 nursing home closed claims with an indemnity of \$0; there were 199 in 1997. But the cost of closing these claims (ALAE) went from \$111,793 to \$979,073.

- For assisted living facilities, there were 62 claims with \$0 indemnity paid up from 6 in 1997 but the increase in ALAE went from \$680 to \$133,562.
- These \$0 indemnity cases are the first ones closed, where there is 0 liability. The mid-range cases (<\$250,000) and larger cases (>\$250,000) are part of the tail of unresolved cases.
- There has been a significant adjustment in resolving the \$0 indemnity claims. These are the beginning of the wave. The situation will deteriorate when the medium and large claims (which take longer to resolve) mature.

Summary for nursing homes:

- Claims closed with no indemnity payout in 1999 were 132% of the 1997 level; ALAE for these claims was 875% of the 1997 amount.
- Claims closed in the \$1-\$250,000 amount had an increase of 1 claim from 1997 to 1999 and indemnity paid was down 12% from 1997 and ALAE was up 2% in from 1997 to 1999. For claims closed there is a certain amount of stability but it may be that the calamity hasn't hit yet.
- Claims closed in the above \$250,000 for 1999 were 169% of the 1997 level; indemnity payments were 172% more and ALAE is 114% of the 1997 levels. Here there is a significant increase but the trend isn't dramatic at this time.

Summary for assisted living facilities:

- Claims closed with no indemnity payout for 1999 were 1033% of the 1997 level. ALAE for these claims were 19,641% of the 1997 level.
- Claims closed in the \$1 to \$250,000 had an increase of 2 in 1999 compared to 1997; indemnity paid in 1999 was 207% of 1997 level; ALAE was 160% of the 1997 level.
- Claims closed in the above \$250,000 had an increase of 2 in 1999 compared to 1997; indemnity payments of these claims was up 4%; ALAE was 310% of the 1997 level.

Conclusions:

- Facilities may be going outside the Florida insurance market for coverage.
- There is further deterioration in the Liability insurance market place but it has not bottomed out.

The Chairman asked if this means that there is not an explosion of claims but an increase in the amount that is paid out relative to the claims that exist.

Mr. Sumner said that the \$0 indemnity cases are where the claimant gets \$0 indemnity but it costs to defend and adjust the claim. These are closed first but are the beginning of the wave and there is an enormous increase in the cost of adjusting those claims.

The Chairman asked if this was related to a quality of care issue and being opened up to excess liability or is it over litigation.

Mr. Sumner stated that the survey does not reflect quality of care or litigation which is outside the domain of DOI. It reflects a deterioration in the losses and the cost to adjusting claims. When you look at loss ratios, costs will be impacted by quality of care and the tolerance of the public for a level of quality of care. If the quality drops, you will have claims. Loss prevention is the doctrine of the insurance world: by managing the risk, you can operate in such a way that a claim never occurs.

Dr. Calkin asked about the denominator for the first set of comparisons: e.g. if there were 100 companies insured at Time A and 50 at Time B, then the denominator changes. What is the N in each year? And why does it matter if it is admitted or surplus?

Mr. Sumner stated that the distribution is between admitted and surplus (for policies written or for beds): i.e., the denominator is admitted + surplus and the numerator is admitted or surplus. The percentage of policies or beds covered in the admitted or surplus lines is an indication of the health of the market. To have a surplus line policy means that the insurance agent asked at least 3 admitted insurers who declined, providing a sworn declaration that you cannot obtain coverage in the admitted market.

Mr. Liptak clarified that knowing the number of policies written each year (not just the percentage) would explain the conclusion that companies are moving out of the insurance market and self-insuring.

Mr. Sumner referred to the letter provided to Lt. Governor Brogan from Suzanne Murphy with the gross numbers for both NH and ALF.

Rep. Argenziano asked if these fluctuations were a part of periodic changes in the market?

Mr. Sumner said that in worker's compensation, there was the liability crisis of 1986. The market deteriorated then and there was a gain in the surplus lines and people going bare. These are indications of market disruption.

Mr. Freidin asked if the claims in the tables represent all claims paid out in one year: did every insurance company provide their data?

Mr. Sumner stated that this was a survey of first 500 and the 79 companies that were most likely to be involved in nursing home and ALF liability insurance. The numbers are not scientifically validated but they do represent insurers all over Florida, in both admitted and surplus lines, who we believe are doing business in long-term care liability market. There is no margin of error calculated. The response is usually pretty good because companies are examined onsite against their responses.

Mr. Freidin asked if the 497 claims in 1999 [against nursing homes] represent close to the total of actual claims closed that year?

Mr. Sumner said he believed this was representative of the overall trend.

Mr. Sherberg asked how current is the 2000 information about policies.

Mr. Sumner said that they are current through mid-Summer.

Mr. Liptak said that is important to distinguish between reported and resolved claims; these are resolved numbers. They could be significantly higher. This task force should see not only the closed claims but also the pending claims reported by year—to know if actual litigation cases are increasing year by year.

Mr. Sumner agreed that if the Task Force could get access to claims that are not closed, it would impact these numbers. Getting non-closed claim from insurers is difficult because these are still at the lawyer's office. They are being adjudicated.

Mr. Grofic stated that admitted companies report this data on an annual basis in their financial reports.

Mr. Sumner said that it would included under the commercial peril or other liability packages [and so not distinguishable from non-nursing home business].

Mr. Randy Miller, from the Associated Industries of Florida, addressed the issue of the Florida's business climate for nursing homes.

- In tight labor markets, employers seek every advantage in attracting and retaining employees which is why they're absorbing higher health care costs.
- Employers want to add long-term care insurance to their benefits.
- They need to know that there will be a viable nursing home industry in Florida if the current problems aren't cured: inadequate government reimbursement and wasteful litigation.
- Quality of care is directly related to inadequate staffing and wages; personnel costs are nursing homes' single biggest cost.
- Medicare and Medicaid fees cannot be adjusted so personnel costs are cut, quality decreases, and litigation increases.
- Staffing nursing homes with higher numbers of competent employees will improve the standard of care.
- Increasing the reimbursement and redirecting the money away from litigation and back to caregiving will also improve care.
- We must protect residents who are harmed by negligence (intentional or unintentional) by eliminating the burden of wasteful lawsuits because it will direct more money to their care.
- The result will be an improved prospect for long-term care insurance—a product that transfers the cost of care more to individuals (and away from government).

Mr. Steve Rachin described the Long-Term Care Ombudsman Program, complaints about long-term care, and suggestions for improving care.

- Ombudsmen are advocates for long-term care residents: educate the public and facility staff on LTC issues; promote resident councils; mediate between residents and staff; advocate for policy change; and investigate complaints and conduct annual inspections.

Florida has 14 local ombudsmen councils with 15-30 ombudsmen per council who are members of the local community and include: consumer advocates, social workers, nurse dietitians, pharmacists, attorneys, and physicians. They are all volunteers (in Florida) and there is one paid staff coordinator per council.

- In last few years, complaints have been ranked (1998-99):
 1. staff shortage (n=500)
 2. gross neglect (n=300+)
 3. dignity and respect issues (n=300+)
 4. medication (n=300+)
 5. personal hygiene issues (n=300+)
- Complaints from 1989-1999 have ranged from 3946 to 7580 (in 1998) for nursing homes and 1879 to 2491 (1998) for assisted living facilities and adult family care homes.

- These trends mirror U.S. trends. The GAO report on quality of care cites that ombudsman complaints have increased significantly in last decade. This may be due to higher visibility of ombudsmen.
- Sources of complaints are:
 - Friends and family (approx. 50%)
 - Residents (approx. 12%)
 - Facility staff (approx. 12%)
 - Anonymous (approx. 12%)
 - Other (ombudsman, medical staff, agency staff, etc.; approx. 12%)
- Recent accomplishments in Florida to improve quality of care:
 - Gold Seal Panel (improvement over earlier nursing home rating system)
 - Quality monitors to make sure that problems to not get worse in the future.
 - \$32 million allocated to staff retention
- Additional areas to improve quality of care should be:
 - Even more on staffing (especially given HCFA's recent report): additional funds for staff retention and training.
 - Offer community-based care options
 - Provide more resources to ombudsman program (as suggested in GAO report)
- Ways the Ombudsman program has improved access to ombudsmen:
 - Toll-free phone number in 1999
 - New website: www.myflorida.com/ombudsman
 - Educational materials created and disseminated for first time in 20 year history (with new funding).

The Chairman asked if the anonymous complaints are found to have merit?

Mr. Rachin stated that 40% to 45% of [all?] complaints were substantiated in the last year. Often we mediate to resolve the issue rather than substantiate the complaint.

The Chairman stated that in other arenas, number of complaints need to be put into context and to know if they are grounded in fact.

Mr. Sherberg stated that ombudsman is a Swedish term that means "one who resolves complaints or speaks for another." With the financial problems of the ombudsman program, if it went back to its original mission of resolving complaints and mediating rather than investigating and administrative inspections, there would be adequate funding.

In addition, there is redundancy between Adult Protective Services, AHCA, the Ombudsman Program, and the Human Rights Advocacy Council. How do these agencies intertwine in regard to complaints?

Mr. Rachin stated that the Ombudsman program is the one group that has resident advocacy as its mission. The others have a multitude of responsibilities. Ombudsman program is not a regulatory authority they do advocacy and primarily in a non-adversarial role.

The Chairman asked if the Ombudsman program is responsible for reporting complaints to other agencies?

Mr. Rachin stated that the first intention is to resolve the complaint by working with the facilities. If it cannot be resolved, then they refer it to AHCA or APS. Resolved complaints are not reported to AHCA or APS.

Rep. Argenziano stated that over the 20 year history, the State has not taken better advantage of the Ombudsman Program. Families, workers, and administrators are pleased that complaints can be resolved without going to the regulators. As Chairman of Elder Affairs, I'm going to continue to strengthen the Ombudsman program. She also asked if the program should remain independent of regulators.

Mr. Rachin said that he completely agreed.

Rep. Argenziano asked about legislative issues:

- Travel pay.
- Expanding ombudsman program to home health care.
- Will increases in nursing home staff improve the other areas of complaints (gross neglect, dignity, medication errors) and reduce litigation?
- Are some of the complaints (inadequate care) related to normal aspects of aging, illness, and dying?
- Should any of the legal cases and large sums awarded never have happened, in your opinion?

Mr. Rachin stated that improved staffing would help in all areas and could help the litigation issue. For example, one visit with the Representative at a nursing home where there was a complaint, a month later, it was resolved and prevented litigation.

Dr. Dwyer asked if there was variability among the 14 councils in their effectiveness and what are the characteristics of the best councils so we know where additional money would make a difference. Are you aware of any data linking complaints to ombudsman program and the likelihood of litigation?

Mr. Rachin stated that all ombudsmen are dedicated but some need training. The educational materials need to be in every council, and the toll-free number is important. The GAO report has national data on ombudsman complaints but we do not have good empirical data linking complaints to litigation.

Shawn Phelps, Agency for Health Care Administration addressed nursing home quality.

- Severity Index is one measure AHCA uses to measure quality and was used when the decision to cancel Medicaid contracts with 6 nursing homes was made.
- Any facility that is certified to accept Medicare or Medicaid payments, is required to have an annual survey by AHCA. Complaints will also instigate a survey. The survey is a record of deficiencies in the nursing home that are known as "F-Tags." The F-Tags are entered into a Federal database called OSCAR.
- In the recent decision regarding 6 nursing homes, AHCA looked at a 24-month history of deficiencies.
- Deficiencies are measured in terms of scope and severity. Scope is how wide-spread is the problem and Severity is the potential for harm or actual harm to residents.

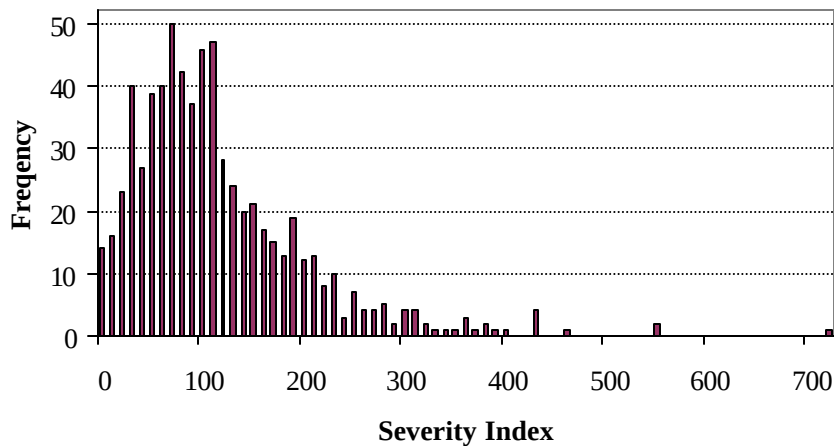
- Points are assigned depending on the scope and severity:
- The scale goes from 0-60 points. Certain deficiencies are considered critical and so their points are doubled: failure to prevent or treat pressure ulcers correctly; failure to maintain resident's nutritional status; giving a resident unnecessary drugs.
- An sample history shows how the severity index is computed.
- In the example, F-221 is physical restraints (double weight); F-314 is pressure ulcers (double weight); F-353 is insufficient staffing (normal weight). Total points are divided by the number of annual surveys for an average score.
- The average 24-month severity index score is 95; there is handful of nursing homes that have very poor scores over a two year period.
- Florida has a higher average F-Tag total on the annual survey (unweighted: 7.3) when compared to the US (5.6) and Southeast (6.1) in 1999 but is the same as the other regions in 2000 (6.1).
- From 1997 to 2000, Florida's Annual + Complaint tags (unweighted) averaged 8.6 in 1997; 11.9 in 1998; 10.8 in 1999; and 9.8 in 2000. 1998 included several nursing homes that were classified as "immediate jeopardy" which is severe risk to resident's health or possible risk of death. Many of these have closed and were not part of the 1999 and 2000 statistics.
- In addition, there have been more visits by AHCA regulators with the new administration since 1998, for each complaint rather than bundling them together as had been done in the past. There have also been more financial monitoring visits of nursing homes suffering from financial distress. And there have been quality monitor visits more often because of a 1999 bill passed by the legislature.
- Comparing for profits to not for profits, FP have a 40% higher severity score than NFP but FP also had a greater number of Medicaid residents and a lot of facilities in bankruptcy.
- In multivariate analysis to look at what predicts change in the severity increase, the following variables increased the severity (worse quality of care):
 - Number of Medicaid residents
 - Number of unoccupied beds
 - In bankruptcy or affiliated with bankrupt chain (for profits only)
 - For profit status (weak relationship)
 - Acceptance of Medicare (for profits only; weak relationship)
- The following variables decreased severity (better quality of care):
 - Number of private pay residents (for profits only)
 - Number of Medicare residents (for profits only)
 - Religious affiliation (weak relationship)
- Controlling for all these variables, for profits have higher severity scores than not for profits but the effect is reduced in half and is not statistically significant. For profit status and religious affiliation have the same effect size but FP increases severity and religious affiliation decreases it but both of these variables are weakly significant.
- The six nursing homes that had their contracts terminated had 12% more Medicaid residents than the state average and had an occupancy rate that was 22% less than the state average.
- The next step is to publish a nursing home guide that will use the same type of scoring mechanism that is used in the deficiencies used in surveys and rating the facilities from 1-5 stars depending on the severity index scores.

Severity				
Immediate Jeopardy to Resident Health or Safety	J=32	K=45	L=60	
Actual Harm that is not Immediate Jeopardy	G=16	H=22	I=28	
No Actual Harm with Potential for more than Minimal Harm	D=5	E=8	F=11	
No Actual Harm with Potential for Minimal Harm	A=0	B=1	C=3	
	Isolated	Pattern	Widespread	Scope

Points are doubled for the federal Health Care Financing Administration's Critical Deficiencies.

Survey Type	Survey Date	Tag	Severity & Scope	Points
Annual	Sep-10-98	F 221	D	10
		F 279	B	1
		F 314	G	32
Annual	Aug-8-99	---		0
Complaint	Dec-4-99	F 353	C	3
Annual	Jul-23-00	F 371	E	8
Sum				54
Number of Annual Surveys				÷ 3
				<u>18</u>

Severity Index



The Chairman stated that any accountability and reporting system will have problems but it is critically important that one exist. He asked what percentage of the 684 nursing homes in Florida accept Medicaid and whether or not Florida has the ability to sever contracts without cause.

Mr. Phelps stated that 11 do not accept Medicare nor Medicaid; 23 don't accept Medicare; and the remainder accept Medicaid.

Mr. Sharpe stated that the ability to sever a contract has been true for 3 years and the Federal government only said there was a problem with that cause a week ago (when the State severed the 6 contracts).

The Chairman stated that after attempting to sever the 6 contracts, they were taken to court promptly and HCFA issued an opinion that they had trouble with Florida enforcing the severability without cause aspect of their Medicaid contract. He asked for an update on the facilities and how many other states have such a clause in their contracts.

Mr. Sharpe reported that 6 facilities were noticed for termination; two have virtually emptied their facilities; three have reached a settlement with the State (Vencor) after going to court to challenge the termination. They developed a quality improvement agreement with Vencor for all of their facilities in Florida. They are completing a baseline assessment of their residents and developing a corrective action plan. The last facility is negotiating an agreement and the termination date was moved from 11/2 to 12/2. At least three other states have the 30-day without cause clause in their provider agreements (TX, NJ, FL).

Mr. Connor commended the administration for decertifying the 6 facilities and stated that it will be the most effective way to enhance quality of care. Few individuals have the buying power to influence quality of care but when the State votes with its dollars, it will have a profound effect.

The Chairman stated that the state has an overarching responsibility to first and foremost help to see after the long-term quality of care provided by the industry to our most fragile and vulnerable citizens. Florida is on the road to developing a first class system of accountability on this issue along with reporting to senior citizens. People will question the data but at the end of the day, somebody has to oversee the expenditure of dollars and that residents are receiving quality care. If we don't, we are providing tenure to the nursing home industry.

Dr. Calkin stated that the FHCA supported the decision to sever the contracts and the facilities that were affected had notice from AHCA.

Rep. Argenziano stated that the Federal government should not be telling the State what to do with its dollars or how to protect its residents. She asked for clarification about the private pay and for profit facilities having less violations. And what was the correlation with staffing?

Mr. Phelps explained that for profits that accept just private pay residents had better scores. There isn't data on staffing for private pay facilities; they aren't required to report staffing to AHCA.

Ms. Fierro asked if F-353 (insufficient staffing) one of the variables that is doubled in the severity index. (Phelps: no). If not, it should be considered by AHCA. In terms of the nursing home guide, it would be useful to have information about insurance included. Finally, a list of all civil money penalties against facilities, the amounts of collections for the last few years was requested.

The Chairman asked if the model that is being developed to evaluate nursing homes is taking into account the perspectives of the nursing home industry, insurance industry, and attorneys so that when it is finalized, all parties will feel they had a hand in it and generally support it.

Mr. Phelps stated that informal meetings on the scoring model have been held and open to anybody since 1998. The guide was developed through focus group discussions.

Dr. Bruce Robinson spoke about quality improvement in long-term care: the Medical Director's perspective.

- Much of what is done to improve quality in Florida subscribes to the theory of bad apples (Berwick) which states that quality problems are caused by people or organizations that are lazy, incompetent, and recklessness.
- Quality improvement under this theory is through inspections, deficiencies, making workers prove they are acceptable, deterrence through litigation, punish poor performers.
- Result has been negative in industry (they search for escape rather than understanding; need to prove they aren't deficient/blaming others rather than admitting problems and working on solutions) and is not supported by recent advances in understanding causes of and solutions to quality problems.
- Continuous Quality Improvement (CQI) recognizes:
 - Fear poisons opportunity for improvement
 - Focus on the average product, not the mistakes
 - Focus on learning for staff, family, and residents and not defensiveness
 - Defects in quality are rarely attributable to lack of will, skill, or intentions of staff: every defect is a treasure
 - To progress, need to accept that quality problems are built into complicated processes
- No home has been able to stop all pressure sores, prevent all fractures, stop every unintended weight loss. Need to understand it in terms of numerators (the number of incidents) and denominators (total residents).
- The pressure to avoid incidents or deficiencies makes all facilities feel like bad apples.
- Priority for improvement is dictated by survey and not by the opportunity to improve. For example, over 100 hours of training went into teaching staff to estimate the percentage of food eaten on the plate but it is irrelevant to improving quality in the institution.
- Litigation is consuming stretched resources. The biggest problem is finding good people to work: from doctors (who aren't willing to put their license on the line); DON; Administrators; etc.: because of the stress around every incident that occurs and is assumed to have the worst possible explanation.
- Value to the consumer (quality/cost) is falling due to:
 - Inefficiency that comes from mistrust and fear
 - Increase outlays for insurance
 - Misdirected energy of staff into excessive documentation to prove you aren't deficient.

- Hope for the future is that regulatory agencies and industry support honest quality improvement efforts that will replace what we currently do and the result will be efficiency and value given limited resources for long-term care.
 - Choose critical outcomes (not every outcome) and measure them fairly in all facilities.
 - Change the focus of surveys from incidents to process and achievements measured using numerators and denominators (every pressure sore is measured in terms of total patient days).
 - Need a well thought out way to judge quality in a building
 - Learn from other industries
 - Work with the public to promote an understanding of the difficulty of achieving affordable and compassionate care: not seeing every death as a deficiency.
 - Need to look for more effective, systematic ways of building quality into long-term care facilities: if you do what you've always done, you'll get what you always got.

Rep. Argenziano stated that early in the presentation Dr. Robinson noted it was not lack of skill or will that caused problems but later, he said (as did Mr. Ransom) that it was a lack of quality workers and that lack of skill can cause inefficiency, in addition to lack of pay for a high stress job. The quality monitors are one way that we are doing things differently than we always have. She stated that staff do not go to work thinking how many people will they hurt today or the attorneys aren't thinking how many nursing homes can we get. It is truly an issue of quality of care and the lack of skilled workers is causing some of the problems.

Dr. Robinson agreed that you can build a skilled work group but to keep them is challenging in the current environment. Some of the stress comes from the exact processes we set up to make it better: the survey processes, the deficiencies, fault finding. It can lead to unhappy employees who move on.

Rep. Argenziano asked about doctors participating more in nursing homes and helping RNs and LPNs.

Dr. Robinson said that good medical care is essential to good long-term care. But if he had to advise how to spend limited resources, and the choice was 1 hour of an MD vs. 8 or 16 hours of a CAN, he would put money on the CAN.

Mr. Sherberg asked how facilities can ask for help with a problem without fearing retribution.

Dr. Robinson stated that there needs to be more acceptance of honest concerns expressed by a facility.

Dr. Calkin asked about the difference between acute care and long-term care survey process (for patients on Medicaid and Medicare).

Dr. Robinson stated that the hospitals use a CQI process and the surveys focus on that process and movement towards better care rather than measuring deficient care.

Ms. Chmielewski asked if the Medical Directors' Association to train physicians who come to long-term care on how to work within the scope of regulations and to understand the stress of

the staff and to provide education and assistance to them (rather than fight them). Also, does the reimbursement issue for Medicaid patients and the tie to liability a problem.

Dr. Robinson said that the MDA does work hard within its membership but there is the problem that very few doctors identify with long-term care. Medicaid reimbursement is terrible (although overall reimbursement in long-term care is okay) so a doctor with a lot of Medicaid patients cannot survive.

Lauchlin Tench Waldoch, Elder Law Attorney, described what elder law attorneys do and the importance of Chapter 400 resident rights.

- Elder law attorneys serve the whole continuum of care from the first moment a family member needs assistance.
- They help clients to navigate and negotiate a fragmented process; really part of family care—treating the whole family—and providing more than just legal advice. It is unfortunate that elders and families need to turn to an elder law attorney or geriatric care manager to negotiate a system that is supposed to be designed to help them.
- The National Academy of Elder Law Attorneys and the Academy of Florida Elder Law Attorneys that are ready and willing to help the Task Force.
- Eligibility is one of the ways that access to affordable long-term care is denied:
 - The income cap to qualify for Medicaid institutional care program (ICP) is \$1536/month. If income is even 20 cents more, the individual has to file a Qualified Income Trust (QIT) for the amount over the income cap. Her entire income is paid to the nursing home, the QIT just inserts an attorney into the process and makes Medicaid think that it is serving only those who are under the cap.
 - For those in the same situation who are already in a facility and do not know about QITs but just miss the income cap and asset test (<\$2000 in bank), but can't qualify for Medicaid and so the facility cannot get Medicaid reimbursement for them.
 - Level of care should not restrict access to care: clients can qualify for nursing home care but not to get the extra \$200/month they need to stay at home.
- Quality of care means resident rights as outlined in state statutes and federal law. These rights should be what we gauge quality by. They are more than the medical issues and horrendous things that do happen. They are the basic rights: to have your mail unopened, take a bath in privacy, keep your door closed.
- Resident rights are only as good as the means available to enforce them.
- Quality is a table with four legs: licensing, regulation, ombudsman, and judicially based civil remedy. If the civil remedy is removed, the panoply of rights of rights will suffer and quality of care will suffer.
- Staffing is key to resident rights: they need to be trained to know the rights and paid to provide them.
- Medicaid reimbursement rate is unreasonable. Facilities turn away Medicaid eligible applicants in favor of private pay. Facilities with the highest number of Medicaid patients have the lowest staffing levels and lower standard of care.

The Chairman asked if Ms. Waldoch was advocating the total elimination of income caps.

Ms. Waldoch stated that she is advocating for the elimination of income caps; under today's rules, someone with \$10,000/month in income can qualify for Medicaid with a QIT.

Mr. Sherberg asked about the GAO report on assisted living facilities that said ALF contracts should include when somebody needs to move out, what the ALF can handle, etc. To be complete, it could mean a 15-page contract (such as developed by the National Association).

Ms. Waldoch stated that she isn't representing an association but she would advocate having everything in writing and yet residents will not understand what is in the contract so anything that can simplify but accurately describe the services would be good.

Mr. Rodriguez asked what is the most common violation of resident rights in her practice.

Ms. Waldoch said it was to be treated with dignity and respect. They also have the right to a telephone but it is kept behind the nurse's station; they aren't allowed to close the door to use the bathroom because of safety concerns. In large part this can be tied to staffing deficiency.

Ms. Chmielewski asked for clarification regarding nursing homes turning away Medicaid patients. Her experience has been that private pay residents are rare and most of the time staff are helping people to apply for Medicaid. In addition, AHCA (during survey) asks where is the residents' phone and buildings get cited if it is not available. Most buildings go out of their way to provide private areas because they will be cited.

Ms. Waldoch stated that she was basing her statements on observation of one facility that didn't have all the resources they needed and perceptions from her clients. Also, she hears all the time that someone can enter a facility as private pay but not as Medicaid even though there are federal and state laws that forbids discrimination by payor source.

Rep. Argenziano stated that she found about 50% of nursing homes she visited who had a private or portable phone for residents.

Mr. Liptak asked if resident rights should be included for in-home care as well.

Ms. Waldoch stated that the regulation of resident rights begins with the constitution. In-home care needs to be regulated in some manner. In your own home, you have a significant battery of rights that can be enforced. It should be different for a communal setting than one's own home.

Mr. Lance Block, President, Academy of Florida Trial Lawyers, spoke about the right to cause of action.

- Urge the Task Force not to disturb the resident's bill of rights in any way.
- Need to recall Resident Rights history (referring to Grand Jury reports in mid-70s in Dade County):
 - o An elderly woman who could not pay her \$200 donation was moved to the "snake pit ward" where patients wander about nude and filthy and inadequately supervised and later moved to another home without notifying her family.
 - o In 1979, a daughter described her mother being tied to her chair with the smell of urine. Another woman had open sores on her legs and arms.
 - o Others noted flies, uncovered garbage cans, mouse trailings and rodents present.
 - o The report stated that physical restraints of residents and use of psychotropic drugs were common practices for the convenience of staff.

- It concluded that quality of care was essential: clean and safe; physicians are available; Nurses are skilled and caring; staff trained and competent; are tranquilizers and restraints prescribed excessively.
- As a result, it enacted the patient bill of rights in 1976. In 1980, the legislature enacted a civil cause of action to ensure that residents could enforce those rights. Legislature determined that residents are one of the two most vulnerable classes of citizens in our state (the other being the mentally retarded/developmentally disabled). The good will of the nursing home industry alone and government regulation are not enough to protect seniors who reside in nursing homes.
- It has worked for 25 years.
- It is no surprise that the cutbacks in Medicaid and Medicare have brought hospitals and nursing homes to their knees and there has been a deterioration of quality of care. There is a nationwide crisis of care which has led the insurance industry to recognize that there is too much risk to insure facilities.
- In the 1998 session, industry lobbyists for a last minute amendment to cap attorney's fees at \$50,000. The purpose of attorneys fees provision which was added in the early 80s was to encourage lawyers to look at nursing home cases.
- As a result of the 1999 tort reform act, there is a cap on punitive damages of three times the compensatory damage cap. So a \$20 million dollar verdict for a woman who was left to die as a result of dehydration, lack of food, bed sores, would be reduced to \$500,000 for compensatory and \$1.5 million for punitive.
- There were also efforts to require mandatory mediation within 120 days of filing a complaint. If the nursing home makes an offer but it is rejected by the resident who ultimately wins in a jury trial but the judgment does not exceed the original offer, plaintiff attorney fees are not paid.
- There is a group of nursing home litigation lawyers who have started a panel and have been meeting for several months and are willing to assist this Task Force. They are working on ways to streamline litigation and tying it to quality of care.
- In 1999, we took away the rights of citizens by enacting the tort reform act. We were told it would attract more business to the state; that products would be cheaper; and that insurance would be less expensive. And two years later, no businesses have relocated to this state, products are not cheaper; and insurance rates are not cheaper. But Firestone will benefit from those changes to fundamental rights that Floridians and other Americans have.

Mr. Connor asked Mr. Block to clarify Florida's "presumptive cap" on punitive damages. That even if the punitive damages exceed the compensatory damages by more than three times, that award is presumed to be excessive unless a judge finds that there's clear and convincing evidence to warrant exceeding the cap. And why shouldn't the Task Force recommend artificial caps on claims by residents?

Mr. Block agreed and said that the MR/DD and abused children are also entitled to the presumptive cap. Caps are recognized by the courts and by this legislature at various times in its history as being fundamentally unfair. When someone has been wrongfully injured or killed, our constitution has recognized that we are to judge that case based on its merits and not apply a fundamentally unfair and arbitrary cap. The point is to provide an incentive for wrongdoers not to engage in the behavior again. With an artificial cap, it just becomes another cost of doing business.

Ms. Chmielewski asked if the Academy has any statistics after the resident rights law was passed regarding the number of lawsuits filed for people left running in the hallways as it was described up until that point? Because in my experience, through the survey process, buildings were steadfastly moving forward but I very rarely heard from an attorney, that happened in the mid-90s. Maybe there weren't any problems in the first decade and they just evolved in the last decade.

Mr. Block stated that the Academy does not have that kind of data but that he understands this Task Force is attempting to obtain this data but it is being limited to the Tampa area which we think is a mistake—if you are studying the volume of nursing home cases, it should be a representative sample. And Tampa is home to one of the more high powered nursing home litigators in the state so the numbers may be skewed.
[in response to a question about the number of NH litigators]: there are about 40 around the state. The vast majority of Academy members do not engage in NH litigation.

Dr. Calkin commented that in her role with Extendicare and that the case that Mr. Block described was one in which she and two other Task Force members were involved. The information provided was not accurate and she will provide the members with a description of the case. She asked whether the Academy has looked at other jurisdictions where trial attorneys are not used in the quality improvement process. [Mr. Block: no.]

Mr. Grofic clarified that for nursing facilities there are no caps but do hospitals and other businesses have caps on punitive damages? He also asked that the trial attorneys provide draft legislation to try to resolve the issues so that nursing homes are not driven into the ground.

Mr. Block stated that since 1999 there has been a presumptive cap on nursing facilities punitive damages but it uses a different standard than hospitals and other businesses. There is a working group who is working on proposals for the task force.

Mr. Sherberg asked about the Knowles situation in South Florida.

The Chairman asked that this be discussed later because there were still four more presentations.

Ms. Cathy Ates, Emerald Healthcare, spoke on quality and litigation.

- Banking, insurance, and legal experts have provided testimony that clearly show that something is wrong in Florida.
- Florida nursing facilities are sued three times more often than facilities in any other state.
- Florida liability insurance rates are the highest in the country, if you can find a carrier who will insure you.
- Lawsuits are slowly destroying the system they were supposed to improve and are driving good people from long-term care and driving a wedge between caregivers and families.
- Quality of care in Florida is not poor. Statewide, our care is above the national average for the past three years, based on Federal Survey data and scope and severity deficiencies. Florida is four times better than the national average in the “immediate jeopardy” category

and better in the substandard care category. Florida is a leader in preventing contractures and fewer patients show signs of depression.

- Florida has more patients who are incontinent however Florida facilities lead in having them participate in bowel and bladder retraining programs.
- The attention is always on the one-tenth of one percent of homes cited for immediate jeopardy but not on all the others that are doing a good job.
- There is agreement on the need for more staff but no solution with how they are going to be found and paid.
- In at least one county, two CNA training programs have closed.
- Her facility staffs at 3.4 hours per patient day, well above the state minimum standard. This is done using outside temps who do not know the residents as well as the staff does. They don't provide continuity of care and are expensive (including paying for transportation).
- Need creativity and flexibility in staffing; extra in-service training is needed to keep staff up to date on the changing conditions of the residents. Recommend increasing the minimum from 12 to 18 hours/year.
- The state pays less than \$5/hour to the nursing home which is less than minimum wage. The state should fully fund the patient care cost. It should also pay more for higher acuity patients. Even with the recent add ons; 50% of Florida's nursing facilities are still paid less than the Medicaid allowable patient care cost and 90% are paid less than the Medicaid allowable operating cost. The state should remove the target payment method.
- NFP facilities are able to subsidize their Medicaid losses through higher private pay and charitable resources and different tax treatment (e.g., a NFP facility cost is \$89/day and is reimbursed \$81/day; a FP facility average cost is \$79/day and is reimbursed \$75/day).
- FHCA advocates a peer review mechanism for its membership that calls for full public accountability through public disclosure of quality and consumer satisfaction data and the creation of high performance standards. A self assessment and an education and consulting service division will be available to support members to achieve excellence. FHCA will impose sanctions on members who do not maintain high standards (terminating membership). Quality assurance meetings should be held monthly and not quarterly as required; risk management programs should be instituted.
- All these efforts to improve quality will not succeed if providers are sued out of existence and investors are not willing to build modern facilities and fund capital expenditures, and insurance carriers do not provide affordable insurance.
- An investor testified in public testimony that they are getting out not because of quality of care but because of the high litigation.
- Many facilities are going without insurance so that legitimate claims are not compensated and employees are not defended.
- Nurses spend too much time on records and requests, depositions, rather than on patient care.
- Every accident in a NH or ALF becomes an abuse or neglect case so that attorneys can use the liability laws: paying them extra fees with no limits on damages.
- The state wants to rely on ALF for less expensive care but if ALFs cannot get insurance, by law, they must close. They are being told to drop their ECC license which allows them to offer more nursing services. Residents will now be forced into nursing home care.
- Dollars spent on lawsuits are not being spent on patient care.
- Mr. Wilkes has admitted that his real goal is simply to bring down the entire system.
- The solution is the same one that was used 15 years ago when doctors and hospitals were the target of lawsuits. This was solved with the Medical Malpractice law and today there is

quality care in hospitals and from physicians and insurance is affordable and investment is available. These laws encourage speedy arbitration and early settlements. Nursing homes should be on the same legal grounds as other medical professionals.

Rep. Argenziano asked if the industry could and should chip in to improve staffing (through providing their own training, increasing wages) and that would help to reduce litigation.

Ms. Ates said that [HB 1971] was wonderful and that the industry felt that way as well but the problem was getting [the CNAs] in the door.

Ms. Chmielewski asked if some of the industry's suggestions couldn't be implemented without legislation, such as more frequent QA meetings and increasing CNA training. For years, the industry has hollered about being controlled by government regulations and she wouldn't want industry zealotry to fix things lead to over regulation.

Ms. Ates said that the industry is trying to make it a standard of practice.

The Chairman made the analogy to education: there are a lot of changes that have taken place that could happen without one new law, state policy, or rule. But then there are those who don't change without state involvement.

Mr. Erwin Bodo, Florida Association of Homes for the Aging spoke on the cost of litigation on non-profit facilities.

- Providing data analysis from a combination of databases available from AHCA and DOI to look at the differences between FAHA members and non-members.
- Using Shawn Phelps severity index, there are significant differences between FAHA members and nonmembers.
- RN and LPN staffing is higher for FAHA members vs. nonmembers. Florida has been above the national average and has been increasing its staffing ratios for the last 7-8 years.
- FAHA members spend significantly more a day on residents compared to nonmembers. Medicaid spends more for FAHA members because they have more staff and offer some additional providers and services.
- Cannot find a correlation between quality and litigation.
- FAHA members and nonmembers have both experienced increases in liability insurance costs of 405-410%.
- About two-thirds of FAHA members had claims against them in the last three years. Among all facilities, 80% have had a claim in the past three years.
- For the first time ever, CON beds have not been exhausted by applications: fewer beds have been applied for than are available. It used to be that we had applications for 4 times more than what was available.
- Recommend:
 - o Adequate staffing directed to facilities with a problem.
 - o Reimbursement levels still need to be improved. It used to be that 65% of facilities had their costs covered by Medicaid now 65% do not have their costs covered.
 - o Additional regulatory enforcement powers are needed.
 - o Encourage more NFP facilities
 - o Need to address the ALF issue as well.

Mr. Grofic asked how FAHA members are paying for the liability insurance increases.

Mr. Bodo stated that several facilities have indicated that they are considering closing down; some of the CCRCs took a double hit because if liability insurance goes up, they have to put more into reserves. Some are increasing the private pay but private pay revenues cannot be increased enough to really offset the liability insurance costs.

Ms. Chmielewski asked if NFP have more avenues of access to monies that allows them more staffing than for profits do (e.g. a religious CCRC is able to turn to their church affiliate) which would affect their ability to provide care versus the public funded or the public homes that have only Medicare, Medicaid, VA, and possibly HMOs to reimburse them.

Mr. Bodo agreed. A lot of charitable organizations are involved with nursing homes and members get contributions in excess of what a for profit organization would get. Most of the money does go for care. With 80% of the facilities for profit, the State is obligated to allow them to make some profit in providing nursing home care. To the extent that it is not happening with Medicaid, you'll continue to have a problem.

Mr. Connor stated that Mr. Bodo had demonstrated convincingly that NFP are doing a better job in many areas compared to the FP and asked if most FAHA members were NFP organizations. He asked also what incentives should the Task Force recommend that would increase the likelihood that we could draw NFP to the market place; and what has FAHA done to explore why members are being penalized by existing risk pooling? Have members considered self insurance programs or programs for NFP where you don't include repeat offenders?

Mr. Bodo said that most FAHA members are NFP. They have worked with Brown & Brown Insurance company to look at self-insurance and found they have not been successful. They aren't lower cost or available. Part of the problem is that even 70% of our members have claims against them. FAHA hasn't found a risk pool that would make liability insurance more affordable.

Ron D'Addio, Plastridge Insurance Broker, spoke about the liability insurance crisis for assisted living facilities.

- Insurance carriers indicated in the past that without serious tort reform, they could no longer do business in Florida. Many did not take the crisis seriously which led to the crisis that exists today.
- One year ago, there were 17 carriers writing general and professional liability insurance for assisted living facilities in Florida; today there are 6.
- Because the perception that the concerns were ignored during the last legislative session and overwhelming losses, the following carriers advised their agents they would not be renewing their entire book of business of assisted living facilities:
 - o Reliance
 - o Caliber One
 - o Pacific
 - o Colony
 - o Burlington
 - o Lexington

- o General Star
- o Acceptance
- o Essex
- o Sentry
- Pay losses for Lexington who came to Florida in 1995 with a program for assisted living facilities only. During this 5-year period, they earned \$436,784 in premiums and paid out \$3,444,646 for a loss ratio of almost 730% (loss details are available to the task force).
- A carrier with these kinds of losses, has to either increase their rates a minimum of 8 times to break even; 12-15 times to pay expenses and make a small profit.
- They left Florida to move to another state where it is more friendly.
- Six carriers remain and they have to absorb risk that their rate levels were not designed to do. (Their guidelines and minimum premiums are available to the Task Force). Only one is an admitted carrier which means they come under the protection of the Florida Guarantee Fund and regulation by the DOI.
- New trend in the last six months is that we are receiving from attorneys requests for the complete policy information and insurance limits before they even request medical records (a sample is available).
- Managing a book of insurance that includes 150 assisted living facilities, I review daily surveys and can tell you that for these facilities, most deficiencies are clerical and failure to document. Residents are happy and well cared for and pleased with their level of care. The owners or administrators are hard working; many started their facilities with personal funds. Now they feel that all they have worked for can vanish.
- In January 2001, will be holding insurance seminars to make available a comprehensive risk management program.

Lyn Bentley, Marriott Senior Living Services and Florida Assisted Living Association spoke about litigation and assisted living facility viability.

- Unlike nursing homes, ALFs to be licensed are required to have liability insurance.
- 64% of all licensed ALF are licensed for 16 people or fewer.
- Cost of increased liability insurance is passed on to the consumer. But for those who are on the optional state supplementation (OSS) or in the Medicaid Assisted Living for the Elderly (ALE) waiver program, there is no way to pass the increase on.
- The inability to have a limited nursing services or extended congregate care license is having an impact too.
- A typical individual cared for by the ECC license, needs assistance with: housekeeping, reminders for meals, choosing and cutting food, getting in and out of her chair; bathing her lower body; reminder to use incontinence briefs; assistance with medications; assistance with dressing; reminders to wear clean clothing and to attend activities. She can qualify for the Medicaid Waiver which means that she is nursing home eligible. She must be in a facility with an ECC or LNS license (50% of the 39,000 ALF beds have one of the licenses). But now the insurance carriers are requiring that the facility give up the LNS or ECC license so this woman will be sent to a nursing home.
- The impact of lawsuits on staff in ALFs are: demoralization and loss of staff.
- Record requests include requests for information that is in the public record and could be found without asking the ALF to spend extra staff time away from residents to produce these and make multiple copies.

Rep. Argenziano asked if litigation goes down, will insurance costs go down and if staffing and quality of care increased and litigation went down would it have the same effect.

Mr. D’Addio stated that there are already minimum staffing ratios that have to be adhered to so it isn’t clear that more staffing would reduce litigation; it isn’t evident in the claims information. The typical claim is for a resident who slips and falls (which they can do in their own home) but since it is in a retirement home, a lawsuit is entered. Staffing does not have a direct relationship with litigation.

Rep. Argenziano asked if this crisis was like with the weather in Florida and creating the JUA. Whenever there are increased claims, they don’t want to be there anymore.

The Chairman stated that it is supply (of residents) and demand (of high quality services) and extraneous factors that stand either in between or in support of the two like the cost of supplying services. Litigation is one thing that takes money out. With less money, you need to reduce costs, so less staffing which will impact quality of care.

Mr. D’Addio said that he could agree that if there was more staffing that there could be better quality but from his experience, there are very few instances where a facility has been cited for poor staffing. And in details of a lawsuit, very rarely is improper staffing a result. Increased staffing also increases the costs to the ALF.

The Chairman agreed that automatic increases in staffing do not necessarily automatically equate to higher quality of care.

Mr. D’Addio said it is not the number of staff but the quality of the people.

Business meeting adjourned at approximately 1:30 p.m.

October 31, 2000

Present: The Honorable Frank Brogan (Chairman), Dr. Gema Hernandez, Mr. Bob Sharpe, Mr. Philip Freidin , Mr. Larry Sherberg, Mr. David Grofic, Mr. Walter Liptak, Mr. Rene Rodriguez, Dr. Jeff Dwyer, Dr. Jesse Lipnick, Ms. Cherryl Chmielewski, Mr. Kenneth Connor, Dr. Joy Calkin, Mr. Ed Boyer, Mr. Robert Miller, Ms. Victoria Fierro, and The Honorable Nancy Argenziano.

Absent: Mr. Ray Noga, The Honorable John McKay

Staff present: Dr. Larry Polivka, Dr. Kathryn Hyer, Ms. Jennifer R. Salmon, Dr. Paul Duncan.

The minutes from the October 16-17 meeting were amended by Ms. Fierro to include a statement by Anna Spinella in her expert testimony that she recommended a volunteer training program in nursing homes. Dr. Calkin motioned to accept the amended minutes; Mr. Grofic seconded and the motion passed.

A discussion on the logistics for the remainder of the Task Force meetings ensued with the following decisions:

- Recommendations due date changed to November 6th with lee-way for FALA and any other organizations who need extra time.
- Task Force members should get their own recommendations in at the same time as the general public; they should be conceptual and don't need to be specific.
- Mail table of contents and description of all research projects by November 10th.
- Change November 15th conference call to in person meeting November 20-21 in Tallahassee to discuss recommendations received and synthesized and hear from insurance industry.
- Mail first draft of report on November 22 for the December 4-5 meeting.
- Have a shorter public testimony period in Miami and Jacksonville. Hold the public testimony in Jacksonville in the morning.
- Draft Final Report mailed to Governor, Senate President, and House Speaker by January 1, 2001 and circulated to Task Force members for final review and comment.

In the midst of the above discussion, concerns by Task Force members related to content of the final report were raised:

- Description of how money flows in the state and what aspects are legislative vs. administrative (allocation process).
- Need to focus on the 4-5 things we want to decide on and set priorities.
- Desire to followup the residents of the 6 facilities with terminated contracts to see what happened to them.
- Concern about a staff-driven report.
- Need information from insurance companies regarding what will get them to lower their rates.
- Need to have proposals reviewed by insurance industry to see if it would make a difference.
- Need a summary of key points from meetings.
- Are all the items requested provided to Task Force members (checklist).
- There appears to be three things being stated: 1) litigation is driving the insurance rates so we have to take away all the rights of residents to bring down these costs; 2) can't solve the quality of care issue without the money drained for litigation and the lack of adequate reimbursement; and 3) need one meeting with the insurance industry to find out what it will take to stay in the market. Need to move towards solutions. What will providers, insurance industry, trial attorneys, and regulators accept.

The meeting adjourned at approximately 12 noon.

Respectfully submitted,

Jennifer R. Salmon
Project Coordinator
Florida Policy Exchange Center on Aging

Approved December 18, 2000

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

BUSINESS MEETING

November 20, 2000

Senate Room 37, 400 South Monroe Street, The Capitol, Tallahassee

This meeting will be tape-recorded and transcribed for the public record.

9:45 Introductions **Lt. Governor Frank T. Brogan**

Old Business: Accept or amend October 30-31 minutes

New Business: Liability Insurance Update

10:00 *Belinda Miller, Division Director, Division of Insurer Services, Department of Insurance*
Regulator Perspective: What Can Be Done to Stabilize Liability Insurance in Long-Term Care?

Clint Smawley, Katz, Kutter, Haigler, Alderman, Bryan & Yon, Attorneys and Counselors at Law: How Does Liability Insurance Work in a Free Market Environment vs. Regulated/JUA?

Theresa Bourdon, Aon Risk Consultants, Actuarial Perspective: For-Profit Facilities and Liability Insurance Increases

Virginia Petrie, Resident, Westminster Oaks and Member, Florida Life Care Residents Association: How Do Increases Impact Private Pay Residents of Continuing Care Retirement Communities?

11:15 BREAK

11:30 Discussion: Task #1 Recommendations: Home and Community-Based Alternatives and Funding.

Note: Discussion will focus on the synthesis of recommendations received by November 9, 2000 from all interested parties including Task Force member and disseminated to Task Force members. The goal is to achieve consensus on recommendations for Task #1 and to begin discussion on recommendations on tasks #3 and #4. Task #2 (Financing Long-Term Care) will be addressed partially in the discussion of Home and Community-Based Alternatives. Discussion on financing, litigation, and quality will continue at the December 4-5 meeting.

12:30 Adjourn for Lunch

1:30 Finish Discussion on Task #1

3:00 Break

3:15 Initial Discussion on Task #4: Nursing Home Litigation

4:30 Break

4:45 Initial Discussion on Task #3: Nursing Home Quality

6:00 Adjourn

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

BUSINESS MEETING

November 21, 2000

Senate Room 37, 400 South Monroe Street, The Capitol, Tallahassee

This meeting will be tape-recorded and transcribed for the public record.

9:00 Open Discussion:

1. All Tasks
2. Feedback to staff on early draft of Final Report

12:30 Adjourn

MINUTES

Task Force on Availability and Affordability of Long-Term Care

November 20-21, 2000

Senate Building 37, The Capitol, Tallahassee

November 20, 2000

Present: The Honorable Frank Brogan (Chairman), Dr. Gema Hernandez, Mr. Bob Sharpe, Mr. Philip Freidin, Mr. Larry Sherberg, Mr. David Grofic, Mr. Walter Liptak, Mr. Rene Rodriguez, Mr. Ray Noga, Dr. Jeff Dwyer, Dr. Jesse Lipnick, Ms. Cherryl Chmielewski, Mr. Kenneth Connor, Dr. Joy Calkin, Mr. Ed Boyer, Mr. Robert Miller, Ms. Victoria Fierro, and The Honorable Nancy Argenziano.

Absent: The Honorable John McKay

Staff present: Dr. Larry Polivka, Ms. Jennifer R. Salmon (FPECA); Pete Buigas (AHCA).

The Chairman described meeting with incoming members of the Florida House and Senate with 60 new members. What is lost with term limits is made up with 60 people who may be willing to look at the world in a new way. He told them that long-term care would be an important issue on the agenda in the next session. It is a high priority on both sides of the aisle; in both the House and Senate; and with the leadership.

Task Force members introduced themselves.

The reading of the October 30-31 meetings was deferred.

Mr. Connor asked about the sequence of the agenda and if the order could be changed so that quality was addressed prior to litigation. This suggestion was approved.

Ms. Belinda Miller, Department of Insurance addressed What Can Be Done to Stabilize Liability Insurance and Long-Term Care.

- DOI regulates carriers who are admitted to the state of Florida for both their rates and forms and solvency. In order to raise rates, an admitted carrier needs to demonstrate to DOI that the current rates are inadequate, not excessive, nor discriminatory. They also file financial statements that show us their experience on various lines of insurance and whether their losses exceed their premiums.
- Nursing homes and assisted living facilities are not a line of insurance by themselves; they are part of "other liability."
- Insurance companies look at the whole market when they decide whether or not to remain: loss ratios (the ratio of a company's losses over premiums). In life insurance, they can invest the income so the loss ratio can be over 100% and they still make a profit. In all other lines, loss ratios over 100% indicate they are not making a profit.
- Followed up initial survey (presented by Dan Sumner, October 30) with questions about loss ratios for nursing homes and assisted living facility policies.
- In "Other Liability," the national average over the last five years is a loss ratio of 63.5%.

- For NH and ALF, the loss ratios have been all over the map:
 - For Surplus lines in nursing home insurance:
 - *Admiral went from 95% in 1997 to 281% in 1999
 - Caliber went from 70% in 1998 to 234% in 1999
 - *Royal Surplus went from 509% in 1998 to 355% in 1999
 - For Admitted companies in nursing home insurance:
 - *Reliance went from .86% in 1998 to 383.55% in 1999
 - Guide One went from 13.5% in 1995 to 554% in 1996 to 38% in 1999
 - Phico went from 1095% in 1997 to 35% in 1999.
 - Hartford went from 551% in 1995 to 659% in 1998 and 49% in 1999.
 - For Surplus lines in assisted living insurance:
 - *Admiral went from 208% in 1998 to 281% in 1999.
 - Caliber One went from 149% in 1998 to 293% in 1999.
 - Century Surety went from 116% in 1995 to 796% in 1999.
 - Western Heritage went from 1407% in 1996 (and 1567% in 1998) to 7% in 1999.
 - Centennial had a steady loss ratio from 1996 to 1999 (268%-237%).
 - *Reliance had a steady loss ration: 552% in 1998 and 543% in 1999.
 - Phico Insurance went from 159% in 1997 to 613% in 1998 and back to 35% in 1999.
 - Hartford went from 0% in 1995 and 1996 to 4541% in 1998 and back to 0% in 1999.
- *=did not include Incurred But Not Reported (IBNR): incidents that occurred but no notice of claim has been received.
- Insurance companies look at 5-year average, but for these companies it far exceeds the “other liability” line average of 63.5%
- These unpredictable loss ratios most likely were the reason for leaving the market because it makes it difficult to make a rate filing (if an admitted carrier).

Mr. Sherberg asked is the percentages are for claims paid and policies written in each year. If there was a notice in 1997 of an incident; would it be included in 1997 or in the year it was litigated. And is it based on percentage of income or premiums so that if a company stopped writing in one year, their percentages would look worse since they aren’t collecting new premiums.

Ms. Miller explained that losses are made up of paid claims + claims they know about for which a reserve is set up + incidents incurred but not reported. A claim is entered first in the year it happens; it may increase as the claim develops and so the increase would be put in the appropriate year. The year a company stops writing premiums does influence the loss ratios. Some of the very high or low ratios may have to do with when a company begins or stops writing in a given year. One of the trends is that the surplus lines (not regulated by DOI) companies are taking over when the admitted market leaves. Surplus lines are designed to take unusual risks (e.g. artwork or a Mazzaratti).

Mr. Connor stated that in April 1994, nursing care standards set forth in the Florida Administrative Code were emasculated. Substantial standards pertaining to the care of nursing

home residents were removed. There appears to be a temporal association between the emasculation of the standards and the losses that nursing homes have experienced.

Ms. Miller stated that the data did not go back prior to 1995.

Mr. Connor stated that he believes there to be a correlation between effectiveness of the regulatory environment and litigation.

Ms. Miller stated that companies do look at risks and impose underwriting standards that may or may not be the same as the state minimum standards. For example: financial stability (a facility close to bankruptcy is not a good risk because it is probably cutting corners); staffing; training; turnover; and risk management tools.

Dr. Calkin stated that the assuming correlations as opposed to causal relationships can be problematic. She also asked about the availability of reinsurance.

Ms. Miller said that there are 3 or 4 remaining. It is reinsurance that has caused the withdrawal of the carriers or at least the inability of carriers to return to the market. An insurer may write a policy for \$1M limit. Part of the rider may be covered by reinsurance (e.g. >\$500K or 50% of every claim).

Mr. Liptak asked if admitted companies have significantly more surplus than surplus lines companies and if they have more surplus relating to premiums than surplus lines companies that don't and if it is more prevalent to have larger percentage of admitted companies with reinsurance as compared to surplus line companies.

Ms. Miller stated that admitted companies must have some surplus (comply with laws); some surplus lines companies may have a large amount of surplus (they aren't regulated). Their data did not include this particular type of coverage.

Dr. Calkin stated that it has been her observation that admitted companies typically retain more risk within their structure as compared with surplus lines companies and requests that no assumptions be made.

Ms. Miller stated that some of the admitted carriers kept 70% of the risk, but others kept 20 and that the risk varies. She then explained the reasons for the exit of surplus lines companies.

- The most recent trend is the number of filings for admitted carriers for very low limit policies, one for \$25,000 and other for \$250,000.
- Typical limits for a several years ago were for 1,000,000 – 2,000,000 coverage, a million per claim, 3 million in the aggregate.
- Some insurers have quit writing
- Some have limited writing to certain states.
- Some charge premiums that insured cannot pay.
- Some insure only the not-for profits.
- There are some that have changed to a "claims made" policy which requires that the claim be made in the year the policy is in force. This results in less IBNR (incidents that occur but not claim has been made).

Insurance companies can be brought back by stabilizing the liability coverage for nursing homes and assisted living facilities:

- Increase the quality of care
- Raise the staffing requirement
- Increase risk management tools
- Decrease remedies
- Create an alternative market
- Create a JUA or reinsurance pool
- Incentives for companies in the form of tax relief

Mr. Connor asked if Commissioner Nelson favored diminishing the legal remedies than nursing home residents have a s means of improving the insurance market.

Ms. Miller stated that the Commissioner would not advocate cutting of all claims in order to make the companies come back.

The Chairman asked for clarification: is Commissioner Nelson opposed to any change on the issue.

Ms. Miller stated that she thinks his position is that we should lower the losses and come up with a remedy that crosses a variety of lines and he would not advocate cutting of any remedies for people who are genuinely injured.

Mr. Connor asked if Commissioner Nelson is opposed to or not advocating for any change on the issue of remedy.

Ms. Miller stated that she thought the Commissioner would like to see what changes are proposed.

Mr. Connor asked who gathered the data and if the carriers stated that lowering the losses would help from their standpoint.

Ms. Miller stated that members of her staff gathered the data and the she personally talked to some of the carriers and the carriers point to:

- The Patient's Bill of Rights.
- They are withdrawing from Florida and Texas because they perceive that the legal climate is worse here.
- Immediate coverage of higher verdicts
- Some would consider coming back if things changed
- One stated that they would not come back until the Patient's Bill of Rights changed and was followed through courts.
- Public perception of nursing homes
- Under capitalization of some of insurers

The Chairman stated that the insurance companies find the legal climate not to their liking regardless of the reason.

Ms. Miller agreed that from the carriers' perspective they don't care if the verdicts are high because of the perception or because grievous injuries are taking place. If losses are high they are going to withdraw. If they cannot predict the rate they need to charge or they cannot charge an adequate rate to make sure that they make money, they are going to withdraw.

The Chairman asked if the carriers mentioned capping damages.

Ms. Miller stated they had many recommendations on capping damages.

Mr. Freidin asked what Ms. Miller thought about unilaterally allowing changes in the law, especially in the area of decreasing remedies on the possibility that the insurance companies would consider coming back and what was the feasibility of forming a self insured trust among nursing homes in which they could promulgate their own standards based on performance as well as quality of care. One way of funding such a trust is targeted tax relief and getting started with the help of state funding.

Ms. Miller stated that she had experience with different types of self insurance . These trusts are assessable trusts. If a doctor has large claim and the claim is for more money than the trust has, the other doctors are assessed to help pay for that claim. If you have that type of arrangement and the losses continue to be very high some of the nursing homes who are members of the trust are going to have a hard time paying and you'll have a hard time collecting it from them.

Mr. Freidin stated that without some change in quality of care and decrease in remedies nothing is going to work. He asked why change these things if the insurance companies say, we might come back and we might consider coming back if you do the following things. This means they might not come back.

Ms. Miller stated that the insurance companies will come back when they are sure they can make money in the market.

Mr. Grofic asked if Ms. Miller had anything in writing relative to the insurance companies position.

Ms. Miller stated that she did not.

Dr. Calkin asked if there is something causal to litigation, for example, quality of care, staffing increased in risk management and a decrease in remedies. She stated that she had talked to the eye surgeons about their insurance pool and they simply increase their prices in order to cover their insurance. If a claim is paid, either the doctor pays, the insurance pays or it passed on to the patient? Is that correct? In our case with assisted living and nursing homes we also have Medicaid and Medicare and are these the only payers? At some point the low quality nursing homes leave the market, will litigation turn its attention to high quality nursing homes.

Ms. Miller stated she had no data to base that on.

Dr. Calkin stated that she was hearing from the reinsurers that the bigger the market the greater the spread of risk and the more attractive the market, and then it was suggested that the market should be a smaller high quality market. Could Ms. Miller clarify?

Ms. Miller stated that the first is a fundamental insurance concept from the law of large numbers. If you have a lot of insurers they can absorb one big loss a lot easier than a small pool. It doesn't mean that the insurance companies would rather have a smaller pool of much better risks than large pool of terrible risks.

Mr. Clint Smawley of Katz, Kutter, Haigler, Alderman, Bryan & Yon, discussed how liability insurance works in a free market environment vs regulated/JUA.

- A JUA is a public insurance facility that furnishes insurance coverage to insurers who are unable to obtain insurance from the private market.
- JUAs are authorized when insurees cannot obtain insurance in the private market and policy makers decide that a mechanism must be found to provide coverage or policy makers are unable to take action to address private market disruption.
- JUA can give the appearance of solving a market availability crisis by have no capacity to reduce losses.
- If deficits are large enough to significantly compromise claims paying ability several approaches have been used.
 - Assessments of JUA policyholders
 - Market share prorated assessments on insurers who write that line of business. If an insurer writes 10% of the private market, they would be responsible for 10% of the deficit
 - Assessment on private market insurers and JUA insurers borrowing and then assessing a combination of JUA and private market insureds and insurers
- Pitfalls of using assessments to pay losses
 - Collection of assessments have triggered extensive disputes between the assessing entity and the entity being assessed.
 - Validity of proposed assessment based on formulas concerning the entity's participation.
 - Refusal to pay causing lengthy litigation.
- Limited circumstances sometimes make JUA appropriate
 - If coverage is required by law and no private market exists.
 - The reason for the lack of a private market is beyond the control of policy makers.
 - JUAs should have rates equal to or higher than private market rates and assessments should be levied only on JUA policyholders thereby encouraging adequate rates.
- Based on what is presently driving the crisis, in historical experience JUA will not solve the long-term insurance crisis.
- Without exception, the use of the JUA resulted in substantial deficits and the private market exiting the state.
- Workman's comp JUA example:
 - Private insurers experiences increasing medical costs and soaring litigation rates
 - Losses and premium increases could not keep up.
 - Insurers sought coverage in the workers compensation JUA
 - Deficit mounted in JUA, from 1992 – 1992 totaled over \$1.9 billion.
 - Private insurers began to leave market.
 - Legislature adopted managed care and workers compensation to control medical costs.
 - Took steps to reduce litigation
 - Abolished the old JUA and created a new workers comp JUA which was required to charge premiums sufficient to cover losses with no assessment authority outside the JUA.

- Addressing the long-term care insurance crisis would require at a minimum:
 - o Providing that plaintiffs and defendants should each pay their own attorney.
 - o Instituting caps on pain and suffering and punitive damages
 - o AHCA survey should be made inadmissible.

Mr. Connor asked about the causal connection if any between poor care, the litigation crisis and increased insurance rates. He quoted a University of California study that reported poor standards of care and short staffing. Would significant improvements in these areas affect premium insurance crisis.

Mr. Smawley stated that he not read that study but other studies find that Florida is about average in terms of quality of care.

Rep. Argenziano asked what would Mr. Smawley recommended that the AHCA surveys be replaced it with? And why would he recommend they be inadmissible. Wouldn't the AHCA survey would have relevance if it indicated a chronic problem of a facility.

Mr. Smawley stated that it would only be inadmissible in civil actions. AHCA would still do the surveys and they would be made available to the public. The surveys have no relevance to the claim. AHCA surveys could be done before or after the incident and could find quality problems that were or were not related to the incident. AHCA surveys are inadmissible in several states; conclusions are based on what is in survey rather than on the elements of their case.

Mr. Connor stated that the AHCA surveys are relevant for several important reasons. It provides notice of the problem, addresses the care of the resident, and it can address the issue of an ongoing pattern of misconduct.

Mr. Sherberg stated that as a provider a single deficiency could be typed up as a 3-4 page deficiency. AHCA surveys are misleading. If somebody falls it has nothing to do with a survey done six months ago.

Dr. Calkin asked if it would be reasonable to set aside litigation and allow any court action to be taken purely on the basis of AHCA reviews. If a home that has a perfect track record then no one in that home can initiate a lawsuit.

Mr. Smawley stated that the problem with the surveys that there is no opportunity to cross-examine or to challenge the information in that survey. The survey can help assess what an institution is like, but it cannot address a specific claim on a specific date.

The Chairman made the point that the issue is a subjective one and whether AHCA surveys are inadmissible or not, they need to be based on a objective look of persons who are trained and knowledgeable as to what are the standardized qualities of care and practice. The surveys can be used to identify weaknesses as well as strengths.

Ms. Fierro stated that there is due process against AHCA surveys in case the facility wants to challenge the survey findings. She also asked Mr. Smawley who he represented.

Mr. Smawley stated that he represented The American Insurance Association and the Florida Assisted Living Association.

Ms Theresa Bourdon of Aon Risk Consultants provided an actuarial perspective on for profit facilities and liability insurance increases.

- Background of Study
 - Collected data from 12 long-term care operators from around the country, all operating in Florida.
 - 12 operators represent 20% of the nation and 35% of Florida.
 - Predominantly for profit operators
 - Shows a historical perspective going back to 1988.
- The sum of the cost of general liability and professional liability claims including the defense cost that companies pay, as well as, the cost paid to the plaintiff and their attorneys, when divided by the number of nursing home beds has grown from \$103 in 1988 to a projected \$6,283 in 1999.
- Why insurance companies are not writing in Florida.
 - In order to provide insurance it must be predictable.
 - Prior to 1995, increases were at about 37% a year
 - Since 1995 insurance costs are no longer stable.
 - Long-term care companies that are paying the losses and many are not buying insurance but are paying claims out of pocket.
- This “lost cost trend” is a combination of two things.
 - Number of claims
 - Size of the claims.

Mr. Connor noted that it looked like after April 1994, when nursing care standards were stripped out of a Chapter 10D29, there was a very steep increase in claims and cost. Is there any correlation between the stripping out of those nursing care standards and the increase in litigation cost and claims?

Ms. Bourdon stated that the increase from '88 to '94, 103 to 1,400 is about a factor of 14, from '94 to '99 the factor is not even close to 14. So the increase was more between 1988 and 1994.

Ms. Bourdon stated that it is more a problem of the number of lawsuits than the size of lawsuits.

- Database included 12,000 claims.
- The largest claim was seven million dollars.
- By 1994 the number of claims had grown by a factor of almost four to 12.

Mr. Liptak asked if Ms. Bourdon had any explanation for increase in utilization frequency from 1992 to 1993.

Ms. Bourdon stated that she thought that in the earlier years not all the participants were tracking their data. The data is complete about 1994 on.

Mr. Rodriguez asked if the numbers been adjusted by the growing number of beds.

Ms. Bourdon stated that it was ratioed to the number of beds (frequency rate per thousand beds). She described the severity trend for the 12 non-profit chains:

- In earlier years Florida losses are as low as \$3 million.
- In 1999 losses were about \$150 million.
- From 1995 to 1999 losses were \$500 million.
- Project losses in the next two years of another \$500 million (if they don't go bankrupt).

Rep. Argenziano asks if Ms. Bourdon has any data prior to '88 dating back about a decade (Bourdon: No.).

Dr. Calkin stated that in '94 the governor asked that there be a plan to reduce duplicate and unnecessary services and to integrate services. There were a number of conflicts, OBRA for example and the state regulations were changed. AHCA moved to outcome measures with a focus on the patients rather than on the paper. Dr. Calkin suggested that it might be helpful to provide a cross walk between the regulations before '94 and the regulations after '94.

It was agreed that this cross walk will be provided.

Ms. Chmielewski stated that the change that came in 1994 put the weight of the quality of care back on the floor versus notebooks. They no longer had to produce big notebooks of policies and procedures for the surveyors. They had to produce patients that looked good. The survey process now leaves very little margin for a building to put everything into policies and pass their survey. The patients truly reflected that.

Ms. Bourdon compared Florida to other states.

- The survey focused on identifying Texas and California results and then grouped all other states together.
- The same 12 companies operate, we assume similarly, in all states, but Florida's costs are much higher than the rest of the country.
- Texas' trend rate has slowed down compared to Florida.
- All states excluding Florida, the cost in 1999 was \$809 per bed. In Florida the cost was \$6,283, a factor of 8.

Mr. Connor asked whether or not in the other states during the same period there were there changes in the nursing care standards or the elimination from their pages of nursing care standards during that same period.

Ms. Bourdon stated that she could not answer that question. However both Texas and California have a plaintiff's rights statute as well. The difference is in the number of claims. In Texas the number of claims have flattened out. It is predictable and that is what the insurance companies are looking for. Florida is at the top of the scale and increasing. Some years between '96 and '97 the percentage increase was greater than the year prior. When you have that kind of a change in the trend rate it becomes unpredictable. It is why companies who self-insure are having a very difficult time putting on their balance sheet what their costs are.

Ms. Bourdon compared the size of claims:

- Florida and Texas are identical in terms of the average cost.

- Florida is much worse per bed, because of more claims, more than twice as many in Texas.
- In terms of size of awards, Florida and Texas are similar on average.

Mr Liptak asked why Texas is up so high as compared with the average.

Ms. Bourdon replied that is was because Texas passed the tort reform but it did not apply to the elderly, and there are no caps. She continued to describe the losses:

- 21.4% is going to the defense attorneys.
- An estimated 27.5% is going to the plaintiff attorneys and with add-on attorney fees as provided for under Statute 400 it is probably more than 35%.
- 51.1% is going to patients and/or family compensation

Rep. Argenziano asked if there are any differences in care standards, staffing standards, or regulatory standards?

Ms. Bourdon replied that only the loss, the claim data and the beds were analyzed. It is not uncommon for any line of business in Florida or Texas to generate higher average awards. Juries in Florida and Texas generally give out higher awards than the rest of the country, having no limits on the damages contributes to that size.

Dr. Calkin stated that she completed a study in eight states. Texas and Florida have the same basic OBRA regulations of which there are about 200. Texas did what Florida did in 1994 and pulled their regulations together, compared them and left the OBRA ones in place in order to get Medicaid funding. Staffing patterns, I believe, are exactly the same in both states, so variance cannot be accounted for by staffing.

Ms. Chmielewski stated that lot of the problems seemed to start in 1994. Her first deposition as a nurse was done in 1994. There was not necessarily a staffing problem in the industry to the magnitude that it is now until that time period. Care levels did not drop, but the perception may have been that they were going to drop because somebody moved some lines on a piece of paper. Litigation was not a big component of life in a facility until after 1994.

Rep. Argenziano stated that in her experience she found that throughout the United States there are differences in staffing from state to state.

Ms. Bourdon continued her presentation:

- The actual total cost per bed now projected to be over \$6,200 per bed.
- It is about \$800 for the rest of the country including Texas. That is a factor of eight.
- Half a billion in the last five years is being paid for these type of claims, 250 million is going to attorneys.

Severity analysis:

- Removed claims \$15,000 and below for the analysis
- Half the claims are \$150,000 or less
- 75% of the claims are \$300,000 and less.
- 20% of claims were in \$100,000 to \$250,000 range
- Out of 12,000 claims in Florida there were only approximately 15 above a million.
- It's not a severity problem as much as it is a frequency problem.

Ms. Virginia Petrie a resident of Westminister Oaks and Member of the Florida Life Care Residents Association discussed how do increases impact private pay residents of continuing care retirement communities.

- As a resident who has contracted to receive nursing home services she shared her concerns as an individual resident of a superior quality community as well as a board member of the Florida Life Care Residents Association Chapter at Westminister Oaks.
- The Florida Life Care Residents Association (FLiCRA) is a singular organization in the state whose membership includes individuals who are receiving assisted living or nursing home care or have continuing contracts to receive such care if it is necessary. Represents a statewide membership of over 9,300 residents living in continuing care retirement facilities from Pensacola to Miami.
- This is a matter of extraordinary public concern that requires equally extraordinary measures to result.
- FLiCRA sincerely encourages everyone who is interested in finding solutions to join us in this comprehensive approach which seeks to guarantee the highest quality of long-term care, protection of residents rights and the lowest cost possible for both residents and providers.
- FLiCRA appreciates the real commercial interest involved in this system. But we cannot compromise the fact that residents of long-term care facilities are the very reason for the facilities in the first place.
- The impact of the increases in liability insurance will cost FLiCRA members more than anyone else.
- Currently based on input from other residents in the state, our members have been assessed as high as \$220 per month in added costs to cover the outlandish premiums being charged for such coverage.
- To the greatest extent possible our recommendations encompassed positions that will continue to protect our important rights at the lowest possible cost to ourselves and those who provide nursing home services.

Mr. Sherberg asked if the rates that are going up to \$220 a month for insurance are for everyone at the property, even the people in independent living?

Ms. Petrie stated that it is for everyone as a resident of Westminister Oaks. We're paying for something we may not be using - the nursing home facilities for years to come hopefully.

Rep. Argenziano asked when was Ms. Petrie informed that the rates would go up and by whom?

Ms. Petrie stated within the last couple of months. She had not spoken with the administrator directly about it.

Mr. Napier, who is the executive director of FLiCRA, clarified that what Ms. Petrie is referring to is specifically at Westminister Oaks in terms of they have not received their increases. Generally, the resident is informed through their administration of what their cost will be in terms of the one example that we used. I think that one was probably back in August when those residents were informed that that would be their assessment to cover the increased liability insurance premium that would be added to their monthly cost.

BREAK

Mr. Connor asked about a discrepancy in the handouts from FLiCRA that stated that Florida has 9,000 nursing home beds for every one inspector while the national average is 1:2000.

Mr. Buigas clarified that there are 264 surveyors in the state for about 84,000 beds (1:318 ratio); but actually there are only 74,000 occupied beds (1:280 ratio).

The discussion turned to the recommendations on home and community-based alternatives.

Mr. Rodriguez asked for a flowchart of how long-term care funds are allocated in the state.

Ms. Fierro asked about what is an entitlement program.

Ms. Chmielewski asked for information about funds expended in each county.

Dr. Polivka introduced the draft recommendations.

The discussion identified the areas of agreement and the areas of concern for each of the recommendations.

Area of Agreement	Area Of concern
Increase affordable assisted living facilities using state and federal financing as available. Use Assisted Living for the Elderly (ALE) Waiver for ALF	ALF subsidy might have a negative impact over time (encourage poor business practices). Remember that 50% of OSS payments go to younger adults
Tie level of need (care to reimbursement levels.	What would it cost to add 1,000 ALE beds Increase in ALE beds would increase costs to CARES, DOEA Increase in ALE beds should be decided in terms of the continuum (e.g. don't increase 1,000 without knowing the full continuum). Don't link OSS and Waiver. Tired system could encourage "gaming" e.g. experience with nursing homes and tiered payment systems. How would a tiered payment system work in a small ALF that served primarily OSS clients (\$697/month increased to \$850/month) Eligibility and reimbursement rates should be tied to Federal Poverty Level (or not tied to FPL) or should include cost of living adjustments. What is the cost of tiers to operators Substitute "level of care" for "tiered payments". Compare ALF and Adult Family Care Homes (AFCH) in terms of statutes.
Increase adult family care homes (especially in rural areas). Increase waiver for home and community-based services.	Need to have home and community based system capacity.
Move Home Care for the Elderly clients into full consumer directed care program.	Merge the current multiple HCBS Waiver Programs into single system to divert from nursing homes. Integrate acute and long-term care. Increase incentives to providers. Managed care is not the same as consumer directed care. Consumer Directed Care (pilot program) currently uses AHCA Medicaid dollars.
Support consumer directed care via vouchers or using existing waiver programs (cash and counseling).	

Restrict Certificate of Need for nursing homes (CON)

Rationale for CON moratorium vs. restrict by % occupancy.

Taking money away from nursing homes (when it is needed, especially with increased acuity of NH residents who remain).
Consider CON limit by county not by region.

CCRC exemption from CON limits

Should CON apply to all NH beds (CCRC, Private Pay, Medicaid) because “every bed eventually can become a Medicaid bed”

Are elders choosing nursing homes in order to get their prescription drugs covered?

Promote long-term care insurance.

Have the four largest LTC insurance companies reviewed staff recommendations for LTC insurance?

What agencies would implement long-term care insurance recommendations?

General concerns

Cost of all proposed recommendations should be understood (to agencies, legislature, staffing, etc.).

Current Medicaid budget deficit will affect the use of Medicaid dollars for HCBS

How will funding recommendations affect overall distributions of NH vs HCBS spending (e.g. 70:30 ratio)?

Does codifying 70:30 split help?

Without increasing HCBS capacity, will NH beds continue to increase?

What agency will administer long-term care programs?

Recommendations should include all ages who need/use long-term care, not just elders (but funding sources can include age-specific programs).

Don't limit choice.

Wary of funding “black hole” for universal home care paid by public dollars.

Break for lunch.

The meeting reconvened at 2:00 p.m.

The principles were amended:

1. *Persons in need of long-term care and their families (consumers) should receive such services in the least-restrictive environment that is practical and consistent with their needs and wishes and one that maximizes their physical, mental, and functional capacity.*
2. Consumer is entitled to a safe and secure living environment that includes public advocacy (e.g., public guardian, ombudsman) to insure protection through all available means.

3. Consumer should have reasonable access to coordinated services from a continuum of care that emphasizes consumer directed choice. Private and public services should be coordinated and access to services streamlined.
4. The public long-term care system will include an appropriate balance between nursing home and community care expenditures. Private planning, insuring, and saving for long-term care should be promoted. Public funding a long-term care should be a supplement. Providers are entitled to an appropriate rate of compensation and taxpayers are entitled to a full and fair accounting.
5. In order to ensure the LTC delivery system truly serves the public interest, all participants in the system must have adequate protection under the law and all participants must act responsibly or face the consequences for failing to do so.

Discussion was started on quality recommendations.

Area of Agreement	Area of Concern
Nursing home quality recommendations are very thorough.	Be sure to identify any Not-for-profit/For-profit differences in quality. Add rehab/improving function. Identify role of all players who have role in promoting quality. Agree on increasing staffing in nursing homes.

The meeting adjourned for the evening.

November 21, 2000

Present: The Honorable Frank Brogan (Chairman), Dr. Gema Hernandez, Mr. Bob Sharpe, Mr. Philip Freidin , Mr. Larry Sherberg, Mr. David Grofic, Mr. Walter Liptak, Mr. Rene Rodriguez, Mr. Ray Noga, Dr. Jeff Dwyer, Ms. Cherryl Chmielewski, Mr. Kenneth Connor, Dr. Joy Calkin, Mr. Ed Boyer, Mr. Robert Miller, and Ms. Victoria Fierro.

Absent: Dr. Jesse Lipnick, The Honorable John McKay, and The Honorable Nancy Argenziano.

Staff present: Dr. Larry Polivka, Dr. Kathryn Hyer, Ms. Jennifer R. Salmon (FPECA); Secretary Ruben King-Shaw, Pete Buigas (AHCA).

The Chairman provided an update on the closing of the six nursing homes and the provision by HCFA that AHCA can terminate contracts without cause.

Discussion with AHCA staff regarding the role of regulators.

Discussion continued on recommendations regarding liability. Areas of concern were identified:

- How would punitive damages cases referred to State Atty. affect numbers of lawsuits in future.
- Timing of reporting (not in middle of litigation) – after verdict

- Secret settlements shouldn't be allowed.
- % of cases plead punitive damages
- Why should provider settlements be disclosed
- Differences if business receives public dollars
- State Atty. does not have dollars to prosecute.
- Prosecuting NHs better deterrent than insurance companies paying out
- Increase in dollars to prosecute NHs more than currently (effect on staff, etc.)
- Don't send civil court decisions to State Prosecutor
- History of secret settlements
- Impact on insurance/increased exposure
- Fines to NHs should be assessed with timelines for collection with canceling/non renewal
- Contracts possible.
- AHCA language on CMP for TF consideration-more aggressive approach.
- Can fines be deducted from Medicaid payments
- Performance improvement included
- % Punitive damages to staffing and training
- Authority within agencies/regulatory
- How do punitive dollars affect NH viability
- How do states with low litigation differ from FL, TX
- Don't tie unsubstantiated complaints to premiums
- Address midrange claims rather than changing ch 400 and prevent most grievous claims (high dollars)
- Deal with atty. Fees provisions to make claims more manageable-often high due to delaying resolution
- Consider mandatory mediation, shorter discovery, fewer costs, and fast tracking resolution.
- Create a threshold for seriousness of the claim
- Read 1st part of FS400 and think about the frail elder
- Need to know what works to improve care before you take 400 away
- Support AARP recommendation to keep 400
- Give draft legislation/proposals to insurance industry to see if there is an impact on liability insurance dollar.
- Number lawsuits (few) are based on patients rights-mostly injury
- Increase staffing to improve care/outcome Med Mal experience in FL and impact on quality and lawsuits
- Med Mal differs from NH cases,
 - o fraud and abuse
 - o Longer cases-frail elder may not survive discovery/litigation
 - o Survivor differences viz recovery
 - o Frail elders in NHs don't have young children or surviving spouse
- Would end litigation against NH
- Set a \$50,000 cap on injury cases or loser pay rule
- Don't set incentive to kill rather than harm resident
- FAHA proposal-protect elders and families but also all participants in NR system
- Offering to arbitrate eliminates exposure to punitive damages
- Using prof. standard could lead to lowest common denominator

- Asking to retroactively affect suits already filed
- Find middle ground between FAHA and AFTA proposals
- Refer to Connor proposal increase reimbursement, etc.
- Need insurance companies to explain position
- Evaluate court ordered atty. Fees
- How does loser pays rule work if loser does not have resources
- Look at all statutes review: abuse and agencies with responsibility AHCA, DOEA, DCF, Ombudsman
- Need to integrate form atty. the public guardianship/ombudsman role in process-other state example.
- Clarify ombudsman program “Bull dog”
- Add resident right advocate who is not politically appointed or has to report to government
- Include quality improvement use carrot approach
- Address presuit mediation, screening etc. but fast-track cases

The meeting ended around 12:30 p.m.

Respectfully submitted,

Pam Stobaugh and Jennifer R. Salmon
Florida Policy Exchange Center on Aging

Approved December 18, 2000

AGENDA

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

Wolfe University Center, Florida International University, 3000 NE 151st Street, North Miami
(305) 919-5800 (day of meeting only)

BUSINESS MEETING DECEMBER 4, 2000

This meeting will be tape-recorded and transcribed for the public record.

9:00 Welcome to Florida International University:

Dr. Raul Moncarz, Vice-Provost, Florida International University

Old Business

Lt. Governor Frank T. Brogan, Chairperson

Accept or amend minutes of the October 30-31 and November 20-21 meetings

New Business

Lt. Governor Frank T. Brogan, Chairperson

9:15 Kathryn Hyer, Ph.D. and Christopher E. Johnson, Ph.D., Quality of Nursing Home Care

9:45 Task Force Discussion: Quality of Nursing Home Care Recommendations

Resource Panel Available to Task Force Members to respond to questions regarding recommendations:

Florida Policy Exchange Center on Aging: Kathryn Hyer, Christopher Johnson, and Larry Polivka

Agency for Health Care Administration: Secretary Ruben King-Shaw, Pete Buigas, and Molly McKinstry

12:00 Adjourn for Lunch (Task Force Members Provided Box Lunch)

1:00 Task Force Discussion: Finish Discussion on Recommendations for Quality of Nursing Home Care and Home and Community Based Alternatives (left over from November meeting)

Resource Panel Available to Task Force Members to respond to questions regarding recommendations:

Florida Policy Exchange Center on Aging: Kathryn Hyer, Christopher Johnson, and Larry Polivka

Agency for Health Care Administration: Secretary Ruben King-Shaw, Pete Buigas, and Molly McKinstry

Department of Elder Affairs: Marshall Kelley; Eric Haug

2:45 Business Meeting Adjourned

3:00 Public Testimony

6:00 Adjourn

AGENDA

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

Wolfe University Center, Florida International University, 3000 NE 151st Street, North Miami
(305) 919-5800 (day of meeting only)

BUSINESS MEETING DECEMBER 5, 2000

This meeting will be tape-recorded and transcribed for the public record.

9:00 Insurance Panel: Sterling Shuttlesworth, Underwriter, MedMarc Casualty

9:30 Mary Oakley, M.A. and Christopher E. Johnson, Ph.D., Liability and Long-Term Care Viability

10:00 Break

10:15 Task Force Discussion: Liability Recommendations

Resource Panel Available to Task Force Members to respond to questions regarding recommendations:

Florida Policy Exchange Center on Aging: Mary Oakley, Christopher Johnson, Hongbin Chen, Larry Polivka
Agency for Health Care Administration: Secretary Ruben King-Shaw, Pete Buigas, and Molly McKinstry
Defense Attorney: Andrew McCumber, J.D.
Plaintiff Attorney: Sean Domnick, J.D.

12:00 Adjourn for Lunch (Task Force Members Provided Box Lunch)

1:00 Task Force Discussion: Finish Discussion on Liability Recommendations and Draft Final Recommendations

Resource Panel Available to Task Force Members to respond to questions regarding recommendations:

Florida Policy Exchange Center on Aging: Mary Oakley, Christopher Johnson, Hongbin Chen, Larry Polivka
Agency for Health Care Administration: Secretary Ruben King-Shaw, Pete Buigas, and Molly McKinstry
Defense Attorney: Andrew McCumber, J.D.
Plaintiff Attorney: Sean Domnick, J.D.

5:00 Adjourn

MINUTES

Task Force on Availability and Affordability of Long-Term Care

December 4-5, 2000

Wolffe University Center, Florida International University, N. Miami

December 4

Present: The Honorable Frank Brogan (Chairman), Dr. Gema Hernandez, Mr. Bob Sharpe, Mr. Philip Freidin, Mr. Larry Sherberg, Mr. David Grofic, Mr. Walter Liptak, Mr. Raymond Noga, Dr. Jeff Dwyer, Mr. Rene Rodriguez, Dr. Jesse Lipnick, Ms. Cherryl Chmielewski, Mr. Kenneth Connor, Dr. Joy Calkin, Mr. Ed Boyer, Mr. Robert Miller, and Ms. Victoria Fierro.

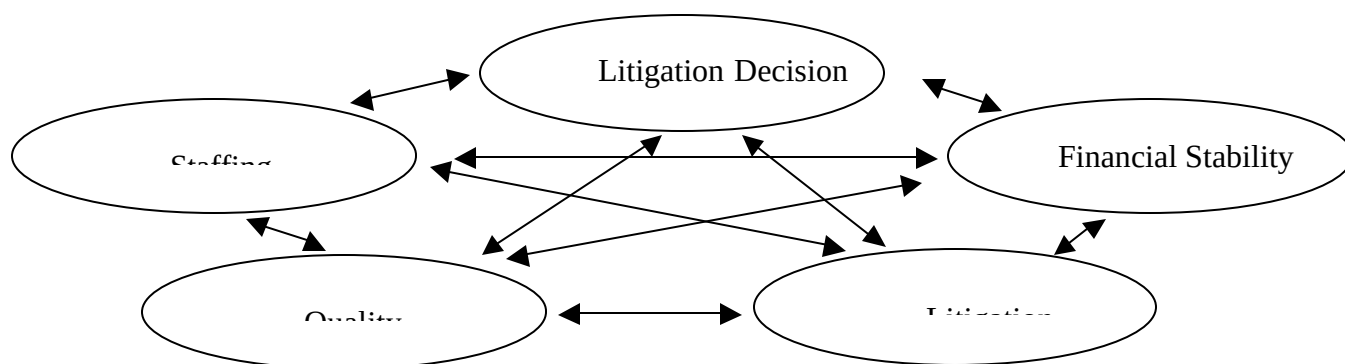
Absent: The Honorable Nancy Argenziano, The Honorable John McKay.

Staff present: Dr. Larry Polivka, Dr. Kathryn Hyer, Ms. Mary Oakley, Ms. Jennifer R. Salmon (University of South Florida); Dr. Christopher E. Johnson (University of Florida); Secretary Ruben King-Shaw, Mr. Pete Buigas, Molly McKinstry (Agency for Health Care Administration).

Dr. Moncarz, Vice-Provost, Florida International University welcomed the Task Force to the North Miami campus.

Dr. Kathryn Hyer and **Dr. Christopher Johnson** presented information on quality of nursing home care. Dr. Hyer stated that:

- Shared concern with Task Force members that quality of care in nursing homes is addressed and balanced with affordability and availability of services.
- Over 75,000 residents in 700 nursing homes in Florida.
- Quality of care is more than a lack of deficiencies.
- Residents care about autonomy, dignity, privacy, security, and to be known as a person.
- Regulations will not achieve quality because we regulate at a minimum level.
- Goal is to have useful choices between facilities and to have clear measures of quality that can be understood.
- Nursing home residents in Florida:
 - Higher acuity compared to the U.S.
 - 50% higher Medicare rate than in the U.S.
 - Minutes per patient needed are higher
 - Higher disability in activities of daily living and chronic conditions
 - More cognitive impairment
 - Require more skilled care
 - Require more personal care
- Of the top ten deficiencies in the U.S., Florida:
 - Better in restraint free care
 - Provides more pressure sore care
 - Fewer deficiencies on pressure sores
 - Worse on supporting resident dignity



Dr. Johnson described the statistical model to understand predictors of quality of care:

- Simultaneous equation model
- Based on OSCAR dataset—best available on US nursing homes.
- Hypothesis tested: the following variables would explain poor or good care measured as total deficiencies, in house skin sore development, and substandard care:
 - Pressure sores
 - Medicaid rates
 - Mission (profit/not-for-profit)
 - Staffing
 - Drug errors

Mr. Connor asked why the hypothesis was stated in terms of quality affecting in-house skin sores rather than vice versa?

Dr. Johnson stated that the hypothesis suggested that as in-house skin sores increase, the number of quality decreases. He then described the findings from the analyses:

- Results:
 - Higher number of deficiencies was related to: Medicaid patient ratio, low staffing, in-house skin sore development, and drug errors
 - In house skin sore development related to: Low staffing and drug errors.
 - Substandard care related to: in-house skin sore development.
 - No not-for-profit effect: possibly because the OSCAR variables don't measure other areas of quality that may be important (e.g. the culture of the nursing home).
- Limitations:
 - Dependent variables are collected by surveyors: the people collect the data are the same people who give citations.
 - Solution is to use an outcome variable like in-house skin sore development.

Dr. Hyer described the goals of quality of care:

- Ensure a culture of care in nursing homes that values residents, families, workers, and volunteers.
- Create incentives to improve quality of care in long-term care
- Change the community standard of care by providing family and residents better access to information about quality of care in nursing homes.

She then outlined the ways that each goal could be met:

- Ensure a culture of care in nursing homes:

- o Improve AHCA's ability to close poorly performing facilities
- o Increase staffing levels of CNA, LPN, and RN
- o Increase training of direct care providers
- o Increase medical and advanced practice nurse presence in nursing homes
- o Change the rules for Medical Directors to ensure more and better medical care
- o Encourage innovative models of care
- o Create Caregiver Institute
- Create incentives to improve quality:
 - o Increase Medicaid reimbursement rates
 - o Provide incentives through Medicaid to reward better performers
 - o Create more public presence: ombudsman program
 - o Develop Master clinicians and administrators as mentors
 - o Mandate a Risk Management program
- Mandate a Risk Management program:
 - o Require approach to avoid risks (e.g., falls prevention, training on difficult behaviors)
 - o Systematic quality monitoring and improvement in monthly QA meetings
 - o AHCA must review program during survey to ensure the process exists
 - o Quality monitors to focus on "watch list" facilities: 11-12 former surveyors who are nurses were included in HB 1971 to work with facilities that are on the watch list or had a recent change of ownership.
- Change the Community Standard of Care:
 - o Increase information availability and educate consumers and residents
 - o Create a system to rate all nursing homes using the Gold Seal criteria: now, the Gold Seal is for the top 5% of nursing homes; we think that the other 95% should be rated on the same criteria (staff stability, staff training, and staff ratios).
 - o Disseminate information about nursing homes widely on the Internet
 - o Develop a nursing home volunteer training program.

Task Force member asked what was DOEA and AHCA's positions on staffing.

Secretary King-Shaw stated that the single most important indication of quality is staffing. You develop rules and requirements for qualifications of medical director but also for the CAN, LPN, and RN because they are the bulk of clinical care delivery. Providers are concerned about the costs associated with staffing; but it is part of their clinical obligation and operation responsibility. If AHCA can enhance and support it, everyone wins.

Secretary Hernandez stated that the issues are: staffing should be associated with the degree of frailty of the patient; use of technology to improve the environment and decrease need for staff; and finding good staff.

Mr. Liptak asked if the national comparisons of deficiencies are comparable: do states collect the data the same way; how frequently are nursing homes surveyed.

Dr. Hyer stated that HCFA itself questions whether or not the standard is applied the same across states, even with in-depth training. Nursing homes are required to be surveyed annually (within a 9-18 month time frame) or if there is a complaint.

Dr. Calkin stated that the providers are concerned about surveyors providing feedback for improving facilities as well as identifying deficiencies; need to have a more reliable measurement (over time and between surveyors); perhaps need to improve surveyor training.

Mr. Buigas stated that AHCA met with the industry to identify 20 critical deficiencies for them to focus on. They also had joint training sessions with the industry and surveyors.

Dr. Lipnick asked about how quality is measured. The presentation used pressure sores and medication errors. These are appropriate for debilitated sector of the population—people who are so demented they can't get out of bed. These yardsticks aren't applicable to the whole nursing home population. Why not include attaining a higher functional level or returning to the community? His concern was to not presume functional decline.

Dr. Johnson stated that they would have liked to include those other variables but the data were not available. They can use a variable like mobility to control for the level of function in a facility.

Dr. Hyer stated that OSCAR is citation and survey data and not individual medical data. For example, in-house pressure sore development is based on the facility census not on individuals.

Secretary Hernandez stated that they should not assume nursing home residents are going to deteriorate but to look at maintenance. We need to be sure there are followup assessments of residents once they are placed in a nursing home. For example, DOEA/AHCA have been assessing residents in nursing homes for as long as two years and 25 clients were able to be moved out and into the community.

Ms. Chmielewski stated that she goes on surveys all the time, and AHCA does look at restoring residents. There are 500 tags (possible citations). The Task Force should be aware of the existing standards of care before offering different ones. A good facility is already doing many of the things that have been brought up under quality voluntarily without legislative mandates. In terms of pressure sores, most of them come with the resident from the hospital. In addition, just increasing RNs doing patient care or giving medicine, won't improve care because they are not the best at that—better at delegating. The CNAs are only as good as the LPNs and the LPNs are led by the RNs who are led by the administrator. CEUs should be in geriatric care.

Mr. Rodriguez asked what recommendations are administrative vs. legislative? What are the data suggesting?

Dr. Johnson stated that the data say the higher number of Medicaid beds is related to deficiencies but we aren't sure why. It could be lower reimbursement levels.

The Chairman likened the issue to poorer and more affluent children in school; the poorer children do not do as well and yet we should still hold schools to the same standards. For nursing homes with a high Medicaid population, they should still provide good care.

Mr. Connor noted that incentives to providing care should include both carrots and sticks; the recommendations here are all carrots. In addition, looking at how Florida compares to the U.S. over time, note that between 1994 and 1995, there is a drop which could be related to major

changes in the state regulations of nursing homes which had been more process oriented. In looking ahead to changes in the tort system, it can not be done without sufficient sticks as incentives. For example, there is a need to increase staffing but there should also be consequences for nursing homes that fail to maintain sufficient staffing.

Dr. Hyer stated that AHCA's ability to close down poor performing facilities is important.

Mr. Connor stated that providing the "death penalty" for a facility is a radical measure and that intermediate steps could increase quality of care without dislocating residents.

Secretary Hernandez asked what staffing ratios were being recommended and are they related to time of day and amount of resident activity.

Dr. Hyer stated that these are addressed in the recommendations.

Mr. Sherberg asked about the association between income and frailty.

Secretary King-Shaw stated that there is a correlation between poverty and illness; in addition education is a predictor.

Mr. Sherberg observed that the poor frail elders are entering the system differently than the more affluent and less frail. So if a facility has mostly Medicaid residents and they are frailer and they are getting reimbursed at a lower rate, so staff get less pay, so everything isn't equal even if it should be.

Dr. Hernandez stated that Medicaid recipients have many alternatives. 80% of CARES evaluated clients are in HCBS and not in nursing homes. Private pay have fewer options because there are fewer services in the community for them to purchase.

Dr. Calkin asked for clarification on some points that had been stated: aren't nursing home residents assessed regularly? In addition, doesn't Florida have a very high discharge rate to lower levels of care?

Dr. Hyer stated that the discharge rate is high in Florida but nursing homes have two populations: subacute/transitional care (rehab) residents who stay for 30 days (and was the reason nursing homes were making use of Medicare financing); and long-stay residents. The question is whether there is a difference between Medicaid and Medicare patients—both appear to be very frail.

The remaining discussion prior to the Public Testimony was in regard to the Policy Recommendations Worksheet for Task #3: Factors that Affect Nursing Home Quality ("blue sheets").

The recommendations comments are listed below:

Recommendations Received:	Comments
Staff: 1) Ensure a Culture of Care in Nursing Homes that values residents, family, workers, and volunteers:	
A. Increase the visibility and importance of direct care workers in long-term care i. AHCA, DOEA and the Governors office should work with the industry and educational institutions to create public information campaign stressing the value and importance of direct care providers, especially CNAs and other paraprofessional staff. i. Develop CNA awards given by Governor at an annual event.	• Is there a reason for leaving out family caregiver? • Focus on the status of workers in long-term care is not high which makes it difficult to recruit. • The family caregivers are addressed in the alternatives section.
B. Provide AHCA with the authority to close chronically poor providers i. Eliminate chronically poor performing nursing homes. Require a thorough analysis and report on the federal and state requirements for taking over or closing poor performing nursing homes. Based on that analysis, develop legislation to expedite that process. If federal barriers are identified, develop recommendations and work with Florida's congressional delegation to eliminate those barriers. ii. Increase the authority of AHCA to collect fines imposed and approved.	• Need to define chronically poor providing providers. • AHCA would need to help with that definition. • Chronic can mean different things to different people. The recommendation could be to have AHCA make that determination. • The recent action to close 6 chronically poor providers was unsuccessful because of court action. • Need to address this issue in terms of the State purchasing substandard care. • The state used a two year period of poor care to define "chronically poor performing." • Result: 2 facilities are closed; 200 individuals are no longer in substandard facilities; the remaining 4 facilities proposed how they would implement quality improvement programs. • Problem with HCFA not honoring their rules that allow the State to close a poor provider without cause. • Medicaid contracts all have expiration dates. • It would be helpful to have recommendations that support this position. • No one disagrees with this position. • But need to be very careful with the contract language. • Are we having trouble collecting fines? • CMPs are another stick • The feds are involved in collecting the fines; some are in litigation. • Need to have the fines occur right after they happen if you want to have an impact. Could make it a precondition of licensure. • There is a PR impact of fines and penalties that can be more severe than actual fine amounts. The press will cover it.
C. Establish and pay for New Mandated Levels of direct care providers: Adopt the HCFA minimum staffing levels for CNA, LPN+ RN, and RN hours per resident per day. i) Establish CNA level at 2.0 hours per resident per day ii) Establish nursing levels (LPN and RN) at .75 hours per resident day iii) Establish the RN level at .20 hours per resident per day.	• Need to tie mandated levels to Medicaid reimbursement levels. • Are these AHCA or DOEA initiatives? • The JTPA training for older workers to become CNAs was cancelled. Need funding from the DOE or welfare to work programs. • This would be state action.

Recommendations Received:	Comments
i. Create innovative approaches to meet need for direct care staff. Allow flexibility to minimum staffing levels rule to meet the needs of residents, not based on three shifts each day. Allow nursing assistants who are in the four-month federal window of training to be counted in the state staffing calculations. Clarify the reciprocity process for CNAs. Ensure that Welfare to Work programs emphasizes the value of CNA and long-term care work and consider mandating a portion of dollars for long-term care training. Continue programs like the Florida Health Care Association's "Train the Trainer" course developed under the Enterprise Florida Jobs and Education Partnership Grant to prepare nursing assistants for the CNA certification exam in member facilities. ii. Increase the minimum staffing levels by 10 percent per year for the next three years to accommodate the sicker and older population of residents and to give homes the ability, and the time, to make necessary changes.	• Concerned with allowing a professional who is not certified to act as if they were certified. • What happens if funding for higher staffing doesn't happen? Don't want to put facilities in jeopardy or greater debt by mandating something that isn't funded. • Funding and mandates should be joined. • With limited funds, is it more important to meet the minimum levels for CNAs or LPNs? (consensus: CNAs more important). • Could the uncertified assistants still be counted if they are assisting the CNAs with bed making, transporting, etc. Or allow two uncertified nursing assistants = 1 certified. • Study has shown that to make the most difference, increasing the RN positions has greater impact. • Add recommendations regarding immediate moratoriums on facilities that have insufficient staffing; failure to meet staffing levels 4 times in a 90 day period, it is a third degree misdemeanor. • Is the 10% increase a year related to where you are today or to a minimum standard?
D. Improving Training of direct care providers: i) For professional staff without geriatric certification require an orientation program that includes geriatric training of 20 hours during the first two months. ii) Improved educational opportunities for direct care workers, including establishing career ladders for that majority of workers who wish to continue working as hands-on caregivers. iii) Increase education requirements from 12 to 18 hours annually for direct care providers with a focus on patient care delivery. Require 6 hours of training with behaviorally challenging residents. Require staff to attend 5 hours of risk prevention training each year that are based on the risk management protocols iv) Train direct care staff or volunteers working with cognitively impaired clients for more than 50% time in a training program similar to the required DOEA program for ALFs within the first six months of employment or time in the facility.	• AHCA and the Board of Nursing would both be involved in setting up the requirements. • And training institutions. • Doctors and nurses do not necessarily have geriatric training. • Does this include professional or direct care staff? • Shouldn't the 20 hour requirement be for anyone who is in direct contact with residents? • But why would you make someone with a 4-year degree, internship, and residency, and make them sit for 20 hours more. • Should the standards and training be left to the associations? • Recommend competence training for direct service staff. • FAC 5990-4.1 (6) specified staff education requirements for nursing care but were stripped out (in 1994). The old rules required content on: skills, methods, and techniques related to provision of care and services of residents: psycho social needs, rehabilitative and restorative services, physical needs, observation of changes, etc. • AHCA does require nursing homes to show education and a full calendar of training on the topics just mentioned. • In terms of nursing hours and education, perhaps make it a gold seal standard. • If MDs don't have these requirements, would they be cited?

Recommendations Received:	Comments
	• Need to mandate that a MD with geriatric and rehab experience should be in each NH. • There are three in Florida with geriatric and rehab experience. How realistic is it to ask for both.
E. Improve the clinical care by increasing the presence of primary care providers as advanced practice nurses, physicians assistants, geriatric clinic nurse specialists and Medical directors i) Require nursing homes with more than 120 residents to have an advanced practice clinician or physician assistant or physician on staff. ii) Mandate changes in Medical Director Role for background and education to comply with recommendations by FMDA iii) Create credentialing criteria for Medical Director and physicians to serve residents of nursing homes.	• 120 beds or residents? • Need to consider an average percent occupancy. • What does “on staff” mean? • Would it be reimbursable by Medicare and Medicaid? • AHCA is considering the rule change on medical directors which would also be part of the risk management program.
F. Ensure prevention is incorporated into the ongoing clinical care i) Require immunizations for flu and pneumonia as appropriate. ii) Build appropriate prevention programs, such as decline in ADL, into the risk management protocols. iii) Create standards of prevention. Have nursing homes document what preventive programs they have for malnutrition, dehydration, pressure ulcers, falls, and fractures and make funding/reimbursements consistent with these types of programs	• Are immunizations for staff or residents or both. • AHCA already asks to see flu shot documentation during survey. It is good practice. • What about short supply of vaccines? • What about staff or residents who don’t want to be inoculated? • What about CDC policy? • Does this apply to ALFs too? • Who will pay for the flu shot? • Need more information on this one •
G. Provide grants for facilities committed to “de-institutionalizing” and changing the culture of long-term care, through i) Adoption of the Eden Alternative, Regenerative Community, and other resident-centered philosophies and approaches to care with demonstrated results. ii) Encourage and support renovation of nursing home buildings to replace traditional dormitory/hospital layout, with designs that create smaller, “neighborhood” type units with 9-20 residents with single rooms and bath	• Are these not issues to be addressed under alternatives? • Is there funding for renovations? • Would this be through DOEA, DCA, AHCA? • Are there more details about these resident-centered programs? • Good facilities already do this; if you give bonuses or grants to those who haven’t been doing it, they may not do it well but get rewarded for it.
H. Require palliative care and hospice services in NH	• No argument on this one.
I. Improving Stability of Staff in Nursing homes: i) Provide bonuses to homes that have maintained staffing turnover ratios in the bottom 25 percent of homes in the state. ii) Provide more points in rating system to places with lower turnover, especially key staff such as Nursing home administrator, Director of Nursing, Medical Director.	• These are all my carrots (Connor) • These elements are largely included in gold seal. • Not a high standard to reward the bottom 25% (low turnover). • Better than bringing in agency people (temps) who cannot provide continuity of care.
J. Develop a Caregiver Institute (for professional caregivers) through DOEA, which would provide professional development and training on caregiving techniques.	• No comments

Recommendations Received:	Comments
K. Study the current regulatory and review systems to ensure its impact on quality of care to address the following issues: i) AHCA has recently implemented a number of changes in the operations of the offices charged with regulatory oversight of nursing homes. These changes should be evaluated and a determination made whether additional changes are required to ensure that this process works as well as possible. ii) Study the regulations – how they are written, their intent and most importantly, their outcomes. iii) Study how the shift regulatory focus from program process and structure variables (staffing levels, admission criteria) to outcome measures (consumer satisfaction, and quality of life measures related to the values of autonomy, privacy and dignity) would affect quality and performance. Consider the implication of tying licensure and reimbursement to outcome measures.	• How could this study be done? • Perhaps this should be under Task #1—a long-term care oversight panel. •
2) Create incentives to improve quality of care in long-term care:	
A. Require a thorough report on the status and impact of each of the provisions included in HB 1971. Evaluate what has and has not worked and why. Use that information to make recommendations that build on what has already been successful.	
B. Medicaid reimbursement should be adequate to cover costs of care but reward better performing nursing homes with an additional 10 percent per diem Medicaid bonus to any homes that have not been on AHCA's watch list for the past 30 months.	• Very much in favor of paying for performance.
C. After establishing appropriate baselines, adopt legislation to charge facilities for repeated re-visits and complaint surveys.	• Facilities that need to be surveyed repeatedly should pay the cost.
D. Provide Medicaid reimbursements for mental health care in long term care facilities	
E. Increase the Community Presence in nursing homes iv) Increase funding for paid staff in Ombudsman Program to allow expansion of program. Ombudsman should study the feasibility of sharing complaints and resident satisfaction information with facilities on an ongoing basis to improve quality and resident satisfaction with care. Report would be due Jan 2001. There should be one or two ombudsmen in each nursing home. i) Increase funding for public guardians to protect the interests of cognitively impaired nursing home residents. ii) Family involvement: Annual Governor's award for the most creative way facilities have improved family or community involvement within the NH	• How about locating the ombudsman directly in the nursing home? If so, would they take on the personality of the facility rather than be independent? • When residents see the ombudsman more, they relate to them better. • This is supported by the IOG reports. • Need to improve and automate the complaint system. • Ombudsman program is a volunteer program. • To have 1-2 ombudsman per facility would require a 100% increase. • They should be mediators not regulators. • How about increase it 10% a year over 3 years. • No comments on guardianship or family involvement.
F. Encourage the nursing home industry to develop a Mentoring and Master Clinician program that allows outstanding clinicians, nursing home administrators and/or Medical Directors to compete to be Mentors and Role models for others. Match these mentors/master level clinicians and administrators with the poorly performing facilities. Ensure that an evaluation of the mentors is conducted by the problematic facility.	• Not mandate this but expect facilities to meet with the Gold Seal program and get names of individuals who can provide technical assistance.

Recommendations Received:	Comments
G. Mandate a Risk Management Program that requires systematic quality monitoring and improvement. AHCA must review program during survey to ensure the process exists. i) Increase AHCA funding for more quality monitors to ensure that the monitors can work with nursing homes on the watch list to quickly implement the mandated risk management. ii) Strengthen quality assurance requirements and create related training opportunities for facility-based quality assurance teams. iii) AHCA should establish a list serve for facility quality assurance team members to use to share ideas and ask questions iv) Require nursing homes to convene monthly Quality Assurance meetings to assess patient care practices and to respond quickly to identified care delivery problems. Provide legislative protection of QA records and information in accordance with federal Nursing Home Reform Act provisions to ensure a proactive, energetic and meaningful QA process. v) Requiring quality assurance/risk management review of records by the Medical Director with respect to medical care.	• Suggest risk management programs for facilities on the nursing home watch list. • Target specific types of ALFs or those with an ECC license.
H. Provide funding to the Teaching Nursing Home at Miami Jewish Home and Hospital to become the state model that works with other education and training institutions to replicate high quality care throughout Florida.	• No comments.
I. Provide incentive funding to Medical, nursing and social work programs that develop curriculum and new clinical rotations in nursing homes	• No comments
J. Revive the current Nursing Scholarship Program (which has been in limbo for five years) by changing the focus. Make scholarships available to nursing students who agree to work in a nursing home setting. Specifically, a nursing home provider would sponsor a student by paying one quarter of the annual scholarship (\$2,000) with the State paying rest (\$6,000). In return, the student will agree to engage in full practice of nursing with that facility for twelve months for each year of scholarship.	• No comments
3. Change the community standard of care by providing family and residents better access to information about quality of care in nursing homes. A. Provide major awards to outstanding providers at public ceremonies attended by high-ranking officials. B. Create a system to rate Nursing Homes. Ensure implementation of Gold Seal Program and establish a mandatory rating system for remaining facilities. Facilities should report the same information as is required by Gold Seal including: staffing, financial information, training of staff, stability of key staff, overall turnover rates, etc., citations by year for the last three years. C. Widely disseminate the Nursing Home Compare Guide i) Make staffing levels a public record so consumers can determine where they should place a loved one ii) Make all survey and quality data public and available on the internet D. Develop a nursing home volunteer training program to be directed and developed by a consumer group related to LTC. Include information on how to support residents, specific training for any single task support authorized by the Legislature (like feeding assistance authorized in HB 1971), and information on how to report complaints or interact with the state regulatory	• No comments.

Recommendations Received:	Comments
system for the protection of residents. Outreach programs can be developed to increase volunteers in facilities.	

Mr. Connor asked that recommendations he submitted under liability be considered in the quality section: 1) electronic surveillance; 2) reinstituting the state regulations that were removed in 1994; 3) punitive damage verdicts be automatically forwarded to the State Attorney; 4) 25% of punitive damages be put in a trust fund to investigate elder abuse cases; 5) moratorium on facilities with insufficient staffing along with penalties for failure to maintain staffing levels.

Task Force members responded with the following comments regarding Mr. Connor's suggestions:

- Is the 25% of punitives for a trust fund legal?
- Privacy concerns for electronic surveillance.
- Staff's privacy?
- What about the placement of the camera?
- Who pays for the surveillance?
- What about a Medicaid resident who wants the surveillance? Who pays?
- When you make low staffing a crime, need more specific language.
- The automatic referral to the State attorney's office may have a staff and resource impact (Mr. Connor: this would only be for punitives applied to cases at the level of manslaughter).

Business meeting adjourned for the day to allow time for public testimony.

December 5, 2000

Present: The Honorable Frank Brogan (Chairman), Dr. Gema Hernandez, Mr. Bob Sharpe, Mr. Philip Freidin, Mr. Larry Sherberg, Mr. David Grofic, Mr. Walter Liptak, Mr. Raymond Noga, Dr. Jeff Dwyer, Ms. Cherryl Chmielewski, Mr. Kenneth Connor, Dr. Joy Calkin, Mr. Ed Boyer, Mr. Robert Miller, and Ms. Victoria Fierro.

Absent: Mr. Rene Rodriguez, Dr. Jesse Lipnick, The Honorable Nancy Argenziano, The Honorable John McKay.

Staff present: Dr. Larry Polivka, Dr. Kathryn Hyer, Ms. Mary Oakley, Ms. Jennifer R. Salmon (University of South Florida); Dr. Christopher E. Johnson (University of Florida); Secretary Ruben King-Shaw, Mr. Pete Buigas, Molly McKinstry, and Carol Shotwell (Agency for Health Care Administration).

The Chairman reconvened the Business Meeting.

After a discussion of logistics for the last meeting in Jacksonville, it was decided to have one day with two hours of public testimony.

A discussion about the changes in the administrative code in 1994 ensued.

Mr. Connor asked that the Task Force look at FAC 59A and see how the regulations on direct care were stripped.

Ms. Chmielewski stated that the HCFA (Federal) regulations cover the same areas that were stripped and the surveyors will give her a tag if the rule isn't met.

The Chairman asked why wouldn't the State want the federal rules in the state statutes/rules?

Ms. Chmielewski stated that the surveyors follow the stronger rules.

Mr. Connor stated that the earlier rules were process driven and not outcome driven. They are specific about the kind of care that is required (e.g. position changes every 2 hours for people confined to a bed).

Mr. Buigas stated that the crisis in care since 1994 is not necessarily related to the rule changes in 59A. The legislative streamlining process was to remove rules that were already established elsewhere in FAC or in Federal code. And these rules at the federal level include both process and outcomes.

Mr. Connor provided additional information on surveillance cameras, referrals to state attorneys office similar to the discussion at the end of December 4th (see transcript).

Ms. Fierro brought up the following concerns:

- Clinical screening of dementia patients (L.A. County project) to divert them from nursing homes.
- Need a higher level of accountability for community-based programs because clients will be in remote settings and have the potential of being exploited.
- Minimal staffing standards discussed yesterday were the lowest threshold in the HCFA study; the NCCNHR standards are more appropriate even if it costs more.
- Recertification of CNAs; need to have at least 8 hours of paid work as nursing assistant within a two year period.
- ALFs should have annual inspections
- Need a substantive increase in surveyors to manage this increased inspection load.
- If Medicaid and Medicare provide relief from liability insurance increases, then settlements should be reported to the public.

Mr. Connor asked if staff will be drafting legislative format for the meeting on December 18th or if we're going to need to do it. I would want them in advance of the final meeting.

The Chairman stated that if there isn't an outright rebellion over a recommendation that's been made, even if there are obvious disagreements about that recommendation, it should be included so that this body can determine it in an official way. It would be nice to have a consensus at our last meeting but it may get down to an up or down vote. It is up to the agencies (AHCA, etc.) to decide to promulgate a rule.

Mr. Connor asked if the Chairman was saying that drafting legislation and final analysis needs to rest in the hands of the people of the legislature.

The Chairman agreed: absolutely.

Break.

The Chairman reconvened the meeting and asked about logistics for the last meeting and voting on the regulations. Mr. Connor suggested a 2/3 majority. Mr. Liptak suggested a simple majority.

Mr. Sherberg made a motion to use a simple majority to vote on recommendations on December 18th. The motion was seconded by Dr. Calkin. The motion passed: 10 in favor; 4 against; 4 absent; the Chairman abstained.

Mr. Shuttleworth, CEO of Uni-Ter Underwriting Management Corporation and Contracted Party for MedMarc addressed the reason for the flight of companies willing to provide professional and general liability insurance to nursing homes and assisted living facilities:

- Insurance market for long-term care is small. Of the 300 carriers, only 20 cover long-term care. Of the 100 re-insurance companies that provide for capacity (large claims), only 6 cover long-term care.
- Carriers cannot operate without reinsurance who provide 20%-50% of the risk.
- Surplus lines companies also need reinsurers for capacity.
- MedMarc specializes in long-term care facilities. They insure small independent chains (1-5 facilities), both for profit and not-for-profit. In determining risk for providing insurance to these companies, they have these criteria:
 - Clinical issues: they conduct an extensive survey with each facility and look at their standard of practice, policies, documentation, training, OSCAR, HCFA 672 forms, hiring practices.
 - Rate on acuity level of residents (not per bed).
 - Financial reports and claims history for past 5 years.
- They have been in Florida for two years and are the last admitted carrier (admitted carriers must file their rates with DOI whereas surplus lines carriers can maneuver their rate structure quickly).
- At an unofficial meeting 8 months ago, several reinsurance companies met with the Governor and Secretary King-Shaw and told them that because of FS 400, the size, frequency, and severity of losses were out of control. They suggested instituting risk management. At the time, they predicted that if there were not changes, Florida long-term care facilities would not have coverage by the end of 2000.
- Followup meetings revealed that there were no changes so the companies have pulled out as they forewarned.
- None of the six reinsurance companies will provide reinsurance.
- MedMarc is canceling its policies as of 2/2/01 (they currently insure 100+ facilities in Florida). There are not able to provide coverage under the current statutes.
- The carriers are not in Florida because they don't have the reinsurance behind them.
- Aon and all actuarial studies have reported that they can't calculate loss cost; they can't anticipate what losses will be.

- In Florida, General and Professional Liability Insurance for long-term care is uninsurable as a profit-making business.
- One option to consider would be to change the law to split custodial and medical exposure, placing medical rights under Chapter 766 and placing meaningful limitations on liability.
- The carriers will have to believe there is a reduction in litigation and awards to return.
- Need to move to risk management in every facility.
- If these two things are done, the industry would have some means of coming back.
- If these things are not done, they won't participate in Florida.

The Chairman asked for clarification on what was being asked for.

Mr. Shuttleworth stated that risk management is not just reducing losses but helps residents and owners. Hospitals have benefited from this approach.

Mr. Noga asked if the high insurance applies to not-for-profit and for profit homes. He stated that without insurance, this will affect their ability to get bonds (or defaulting on bonds).

Mr. Shuttleworth said that it is the same problem because of the lack of access to reinsurance.

The Chairman asked about risk pooling and bonds.

Mr. Noga stated that some will permit pooling; but some won't because they don't want you to share risk with others who have lots of exposure.

Mr. Liptak asked if Mr. Shuttleworth accepts risk for MedMarc and manages it and if they are permitted to have mid-term cancellations.

Mr. Shuttleworth said that admitted carriers don't have the right to cancel, they are non-renewing policies. Surplus lines carriers can cancel mid-term.

Mr. Liptak asked why they couldn't separate their exposure.

Mr. Shuttleworth said that actuaries don't distinguish between the types of facilities.

Dr. Calkin asked about several issues that had been raised: 1) disclosing settlements, 2) selling or giving a facility back to the state; 3) putting all the good facilities in one pool and bad facilities in another pool; 4) is this a US or a Florida problem (is the whole market walking away)?

Mr. Shuttleworth stated:

- They require a bonified loss history from other carriers back 5 years whether they are disclosed or not.
- If the property is sold, the previous nursing home culture usually remains at least until new management takes hold so the facility would still not be insurable.
- Rate making takes into consideration the law of large numbers—both good and bad—to obtain a balance. Pooling provides adverse selection.

The Chairman asked why facilities with no litigation history still have increased rates?

Mr. Shuttleworth said that it was like auto insurance: an individual may feel he is at low risk but insurance carriers take into account the whole universe. And in Florida, there is this anomaly: the Chapter 400 statute and the high awards. In order for rates to come down, the process needs to change. In terms of the national problem, carriers are aware of the changes in health care generally but other than in Florida or one or two other states, MedMarc is doing well for now.

Ms. Fierro asked how long it would take for insurers to come back if there is tort reform (i.e., with the specter of the “tail”). She asked if there need to be other recommendations in addition to tort reform to cover the next few years before tort reform affects carrier decisions. And what will happen to the facility that still can’t get insurance?

Mr. Shuttleworth stated that the tail is a significant issue. They can’t guarantee how long it will take them to return. If reforms could affect the tail, that would help them to speed up the return. Need to materially demonstrate that there is a significant change in order to bring them back.

Mr. Boyer asked why they lump nursing homes and assisted living facilities together, given the Hillsborough County data where 125 ALF had 9 lawsuits in 5 years.

Mr. Shuttleworth stated that they look at the full universe and then break it down by: where you operate, loss ratios, and other actuarial data. ALFs are a small part of the picture.

Mr. Boyer stated that in the Aon study, Florida and Texas have the most claims and that strong patient rights statutes were correlated with claims. The DOI study showed that most carriers were pulling out as part of a nationwide strategy.

Mr. Shuttleworth stated that Texas did attempt to address the issue of punitive damages but reinsurance companies don’t cover punitives. If insurance companies come back it will be based on a “claims made” and will exclude punitives.

Mr. Sharpe asked what is it about Florida that would explain the higher claims over other states? If there were no claims, no settlements, but Chapter 400 was still there, would it still be the problem because of the potential for future claims?

Mr. Shuttleworth said there was no significant differences in the states; generally nursing homes in all states aren’t dealing with risk management; and the statute is the problem.

Mr. Connor asked about the risk/loss ratio and if a business or industry engages in risky behaviors that produce lawsuits, then premiums will go up or they will be cancelled. The HCFA study that shows an association between short staffing and adverse outcomes for skin integrity, nutrition, hydration, etc. and Florida has led the nation by 200-300% in short staffing.

Mr. Shuttleworth stated that carriers are concerned with losses and premiums. And the carriers see the issue as the statute which relates to litigation.

Mr. Connor stated that when an industry engages in risky behaviors (as evidenced by Florida leading the nation on a number of deficiencies related to patient care) that are likely to produce loss, we need to understand if the industry has acted irresponsibly which led to the lawsuits. Especially when GenRe provided a report disseminated by staff that there are 34 states with patient bill of rights laws which allow for a civil cause of action and insurance companies have reported that they are pulling out of all states. So, you say it is the statutes, it may be multifactorial, but I don't accept that the statutes are the cause.

Mr. Freidin stated that in 1986, insurance companies said that the health care liability crisis in Florida was due to litigation but it was actually poor business practices. Why should we disarm residents of their rights if tort reform can't guarantee insurance carriers return?

Mr. Shuttleworth stated that given the aggregated losses and premiums, it does not make sense to stay in Florida if something is not changed.

Mr. Freidin asked about why they can't insure the "white hats" like in automobile and hazard insurance. And would it help to reduce the defense costs.

Mr. Shuttleworth said that the practice is to pool risk together and that he isn't an expert on claims.

Mr. Freidin asked about self-insurance trusts (e.g. doctors).

Other task force members asked about JUAs or other alternatives.

The Chairman stated that these would be stop-gap measures to cover the period between processes.

Mr. Connor asked that the tapes from today's meeting be sent to those members who were absent.

Mr. Sherberg asked about the tail—the lawsuits already filed but with no decision or settlement—and wondered if there is a reserve to manage these potential claims. If the tail could be curtailed, would carriers be induced to return sooner.

Mr. Shuttleworth stated that the tail is factored in as an occurrence basis of claims but that actuaries aren't able to predict even with a known occurrence. They don't know the total exposure. If the tail was removed, they would be induced to return.

Ms. Mary Oakley and **Dr. Christopher Johnson** presented data from the Hillsborough Circuit Court study. Ms. Oakley began by describing the distribution of lawsuits:

- 266 lawsuits against 35 nursing homes from 1990-August 2000.
- 80% of lawsuits were filed since 1995.
- Aside: The 1994 changes in FAC 59A were replaced by OBRA 87 which ensured highest practicable health and mental well-being.
- There was a peak of 81% of nursing homes being sued in 1998, down to 55% in 1999 and 10% in 2000 (through August). The drop-off in 1999-2000 could be unique to Hillsborough County [NOTE: Please see February 2, 2001 update about these data—this study used

only the lawsuits filed in the public records database and did not include all lawsuits filed in the Clerk's database, there is a serious undercount.]

- Three nursing homes with 22-27 lawsuits each over the 10 year period: in 1998, two changed ownership and management and 1 closed.
- 50% of plaintiffs had a length of stay less than 6 months
59% less than one year
median length of stay of all lawsuits was 28 days. Important to note that half of all admissions are discharged, mostly to home (high number of shortstays).
- 50 different attorneys represented the plaintiffs; one firm had 52% of the cases.
- 37% were wrongful death cases
- 44% were resident rights cases only
- All resident rights lawsuits cited the right to adequate and appropriate health care; others cited privacy/dignity, abuse and/or neglect (25%).
- Most cases are filed within two years of the complaint.
- Attorney fees are subtracted from fees in 70% of cases.
- Of 35 unsealed settlements, the average amount was \$360,000 prior to 1995 and \$460,000 after 1995 for a total of \$12.6 million.
- 67 cases statewide have gone to jury trial in ten years:
53 awards for a total of \$88.7 million in 10 years.
- Attorneys report that less than 1% of their cases go to jury trial; if this is so, and 67 have gone to jury trial, than Florida may have had 6700 total lawsuits in 10 years.

Dr. Chris Johnson presented the multivariate analysis.

- There are no other empirical studies on nursing home lawsuits to aid model construction
- Data is extremely difficult to find and masked in a shroud of mystery
 - Industry reluctance
 - Accessing information about court cases is labor intensive
- Our analysis is the state of the art in scientific litigation analysis
- Sample size
 - Limited to 28 homes
 - Limited to four years (1996-1999) due to OSCAR data
- Hypotheses
 - As the in house skin sore ratio increases, lawsuits increase
 - As in house contracture development increases, lawsuits increase
 - As Medicaid ratio increases, lawsuits increase
 - Homes cited for low staffing will have more lawsuits
 - As drug errors increase, lawsuits increase
 - Not for profit homes will have fewer lawsuits
 - As total number of deficiencies increases, lawsuits increase
- None of our hypotheses were significant
- Control variables that predicted law suits
 - Number of beds
 - Tube feeding ratio
- Quality measures do not predict lawsuit activity
 - Homes that had higher deficiencies were not sued significantly more than homes with fewer deficiencies

- Neither in-house skin sore or contracture development was significant
- Increased number of drug errors were not significant
- Structural re-interpretation
- May be that structural variables predict lawsuit activity and should be explanatory variables

Mr. Connor asked about the hypotheses: worse deficiency ratings would lead to higher lawsuits which turned out not to be significant and yet one lawsuit he was familiar with, the facility wanted to have a self-imposed moratorium but the corporation wanted to fill the beds (easier to sell the facility). Did you look at the state ratings of these facilities at the time?

Dr. Johnson stated that based on this model, litigation is a random event or there may be structural variables that are having an impact (e.g. number of beds=greater exposure).

Ms. Fierro stated that there is videotape of conditions in nursing homes that have been sued and yet the model is based on a once a year snapshot of the facility.

Mr. Connor stated that the problem is with the assessment of quality since nursing homes beef up their staff for surveys so the deficiencies don't reflect our experience. The lack of a finding that lawsuits are related to poor quality of care could be because the state isn't getting an accurate picture...There is a correlation, in an individual case, between quality of care and results of lawsuits.

Mr. Buigas stated that there was a disturbing trend. This morning, changes in FAC 59A regulations were the cause of the lawsuits and now we're hearing that there is no correlation between quality and the regulatory function.

Mr. Grofic stated that there isn't data that shows that nursing homes in Florida are worse than the rest of the country; FAHA has provided data that shows we're actually better than average. So if 81% of nursing homes in one county have had one or more lawsuits in 1998 and FAHA found that 67% of its communities have a lawsuit in the last few years...there seems to be a disconnect.

Ms. Chmielewski said that although there was a time when staff new when the survey was coming, since 1998, no one has known when a surveyor is coming.

Dr. Johnson stated that there were five factors important to nursing home survival and each needs to be addressed. Litigation is one area.

Ms. Fierro asked if the data included the number of residents in the homes during the 10 year period with 266 lawsuits total. Or per patient days? Assuming your calculations are right and there were 6000 lawsuits in 10 years with 75,000 residents [a year], then it would be less than 1% of residents are involved.

Task Force member asked how many lawsuits are settled before they are filed.

Ms. Oakley responded that it was very rare.

Mr. Freidin asked how the 1% figure was arrived at for lawsuits going to trial. Where did you get the 6,000 figure? Is that made up? If its 1/6 percent, then its 3,000 cases.

Ms. Oakley explained that it was reported by plaintiff and defense attorneys and judges. If it is a 1/6 percent the figure would increase:

[NOTE: $.01x=67$; $x=67/.01=6700$
 $.005x=67$; $x=67/.005=13,400$]

Dr. Calkin stated that anyone raising the issue about the change in the way rules are written; I will say that advertising began in TVs anchor ads and stores on or about 1994-95.

Ms. Fierro said that she would like a copy of the Hillsborough study [data]. She also asked if indeed, the lawsuits were frivolous.

Ms. Oakley said that the allegations are not frivolous as defined in the report but it still unknown if the nursing home was at fault.

The Florida Association of Homes for the Aging and the Academy of Florida Trial Lawyers had submitted tort-related proposals that expressed divergent views on most issues. These issues were put into a side by side table (see Appendix) and an attorney from each organization was asked to debate the merits of each proposal. Their arguments along with Task Force member questioning follow. Mr. Sean Domnick represented the Trial Attorneys and Mr. Andy McCumber and Ms. Jodi Chase represented the providers.

Who Can Sue/Clarify Knowles and Hamilton cases

Mr. Domnick stated: Chapter 400 problem in law at first: when somebody dies as a result of abuse and neglect, the case went with you because most people didn't have spouses to bring a wrongful death complaint on their behalf. Rep. Cannady proposed an amendment that anomalous situation, the cause of action goes away with the death of the resident. Interpreted that when a resident dies, the personal rep. Can bring the claim for pain and suffering and other economic losses that the resident suffered. Last year, 4th district court of appeals, quelched that and is before Fl. Supreme Court. Imperative that the resident dies as a result of abuse and neglect, the cause of action can be brought against the facility to hold them accountable. FAHA allows for the personal rep. To bring a claim but doesn't say what claims they can bring—only wrongful death under 766 and 768—precludes cause of action because there isn't a spouse.

McCumber stated: Personal representative has a cause of action, consolidated into a negligence action in a LTC setting, much like a hospital setting. There isn't a proposed difference between the measure contained in LTC negligence act and the current Medical Practice scheme. 400.023 has been repealed.

Mr. Connor asked: Does that mean that if you have only an adult child, all that is recoverable is medical and funeral bills? No recovery for mental pain and suffering for the adult children or when a decedent has no survivor.

Ms. Jodi Chase stated that: Every injury to a resident treated the same way. If you are injured and pass away, a surviving spouse, adult child, personal representative can bring suit and recover damages that are allowed for recovery when you are alive. The damages are capped.

Mr. Connor: No recovery for mental pain and suffering of spouse and child but it is of the decedent.

Ms. Chase: Damages capped—whether it is the suffering of the survivor or the decedent. Economic damages offset by insurance liens; non-economic damages (pain and suffering) capped. Damages either for the decedent and/or the survivor. Wrongful death act applies: economic damages (without a survivor).

Mr. Sherberg stated that FAHA on who can sue is MedMal.

Mr. Domnick stated that under FAHA: All actions are being considered medical malpractice (unlicensed personnel).

Mr. Freidin asked how the Knowles/Hamilton was resolved?

Mr. Domnick: We allow for recoveries for adult children, spouse, pain and suffering of resident. NH/ALF cases.

Mr. Connor stated that under Knowles: unless the resident died from the conduct that caused the injury, the cause of action was extinguished. NH residents have a variety of ailments, they often survive litigation. Provides an incentive to extend out the litigation in hopes that the resident will die of another cause. Pernicious form of age discrimination. In every other law, the cause of action does not die with the plaintiff.

Mr. Sherberg stated: Didn't Knowles say you had to go through negligence. But if Supreme Court holds Knowles. What will the effect will be.

Mr. McCumber stated that Knowles does not mean the entire cause of action goes away: no effect on common law and negligence action. Only has to do with the statutory action which was only created in a personal rep. Where the plaintiff could prove that the deprivations caused the death. If the resident died of something else to seek out legal counsel for violation of their rights, then their action was a negligence action (they could still sue for falls, pressure sores, etc.) but not a chapter 400 action and didn't have access to the add on attorney fees.

Mr. Sherberg stated that Knowles threw out the chapter 400 cause of action in the case of death and it would go through general negligence for the survivor (McCumber: yes).

Presuit Notification

Mr. McCumber stated that FAHA was in agreement with respect to presuit: benefit of getting together, exchanging documents, conducting presuit statements; reducing the load of litigation on the court system (like with hospitals/physicians).

What exists for defendants: trial lawyers reduce the time from 90 to 60 days with no force in effect. NH can request a mediation.

Process: 1) notice of intent sent by certified mail to all parties you intend to sue attaching an affidavit from an expert. So the plaintiff has done all their discovery before we get to the presuit stage. Trying to create an opportunity to settle it outside the courts.

Difference is force and effect of presuit notification. FAHA proposal uses 766 so you have the ability to opt out of the legal system completely and go into arbitrary. Additional discovery available to you—independent medical examinations if the resident is still living. It needs to be something that both sides have a reason to participate in. Now, trial lawyers fee ____ from 30-40% if you go into suit. Needs something to offsets the rationale for waiting.

Mr. Domnick stated that the motivation of moving from 33% to 40% vs. being able to achieve a settlement and not have to put all of my costs into a case, more than offset each other. The motivation of going into suit is not to get an extra 7% of the fee. No matter how far into a suit, all sorts of discovery more than what is contemplated in the presuits, the defendants still don't admit liability. In the medical malpractice, the presuit period is a waste of time in terms of getting an admission of liability (<1%). There is a 90-day waste of time; multiple payments by defendants because in the presuit period, defense attorneys hire a claims management company to go through the presuit period and they have to double pay the defense lawyers to do the same things as the claims management people do. Presuit mediation has not been successful in Medical Malpractice.

Still, we believe in resolving the case quickly. Needs to be limited to 30 days because you are dealing with people who are old. With the Knowles decision, the cause of action dies with the defendant which makes it even more important for a speedy resolution.

Net economic damages awardable subject to any collateral payments—Medicaid and Medicare—which reduces the money available. Non-economic damages calculated on a percentage basis with capacity to enjoy life. So this would be a percentage of a percentage which would result in no liability and no accountability.

Informal Exchange of Information

Mr. Domnick stated that AFTL produced records with very short time frame. If not produced on time, expert affidavit is waived. They can take unsworn statements of anybody. It allows for free flow of information.

Mr. McCumber stated that the Medical Malpractice scheme has worked successfully for a number of years. Trial Lawyer proposal says 30 days not 60 days for the presuit notification period. 400.0245 reduces free flow of information to 48 hours. Meaningful exchange of information is affected by this—they have a two year span of time to gather records, collect affidavits, and then they send a notice to NH and expect records (medical, personnel, business records).

Standard of Proof when Filing Lawsuit

Mr. McCumber stated that the proposed LTC Negligence Act: use prevailing standard of care—using workers at every level, not just professionals. This is different than the strict liability analysis in current 400—which allows for a statutory action, a negligence action, a wrongful death action, and maybe a medical negligence action all together alleging that adequate and appropriate health care was not provided. The same incident triggers 4+ lawsuits.

Mr. Domnick stated that FAHA creates an unfair standard of care that does not exist in malpractice or general negligence cases. 400.973(1)(c) specifies each defendant’s deviation from “direct and proximate causes of damages to resident” which does away with concurrent cause. Direct is new language not anywhere else in the law. Concurrent cause says that if someone is sick and then a provider commits a tort against you and causes your death, you still have a cause of action. The defense is “they were sick and would have died anyway.” Also, standard of care is a dumbing down of the standard of care that would be unique to Florida, as opposed to quality of care standards that are set forth in Federal Regulations (Part 483.25) “each resident must receive or the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, psychosocial well-being of the resident”--a national standard of care, they are trying to deviate from that.

Expert Affidavits

Mr. Domnick stated that expert Affidavits are already required when you allege an infringement on the right to appropriate and adequate healthcare. Trial Lawyers furthers the requirements.

Mr. McCumber stated that 100% of the actions have an allegation of infringement on adequate and appropriate healthcare so there is no extension (can't have more than 100%). Now, nurses are giving opinions of causation and cause of death. The plaintiff's attorney has two years to work up a case and then drop it on the doorstep of the defendant and require that the defendant begin producing records within 48 hours and they have their expert review conducted within 30 days so they have can then ask for permission for mediation which is part of the law already. Great disparity between the two proposals.

Mr. Connor stated that failure to provide adequate health care is not the same as failure on the part of a health care provider. CNAs are not health care providers. Failure of health care is failure to turn and position, clean up after soiling themselves.

Dr. Calkin asked, therefore we shouldn't certify nor train the CNAs?

Mr. Connor stated that the law doesn't classify CNAs the same as doctors and nurses because they provide custodial, not skilled, judgemental health care.

Mr. Grofic stated that FAHA isn't moving this to 766, so is this relevant?

Mr. Domnick stated that these are the provisions in 766.

Mr. McCumber stated that we're not moving the action to 766; there is a set of procedures in 766 that is familiar to all parties. It is the same procedure set forth in the trial attorneys but they've taken the teeth out of it.

Arbitration/Mandatory Mediation

Mr. McCumber stated that fundamental difference between both proposals. The only way to make a difference unless there is a way to reduce exposure, and bring the insurance market back. Have to have some predictability, some caps, some ability for defendants accused of negligence to have the ability to analyze what has happened and determine if litigation is necessary. Under 766 and FAHA proposal, NH has ability within 90 day period to take statements, conduct medical examinations, and if they are willing to come forward and say we will not contest liability (a big thing to give up), and move it out of the court system, they get in return some caps on damages. Most significant is cap on noneconomic damages.

Mr. Domnick asked do we allow insurance companies to get the security they want by just setting arbitrary caps? Quality of care doesn't matter? Caps are maxed and we get rid of punitive damages (with FAHA proposal) Or do we see the correlation between quality of care going up/number of lawsuits goes down. Example of Miami nursing home and pressure sores cases which resulted in a pressure sore management program and lawsuits stopped.

Mr. Connor stated that they merely offer to arbitrate, they extinguish all potential for punitive damages.

The Chairman asked: do you both agree that mediation is appropriate way to begin the process (within time limits)

Mr. McCumber said there is a difference between mediation and arbitration. I don't think there is any difference on mediation.

The Chairman asked if there is agreement that arbitration is beneficial to the process.

Mr. Domnick stated that's where it breaks down.

Mr. Freidin suggested: how about this: 120 days of presuit required mediation in which rules are laid out and sworn discovery is allowed within certain limitations of the time and exchange of documents are required automatically: employment records, etc. are mandated to be produced during that 120 day period while at the same time the plaintiff is required to produce the things that defense takes about a year to get when you get to a lawsuit. Mediation process uses not unsworn but sworn usable testimony so there is no need to duplicate it in the lawsuit. The issue of attorneys fees rises or falls with the offer of judgement made in the mediation, as opposed to being confidential. A lot of pressure on either side to conclude case at end of 120 days.

Mr. McCumber stated: contrary to trial lawyers proposal. I don't think you'll find any providers or insurers that don't want to get this into mediation as quickly as possible. What would you do with the discovery provision? Is it destroyed after 120 days?

Mr. Freidin stated: no, everything is used later instead of duplicated. One of the most ridiculous parts of the presuit, is you take a 10 hour unsworn testimony that can't be used. And you have to take another 10 hour sworn statement in the lawsuit.

Mr. McCumber stated that my experience that unsworn statements are informational and much shorter; but the documents exchanged are carried over into the same documents in regular discovery and utilized the same.

Mr. Freidin stated that mediation have the materials that are not duplicated again. 120 days are enough time to exchange information in a mandatorily required manner as opposed to playing around with it for 3 years in litigation. And that there be offer of judgement rules on both sides so that the side that guesses wrong about not settling, is penalized (pays fees) and the one that guesses right is rewarded.

Mr. McCumber stated that concept is better than we have now but insufficient to bring insurers back.

Mr. Domnick stated that they fully in favor of any proposal that allows us to resolve cases ASAP without expensive situations in process. Timeframe may be a bit long because of age of plaintiff; and we get the amendment to 415 that requires the judge to expedite these cases, set forth a framework that would be reasonable.

Mr. Freidin stated that we can't get insurance companies back with guns.

Fast Track Cases

Mr. Domnick stated that provision in law of cases that those who are 65 and older may be moved up on the docket but this isn't happening, so it should be mandatory that the court put it on a fast track.

Mr. McCumber stated that the trouble in principle that the legislature requiring the judges to do something that eliminates judicial discretion. The provision [to fast track some cases] is in there that allows all those arguments to be made.

Make NH and ALF statutes comparable

Mr. McCumber stated that the statutes are comparable.

Mr. Domnick stated that for NH only the licensee is accountable whereas in ALF, it is the licensee or anyone else responsible. In NH's the licensee is held by a shell corporation and the day to day operations are held by a management company not the licensee but is holding all the responsibilities of the licensee and should be held responsible.

Protection of quality assurance and risk management records from discovery

Mr. Domnick stated that there is confidentiality of annual report of adverse incidents of violations of resident rights not available to the public; maintain current law on admissibility of surveys.

Mr. McCumber stated that there was agreement on both sides that you can't have effective risk management without confidentiality. And can't be used by trial lawyers. In both proposals to some extent.

Mr. Domnick stated that current Florida Statutes, there are provisions of medical review committee but this has not been done in NHs.

Statute of Limitations

Mr. McCumber stated that Medical Negligence is currently 2 years; statutory liability (ch 400) is 4 years. FAHA's proposal is a negligence proposal and recommends limit of 2 years. 88% of cases are filed within two years and with the Knowles decision, that a violation of resident rights you bring the complaint within two years.

Mr. Domnick stated that the current status of law (2 and 4) is adequate. When people die in nursing homes, families need time to (grieve) and be ready to deal with these things.

Mr. Grofic stated that you were concerned about the frailty of the people when you were concerned with the 90 days for presuit mediation but now you want 4 years.

Mr. Domnick stated I'm in favor of speeding up the process; but the current state of the law, especially in wrongful death situation, recognizes this extra time is needed.

Mr. Freidin asked what about this: 2 years + 2 years in the event of it not being discoverable or in the event that the resident suffers from disability that makes it difficult to file a claim (like AD or mental disability).

Mr. McCumber stated that current case law, that is how it is interpreted. If you reasonably know of abuse and neglect and are going to seek punitive damages, as were sought in all the cases (in the research study), that's something that should be egregious enough to discover in two years.

Mr. Sherberg asked: is wrongful death 4 years?

Mr. Domnick responded that wrongful death it is 2 years but in chapter 400 it is 4 years.

Mr. Sherberg stated that one of my (ALF) residents is different from the general population for wrongful death.

Mr. Freidin stated that one standard for all cases: 2 years + 2 years for discovery.

Ms. Chiemelowski reminded that we are to address affordability and availability; the insurance companies were clear that we have to worry about the tail (of potential claims). When my own family died, if they had been abused/neglected, it wouldn't have taken me 18 months to do something about it.

Civil Remedies (restricting number of lawsuits that can be filed simultaneously by plaintiff)

Mr. Domnick stated that FAHA lumps every claim that one could possibly have against anybody in the facility into the LTC negligence act so claims against individuals/corporate person individually. That is not available in any other aspect of law.

Mr. McCumber stated that this is borne out in the research study that showed that every case included some aspect of medical care/adequate and appropriate care—triggering all these suits. It is now being spread into chapter 415, under fiduciary duty claims. You can't put any type of limitations on the creativity of the trial bar, unless you bring everything that is based on the same incidence into one lawsuit.

Mitigate fees based on nursing home track records

Mr. McCumber stated that trial lawyers do not mitigate fees; they put survey performance as something for the judge to consider when assessing fees to be awarded to trial attys.

It also expands to ALFs. The plaintiff pleads it: everyone from corporation that runs the facility to a holding corporation, all of the people owned and operated the facility and that conclusion binds the judge all the way through a summary judgement where the judge is then weighing evidence that there is any possibility that the plaintiffs will be able to prove some involvement by this other corporation. So we're destroying the whole of corporate law by allowing this kind of claim against owners.

Mr. Domnick stated that where corporations who are esconsed in Ft. Smith, AR and doing business in Florida, they should be accountable in Florida.

FAHA wants to do away with fee shifting statute; we want to tie fee shifting statute to quality of care: the mandate of what we're talking about. If this is a good facility (adequate staffing levels, minimal records of abuse/neglect) than decrease the amount of the fee you reward plaintiff, and consider the time and amount of settlement offers and consideration of mediation. Fee shifting statutes needed for small cases (money stolen, left naked in bed for days). Fee shifting is when the defendant is responsible for paying the plaintiffs fees.

Failure to report violations.

Mr. Domnick stated that currently, there is not much of a requirement to report abuse and neglect. It is supposed to happen but it doesn't happen enough. Needs to happen and be made available to residents to make informed decisions.

Mr. McCumber stated that this is bootstrapping provision because the finding that trial lawyers would have the facilities make, is that they committed some sort of abuse and neglect. Not talking about a quality assurance provision here where you have a bad outcome or somebody making an honest mistake. They are asking the facility to determine they have committed some sort of abuse and neglect and calling the state and reporting it as a conclusion or an admission. That won't work.

Mr. Domnick stated that it is working in Kentucky

Collateral Sources [added to table by AFTL so FAHA did not have opportunity to address this.]

Mr. Domnick stated that this is the issue of arbitration and limited caps; under FAHA's definition of collateral sources, Medicaid/Medicare is included in that. So you can end up having \$150,000 Medicaid/Medicare bill that comes out of the \$250,000 that you are limited to and we don't think that is fair.

Mr. McCumber stated that if the state has paid for 4 years of nursing home care, and the estate is going to come into some money, than the state has an opportunity to get the money back that they paid for 4 years rather than put it in pockets of trial lawyers.

Mr. Domnick stated that we agree that the government needs to be reimbursed; this shows the dastardly effect of the caps they are proposing. In reality, if there is a high Medicaid/Medicare bill, and there is caps, no suit will be brought forth and there will be no accountability of the NH.

Attorneys' Fees Above Contingency Fees

Mr. McCumber stated that plaintiffs are not getting to the argument made in the Spillman case that add on fees are available because they added a statutory action to the negligence action. We don't believe that the add on fee is needed given the data in the research study that showed one county had 50 plaintiffs attorneys and most were not taking the add on fees but were taking the contingency fee.

Mr. Domnick stated that they want to top end to minimize the contingency fee while still requiring us to do a tremendous amount of work and they want to do away with the attys fees that will destroy the ability to determine that small things don't happen (clothes are stolen, etc.). I can call a nursing home and use the threat of a lawsuit, they will have to pay for it. If I can't take a case with attys fees, then I can't take a case where recovery is only going to be \$500 or \$1000. This class of cases would be totally banned.

Contingency Fees for Attorneys

Mr. McCumber stated that the FAHA proposal, under arbitration, the defendant has to admit liability in order to get the caps, so there is not going to be tremendous litigation, outside the judicial system 60-120 days.

Mr. Domnick stated that arbitration scenarios take a long amount of time. Fees need to stay in there to make sure that smaller cases where people have been abused and neglected, the people can still be held accountable.

Mr. Freidin stated that the cap of \$350,000 against all defendants (aggregate) is that more severe than medical malpractice which is \$250,000/\$350,000 per defendant.

What is the value of arbitration for a case: 85 y.o. with a number of severe illnesses and gets a terrible bed sore and dies, FAHA says that you would get a percentage of the quality of remaining life, how much would they get. (percentage of \$250,000)

Mr. McCumber stated that it depends on a lot of things, I don't have. I don't conclude that break down of skin requires a finding of abuse but since the defendant admitted liability to get to that stage, what we'd be talking about is that, we'd be interviewing and having people who interacted with the resident come before the arbitration panel, and the extent to which that resident's life was affected during the time period of that wound...

Mr. Freidin asked if you had an Alzheimer's patient that was beaten to death; what percentage of their life would be compensable?

Mr. McCumber stated that you rely on the people there, to determine if there was any kind of pain behavior, and you reward compensatory damages.

Mr. Freidin asked if it could be as low as 5%?

Economic compensatory damages

Mr. Freidin stated that there are never any economic damages (beyond paying bills), we're in non-economic damages. The cap gives the impression that someone would get that amount of money. In the medical malpractice act, with a normally healthy person, you might be able to conclude that you could get 100% or 50% of the cap; but to someone on death's edge, that it should be 2% or 5% or 10%.

Mr. Sherberg stated that in the case where somebody comes to you who has been left naked: FALA proposed injunctive relief. We do not promote poor health care; believe in resident rights. Our concern is that it be remedied quickly. We propose injunctive relief—you would go to the court and get it that day. If the facility does not correct it, then they are held in contempt of court and they are fined. If the intent is to improve facilities, than injunctive relief is the answer.

Mr. Domnick stated that I don't want to run down to the court with these kinds of cases; but with the attys fees provision, I can make a call to the facility and they straighten up.

Mr. Sherberg said that the goal is that the residents be cared for properly.

Mr. Domnick stated that injunctive relief is currently available. Somebody can go down now and seek injunctive relief. But this leads to "one size fits all"—this isn't a medical malpractice situation. This is custodial stuff.

Mr. Sherberg stated that if we require repayment to Medicare/Medicaid, isn't this the same as in other personal injury suits.

Mr. Domnick stated that there is a collateral source statute that requires the insurer to recover a percentage of the recovery (pro rata). He said that in regard to punitive damages and caps--the legislature looked at this last session and rejected it. It makes it impossible to get punitive damages from a nursing home. We know that punitive damages doesn't affect insurance company to come back in (not included in rate analysis). Punitive damages is the way to penalize the company's egregious behavior. Boils down to: the insurance guy couldn't tell you which way would work; I want stability in numbers; I don't make social decisions. You need to think about this is: do you want a quality of care aspect or with caps. Changes to NH statute would do away with right to adequate protection under the law.

Mr. McCumber said that punitive damages are what is driving the bus. To talk about separating the punitive damages and to misinterpret the statements of the insurance representative because they don't insure against punitive damages, it is not relevant to their analysis, is an ostrich approach. The way it works, as soon as there is a motion to certify punitive damages, once that is done, the insurance carrier and provider at odds. There is a duty of the insurance carrier to settle that claim within limits of that policy or they are in violation of bad faith. With the tail, we could affect the punitive damages. We got this because of an amendment for punitive damages. Punitive damages can be treated differently from compensatory damages and when you are talking about caps, the defendant has looked at their conduct, made an admission of liability, it is

not appropriate to punch that defendant. They are exposing themselves to at least \$500,000 in punitive damages.

Ms. Chase said she wanted to clarify one thing, Mr. Freidin asked if FAHA can agree to a mediation scheme and statute of limitations. FAHA can't agree to either suggestion as he described them.

Mr. Boyer said that the FAHA proposal says there is a civil cause of action for negligence which seems to exclude resident rights, but what about improper discharge/transfer/use of restraints, end of life decisions not honored, room change, bed hold policies where injunction isn't effective. Will your proposal make me jump through all these hoops?

Dr. Calkin asked: what do you do now?

Mr. Boyer stated that improper discharge: go through a Medicaid hearing and you win, there is a violation of resident rights and another lawsuit.

Mr. McCumber said that the provision that was repealed was 400.023 and not the provisions you are talking about.

Mr. Boyer stated I have to go through all of the procedures in the LTC negligence act? [yes]

Mr. Connor expressed his concern that wordsmithing will lead to unintended consequences such as this one.

Mr. McCumber stated I'm not sure that the cases [Mr. Boyer] talking about that were contested in current framework, I'm not sure it would make any difference. They either agree or disagree.

Mr. Domnick stated that every case (in FAHA's proposal) has to go through presuit mediation

Ms. Chase stated that nothing compels you to file a lawsuit; if you can informally work them out, you can still do that. If now you don't bring them under 400.022 then you would be bringing them under a negligence standard.

Mr. Domnick stated that there is no stick.

Mr. McCumber stated that he didn't think a \$150,000 arbitration award is no stick at all. Litigation is still a bunch of money.

Mr. Domnick stated that it isn't a \$350,000 type of case. You are changing that type of case.

Mr. Connor said it was important to look at cause/effect relationships. Do things that are efficacious. With caps, recall that Aon representative that the size of the award isn't a problem and yet we have these draconian caps. The underwriter said we don't insure punitive damages. And yet these proposals would eliminate punitive damages and yet we know that these remedies have an effect on behavior. Need to ask what is the gain that we get from any of these proposals. All parties are tempted to opportunism.

Dr. Calkin stated that an interpretation from Ken; alternate is that we have a \$280,000 split between Florida and rest of the country. Turning over of facilities to the state and have the state administer the facilities.

Mr. Buigas said that we're having enough trouble regulating them; it takes us out of our expertise to take on the running of facilities.

Mr. Connor said I've been involved for 20 years in nursing home cases, and under Bush/Brogan administration, no administration has acted more aggressively than this administration. I just want to strengthen their hand. My criticism of regulators is not directed at Mr. Buigas or this administration.

The meeting adjourned around 5:00 p.m.

Respectfully submitted,

Jennifer R. Salmon
Task Force Coordinator
Florida Policy Exchange Center on Aging

February 5, 2001

Approved February 5, 2001

Appendix 1
Task Force on Availability and Affordability of Long-Term Care
Litigation Issues as Addressed by the Academy of Florida Trial Lawyers and the Florida Association of Homes for the Aging
Litigation Worksheet

Notes: The areas of concern used to organize this table are a combination of what was addressed in each proposal. These organizations may have a recommendation on items in this table that were not addressed in their proposals (i.e., the absence of a recommendation does not mean there is not an opinion on an area of concern). The table may not represent every recommendation expressed by these two organizations. Please refer to the full proposals for additional details.

Area of Concern	Academy of Florida Trial Lawyer's Proposal	Florida Association of Homes for the Aging Proposal
Who Can Sue/Clarify Knowles and Hamilton cases	Clarify the law to resolve the issues raised in <i>Knowles</i> and <i>Hamilton</i> cases, i.e., that the cause of action under chapter 400 does not die with the resident and that deceased residents are not limited to damages under the wrongful death statute (e.g., funeral bills).	The resident or his/her guardian, or by a surviving child (regardless of age) or spouse or the personal representative of the estate of a deceased resident.
Pre-Suit Notification to LTC Facilities	Residents or their representatives would provide notice to a potential defendant of an intent to pursue a civil remedy for violation of a resident's rights 60 days prior to filing a lawsuit. Notification must include the rights a defendant has violated that are reasonably identifiable prior to the filing of a lawsuit and commencement of formal discovery. The potential defendant has 30 days within which to evaluate the claim and determine if the claim should be rejected, a settlement offer should be made, or presuit mediation requested. Good faith investigation by a defendant rejecting the claim.	s. 766.106 -- Mandatory pre-suit notification to defendant, opportunity for defendant to respond.
Informal Exchange of Information	Records in the possession of the defendant must be produced within 10 days of the receipt of a certified notification of intent, including internal and state required incident reports. If records are not produced within 10 days, the expert affidavit requirement is waived. Parties may submit questions and requests for production within the 60 day presuit notification period and may take the unsworn statements of parties. Statute of limitations (and repose) is tolled for the 60 day case evaluation period and any extension. Case evaluation materials are not discoverable or admissible in civil litigation.	

Area of Concern	Academy of Florida Trial Lawyer's Proposal	Florida Association of Homes for the Aging Proposal
Standard of Proof when Filing Lawsuit	Certification by the claimant's attorney that the claim is based on a good faith investigation. <i>Judicial review available to determine whether a claim or defense rests on a reasonable basis.</i> Sanctions of parties not in compliance with claims investigation evaluation requirements.	Claimant must prove by a greater weight of evidence that each defendant has an established duty to the resident, that each defendant failed to comply with the prevailing standard of care; that each defendant's deviation from the prevailing standard of care was the direct and proximate cause of damages to the resident; and that each defendant's deviation from the prevailing standard of care resulted in either injury or the death of the resident, abuse, neglect or the deprivation of the resident's rights.
Expert Affidavits	In cases where the alleged violation of a resident's rights causes physical injury or death, an affidavit is required from an expert. In 1993, the Legislature imposed a requirement that expert witness affidavits be submitted whenever a lawsuit was filed against a nursing home alleging a violation of the right to adequate and appropriate medication and health care. AFTL's proposal extends the expert witness affidavit requirement.	
Arbitration/Mandatory Mediation	Presuit mediation is required if requested. Within 30 days of the completion of the case evaluation period and upon the request of a defendant, the parties shall complete mediation within 30 days. (Parties can agree to an extension.) The current mandatory mediation piece added to chapter 400 in 1999 is repealed. State that a long-term care facility may not require nor permit a resident to waive their rights to trial by jury; including arbitration requirements in resident contracts.	s. 766.207 -- Voluntary Arbitration
Fast Track Cases	Cases shall be placed on the docket pursuant to chapter 415 upon request of the plaintiff. (Amend chapter 415 to make mandatory that the judge advance the trial on the docket.) The proposal would include a clear statement that the provisions of chapter 766 do not apply to cases brought under chapter 400.	
Make NH and ALF statutes comparable	Conform and amend the language relating to the entities that can be held accountable under section 400.023, F.S. to those found in the Assisted Living Facility statute, i.e., any facility owner, administrator, or staff. (s. 400.429, F.S.), and include management companies. All of these proposals would apply to nursing homes and assisted living facilities.	

Area of Concern	Academy of Florida Trial Lawyer's Proposal	Florida Association of Homes for the Aging Proposal
Protection of quality assurance and risk management records from discovery	[excerpted from proposed bill on risk management] The annual report is confidential and is not available to the public pursuant to s. 119.07 (1) or any other law providing access to public records. The annual report is not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board. The annual report is not available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or the appropriate regulatory board. However, the agency or the appropriate regulatory board shall make available, upon written request by a facility or licensed or certified agent or employee against whom probable cause has been found, any such records which form the basis of the determination of probable cause.	Amends s. 400.118 to require quality assurance (QA) meetings every other month in a nursing home; and to protect QA and risk management records from discovery. Amends s. 400.4275 to protect QA and risk management programs in ALFs from discovery.
Statute of Limitations	State specifically that the applicable statute of limitations is s. 95.11(3)(f). (4 years)	2 years
Civil Remedies (restricting number of lawsuits that can be filed simultaneously by plaintiff)		Long Term Care Facility Negligence Act is created as the exclusive civil remedy for lawsuits filed on behalf of a long-term care facility resident.
Mitigate fees based on nursing home track records	Nursing home defendants can mitigate the amount of fees. Nursing homes that have complied with minimum staffing requirements and have had good track records can introduce these factors to the court in a determination of the amount of an award of attorneys' fees. Factors to be considered in mitigation include content of a nursing home's state surveys, staffing levels, and record of reports of abuse or neglect during the time of the stay of the resident and one year prior. The court can also consider the timing and amount of settlement offers and whether a defendant demanded presuit mediation.	

Area of Concern	Academy of Florida Trial Lawyer's Proposal	Florida Association of Homes for the Aging Proposal
Failure to report violations.	Violations of residents' rights and incidents where severe injury of death has occurred would be reported to the Agency for inspection. Annual report cards for each long-term care facility containing the number of violations and incidents in each category would be made available to the public. Consumers could compare the number and type of incidents in each nursing home and the number and type of residents' rights violations cases filed and make informed decisions about where to place their loved ones. Failure to make reports as required would constitute a misdemeanor.	
Attorneys' Fees Above Contingency Fees	400.023 Civil enforcement (see proposal for wording changes)	s. 766.207(7)(f) -- When a case is arbitrated: Add-on attorneys' fees are capped at no more than 15% of the award. s. 766.209(3)(a) -- If a settlement at arbitration is rejected and the case goes to trial, add-on attorneys' fees are capped at 25% of the award.
Contingency Fees for Attorneys	400.023 Civil enforcement (see proposal for wording changes)	Ch. 766 or 768 -- No caps. Contingency fees are governed by Florida Bar rules.
Economic Damages	Opposes caps on damages.	No Caps
Non-economic/compensatory Damages	400.023 Civil enforcement (see proposal for additional wording changes) <u>specifically in addition to any remedies available under the Wrongful Death Act in s. 768.16-.27.</u> Opposes caps on damages.	For cases settled through arbitration: Maximum of \$250,000 per defendant, but no more than an aggregate amount of \$350,000 against all defendants. s. 766.207 (7)(b). Maximum of \$250,000 per incident, and shall be calculated on a percentage basis with respect to capacity to enjoy life so that a finding that the claimant's injury resulted in a 50% reduction in his or her capacity to enjoy life would warrant an award of no more than \$125,000. If a claimant rejects offer to arbitrate, award at trial may not exceed an aggregate amount of \$350,000 for all defendants.

Area of Concern	Academy of Florida Trial Lawyer's Proposal	Florida Association of Homes for the Aging Proposal
Punitive Damages	The Legislature addressed the issue of caps on punitive damages in cases arising under chapter 400 in 1999, imposing a three times compensatory damages presumptive limitation. The Academy has taken the position that this restriction is unconstitutional. Opposes caps on damages.	s. 766.207 (7)(d) -- For cases that are settled through arbitration -- no punitive damages. s. 768.73(1) -- For cases that go to trial: Three times the amount of compensatory damages or the sum of \$500,000. Where wrongful conduct is motivated solely by unreasonable financial gain and the dangerous nature of the conduct, together with the high likelihood of injury from the conduct, was known by the managing agent, director, officer or other person responsible for policy decisions, punitive damage award may not exceed four times compensatory damages or \$2 million. When defendant acted with specific intent to harm and harm occurred, no cap on punitive damages.
Refer cases with punitive damages to state attorney for criminal prosecution.	In cases where a court permits the pleading of punitive damages, the court shall refer the individuals involved to the state attorney for criminal prosecution.	
Requiring/not requiring liability insurance	Require that residents have the right to know whether a nursing home has liability insurance (would require posting of a notice).	

AGENDA

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

University Center, University of North Florida, 12000 Alumni Drive, Jacksonville

Phone (Day of Meeting Only): (904)-620-4222

DECEMBER 18, 2000

This meeting will be tape-recorded and transcribed for the public record.

Interpreted for the hearing impaired.

8:30 Sign Up For Public Testimony [pre-meeting]

9:00 Welcome **Dr. Anne Hopkins, President, University of North Florida**
Public Testimony Hearing **Lt. Governor Frank T. Brogan, Chairman**

11:00 Break

11:15 Business Meeting **Lt. Governor Frank T. Brogan, Chairman**
Old Business: Accept or Amend Minutes from October 30-31, November 20-21, and
December 4-5 Business Meetings.

New Business: Task Force Members will approve final recommendations in regard to the 16 areas
addressed in HB 1993 as they are organized by the four major tasks. Voting will be by exception
with a majority vote by members.

Approve final recommendations for Task #1 & Task #2: Home and Community Based
Alternatives and Financing Alternatives

12:30 Lunch

1:00 Approve final recommendations for Task #3 & Task #2: Quality of Nursing Home Care and
Financing Nursing Homes.

3:00 Break

3:15 Approve final recommendations for Task #4: Litigation and Liability Insurance

6:00 Adjourn

MINUTES
Task Force on Availability and Affordability of Long-Term Care
December 18, 2000 Business Meeting
University Center, University of North Florida, Jacksonville

Present: The Honorable Frank Brogan (Chairman), Dr. Gema Hernandez, Mr. Bob Sharpe, Mr. Philip Freidin, Mr. Larry Sherberg, Mr. David Grofic, Mr. Walter Liptak, Mr. Raymond Noga, Mr. Rene Rodriguez, Dr. Jeff Dwyer, Dr. Jesse Lipnick, Ms. Cherryl Chmielewski, Mr. Kenneth Connor, Dr. Joy Calkin, Mr. Ed Boyer, Mr. Robert Miller, Ms. Victoria Fierro, and The Honorable Nancy Argenziano.

Absent: The Honorable John McKay

Staff present: Dr. Larry Polivka, Dr. Kathryn Hyer, Ms. Jennifer R. Salmon

The Chairman requested a motion to approve the minutes from the October 30 and 31st meeting.

The motion was made, seconded and approved.

The Chairman requested a motion to approve the minutes from the November 20 and 21st meeting.

The motion was made, seconded and approved.

The Chairman stated that he would ask the Task Force to address each of the four areas (alternatives/choices, financing, quality, and liability). There were approximately 120 recommendations when you include the individual parts. He suggested asking only for objections and then hearing the reason for the objection and then vote as to whether a particular item will remain in the final packet to go to the House and Senate.

Mr. Connor raised two points of order and registered a concern. The first was that the statute that gave the Task Force its charge in subsection six of Section One the mandate "The recommendations of the Task Force must include proposed legislation." Mr. Connor said that the Task Force does not have any proposed legislation before it. He stated that proposed legislation has been submitted by a number of groups, FAHA, Florida Health Care, The Academy of Trial Lawyers, and The Coalition to Protect America's Elders. He thought the Task Force would be provided legislative language in advance. In his judgment the staff report does not meet with the requirements of the Florida Legislature. He provided examples from the staff report of recommendations without legislative language. Mr. Connor stated that it was his understanding that there would be an opportunity to call a roll call vote on every proposal and that the public had the right to know how the various members of the Task Force voted on the recommendation, each should be discussed and then voted on. There should be no assumption of majority support. He also suggested requesting an extension.

The Chairman stated that he shared Mr. Connor's concerns, however, it is a statutory deadline and it must be adhered to. He said that on the issue of specific legislative language, legislative staff had been consulted and it was indicated that what they were looking for was not necessarily specific legislative language, but something they could use in proposing legislation.

Dr. Polivka suggested that the Task Force look at the recommendations in the three areas today, but without the presumption of voting yes or no on any one of them or group of them. One of the

advantages of that would be to keep the focus on the information itself that the Task Force has generated over the last five months. Dr. Polivka said the Task Force might want to consider proceeding with a discussion of the issues, to offer additional information or alternatives to the options and then revise the report for the legislature. Dr. Polivka suggested that the Task Force members may need another two or three weeks to offer alternatives to the staff perspective. In effect, move the report forward to the legislature, but without a formal endorsement of the Task Force on any one recommendation or set of recommendations.

The Chairman noted that there may be recommendations that didn't make it into the document that someone may want to add.

Dr. Calkin suggested that the Task Force members break for lunch to think about how the process should proceed.

Mr. Connor said he didn't object to a recess. He also stated that he felt all three areas were integrated and that before affirming revisions to the tort system, the quality and choice proposals need to be addressed and it needs to be more than conceptually, but concretely, with actual legislative language.

The Chairman stated that whatever is provided to the legislature just begins a 4 to 5 month process of taking it and putting it into legislative and budgetary initiatives. The body of information that has been accumulated is a formidable body of balanced work. The legislature will glean what they feel is right. This work will provide them with a great place from which to begin.

Rep. Argenziano stated that what was being proposed is that the Task Force does not vote on anything at this time. We retain the information that this Task Force has compiled, but also include additional information. She indicated that she did not want to send a message to the legislature that this is the specific intent of the Task Force.

The Chairman said that the Task Force members should have the opportunity to critique the document and provide alternatives as well.

Mr. Sherberg said he was just notified from one of his member facilities in Miami that AHCA visited them today with a notice because they do not have insurance. They have 21 days to produce a policy or they are closed down. He stated that we cannot sit here and not take action.

The Chairman said that this is not the first Task Force that has met on this issue. The format of the document will not determine whether the House and Senate will create legislation. We will have to leave it to the legislature. He also stated that there is an immediate need and the state has already begun the process to work with 38 assisted living facilities to make certain the residents are appropriately cared for. He stated that the Task Force could give the legislature our information in whatever format we decide on; AHCA, DOEA, DCF have all been charged with creating a better long-term care system and being more proactive and aggressive than ever before; and the legislature and HCFA will do the right thing and back the state on reimbursement rates and some of the other issues.

Mr. Boyer said he was concerned that in its present form, the report gives the appearance of consensus and that it is the product of the Task Force, when it may not be. He would like to offer critique and alternative recommendations that would also be a part of the package to the Legislature.

The Chairman stated agreed that semantics are important and yet that ultimately the legislature will decide whether or not they want to use them. Yet, he stated that he wasn't asking the Task Force to come to a consensus to forward the document and assume that they will understand that there was disagreement about certain items.

Rep. Argenziano suggested that the report could include language that indicates the report does not have a full consensus of the Task Force and there is additional information being submitted to take into consideration.

Mr. Grofic said that he had concerns about not voting on the recommendations because the legislative mandate would not be met. Not voting on these issues will make the product ambiguous.

Rep. Argenziano stated that the legislature will have its own versions regardless of the Task Force vote.

Mr. Liptak said that he thinks the information that has been developed over the past six months is extremely important to bring forth to the legislature. The crisis in long-term care in the State of Florida has only gotten worse over the past six months. He said he would also recommend the Task Force put forth the recommendations.

Mr. Connor reiterated that the Task Force was charged not only with the responsibility of making recommendations, but the obligation to include proposed legislation.

Dr. Hernandez said that there were recommendations that could be agreed on and her recommendation is to start by identifying the common ground and then identifying the majority and minority opinions. The situation is urgent as elders are being forced to move out of nursing homes.

The Chairman asked that the Task Force members to consider the logistics: 1) go through all 120 items and vote them up or down or 2) provide members the opportunity to critique or add to the report and the full body of information would be provided to the legislature.

Ms. Fierro said that Task Force members had not received a complete draft of that report and therefore we are not going to be in a position in my opinion to be able to pass the final vote on a final document that we forward to the legislature today. Task Force should be able to view the final report before a final vote.

Dr. Polivka suggested that for the next three weeks following today's meeting Task Force members offer critique information and alternative policy recommendations or options. Then that report would come back to the Task force members within three to four weeks for their approval before it was sent to the legislature. He suggested a conference call to get everyone's final input and perhaps a vote on sending it forward as an amended document.

The Chairman recessed the meeting for lunch.

The Chairman reconvened the meeting. He stated that there are two ways to approach how the report is sent to the legislature; 1) take all the recommendations and discuss them one at a time. This can be done in two ways by vote on each item or voting by exception and discuss only the items in which there is dissent. After discussion the report would go to the Legislature designating those items that

were not agreed upon as informational only; and 2) look over the report and offer opposing views and/or additional information. Staff would coordinate the final revision of the report and it would be sent to the Legislature. This approach would necessitate another meeting or perhaps a conference call.

[The Chairman took a break for a phone call and Rep. Argenziano chaired the meeting.]

Mr. Connor said his recommendations was to circulate the report to the Task Force so their perspectives could be expressed within the staff report; alternative points of view could be registered on the record without their having to be a resolution. The alternative would be to vote, discuss and vote individually on each of the recommendations and the staff would then generate legislative proposals that embody the language which would then be voted on.

Mr. Sherberg asked Representative Argenziano as a legislator if it would be better to have recommendations or documentation without recommendations.

Rep. Argenziano said that if a Task Force is unanimous on a recommendation, it bolsters the legislature; if the vote is split, then it leaves it to the legislature to figure out. The legislation [for this Task Force] charged us with creating legislation which we don't have. There are two options: 1) vote and send a message one way or another or 2) don't vote but perhaps agree on certain parts such as choices and quality and still be able to submit information later on and make it clear that there was no consensus or vote taken on the litigation portion of the bill.

Dr. Calkin proposed that the Task Force look at each recommendation and note where additional specificity is needed to guide legislative drafting, ask for any objections, clarify, and then vote if there is disagreement.

Mr. Connor stated that to vote on each proposal, legislative language needs to be included.

[The Chairman resumed.]

Rep. Argenziano said as past chair of Elder Affairs and Long-Term Care Committee which proposed House Bill 1971, a nursing home reform bill. After two years many of those recommendations had not been implemented because the nursing home industry challenged them until recently. She has also asked for more evidence from nursing homes regarding lawsuits because she has received evidence from the trial attorneys. She wants information that certain poor outcomes are a natural component of aging or dying and should not be brought to a lawsuit. She stated that improving quality will need to be tied to better reimbursement. She suggested endorsing the recommendations where there is agreement. If the report goes without a vote or consensus it needs to be noted that way and send everyone's recommendations. She provided the Task Force with a set of principles that could be endorsed instead of litigation reform.

Guiding Principles for Litigation Reform

Preamble: It is the desire of this Task Force to strike an important balance in crafting these guiding principles. We must work to assure the safety of residents while trying to stabilize insurance rates. It is therefore our intention to provide the Florida Legislature with a set of guiding principles that will seek to encourage insurers back into Florida while maintaining adequate legal remedies for residents who have been harmed. Additionally, we believe the reduction in lawsuits must also come from an improvement

in care through increased staffing in homes as well as an increase in the availability of alternative care mechanisms, including, but not limited to: the home and community-based care systems as outlined in the other chapters of this report. It is important to also note that these two concepts must be indivisible. To enact litigation reform without substantial improvements and changes to the long-term care delivery system will do little to help us achieve our primary goal of providing the best long-term care delivery system in America:

1. Promote the early resolution of claims through the use of an informal exchange of information that benefits both parties prior to filing a suit.
2. Promote the use of alternative dispute resolutions (ADR) in order to avoid costly litigation. We support the concept of voluntary binding arbitration to allow a defendant to admit liability and, in return, the defendant would be able to limit exposure as well as unpredictability through the ADR process. This concept would avoid the costly process of proving or defending fault yet would allow both parties to focus solely on the amount of damages.
3. Eliminate add-on attorney fees in cases involving the personal injury of a resident and allow only limited fees in cases not involving personal injury.
4. Create a mechanism that will increase the predictability of awards for nursing home negligence suits.
5. Limit punitive damages per defendant to a multiplier of compensatory damages with no limits for egregious or intentional conduct.

Mr. Connor said that the advantage to the second is that where there are no dissent or contrary points of view expressed, it is fair to infer that there appears to be implicit consensus. But where there are articulated areas of disagreement, there is division in the house. In those sections, the viewpoints of (for example) Mr. Sherberg and Dr. Calkin should be expressed along with the viewpoints of Mr. Boyer and Mr. Connor. But if there is a vote on recommendations, they must be accompanied with legislation.

Mr. Noga asked as a point of order if Dr. Calkin wanted to pursue her proposal.

Dr. Calkin restated her proposal as a process of proceeding with time limits for each section and assume that those who don't object, agree with the proposals as they are; this would provide the legislature with a better idea of the Task Force's intent. She suggested in the area of tort reform, there may need to be draft legislation. Even so, she withdrew her proposal because Mr. Connor suggested it was the same as proposal #1 from the Lt. Governor.

Dr. Polivka noted that there are significant number of regulatory enhancements in the quality area that would be done in collaboration with changes in the tort statutes.

Mr. Connor offered a substitute proposal (friendly amendment) [note: this is from the handwritten amendment provided by Mr. Connor]:

That in the absence of specific proposed legislation to consider today, and given the shortness of time that remains, that staff will circulate a proposed report among the Task Force which will provide an information base to the legislature and which members of the Task Force will have the opportunity to critique and review with the view that as much consensus as possible will be generated as to the final form, but

where that consensus is not achieved, members would be permitted to express their points of view in the report.

The Chairman asked Dr. Calkin whether she accepted the friendly amendment.

Dr. Calkin stated that she understood there were goals that were being achieved here that she didn't completely understand but that she trusted the Chairman's approach to finding a solution. The proposal would be to seek agreement wherever possible and clarification where necessary. If there isn't a majority vote, the recommendations would fall by the wayside and put in a pile for the staff to clarify.

Mr. Connor clarified that he was not suggesting a vote but a report that includes opposing points of view (e.g. where the report says "there is no correlation between quality and litigation" if the line cannot be excised, then the report should include Mr. Connor's views.

The Chairman reiterated the two approaches: 1) go down item by item and look for consensus; if someone has a problem with an item, debate and discuss and then repeat the process 120 times; 2) accept the document which is full of supplemental information and options (in lieu of recommendations) that include areas of agreement and disagreement (which will be submitted in the next week to ten days) and then reviewed at a conference call later.

Rep. Argenziano said that she wasn't prepared to debate all the recommendations at this time and she was concerned with sending the document to the legislature today that possibly 50% of the Task Force did not agree with.

The Chairman stated that the Task Force has heard presentations and talked about everything that's in the report over the past six months. He asked the Representative whether or not such a report would be helpful upon which to base decisions as an individual member of the House and what recommendations you make to your committee and ultimately to the full body.

Rep. Argenziano said the report needs to be very clear that the Task Force was not able to agree on everything.

The Chairman stated that, as part of the executive branch, the Governor and he have talked about these issues and they will not be satisfied with anything short of a balanced approach that includes quality of care (appropriate monitoring, review, incentives, and sanctions); alternative care placements (additional money is spent on high quality and accountability based alternative care as well as in-home community based care); liability and tort reform is addressed; and all funding issues are discussed (reimbursement rates). They will use the research data presentations and public testimony to build our proposal for long-term health care reform. This does not require a vote on 120 separate issues. The Legislature will not act based on votes but based on good homework, good research, good data, good information and good input from this Task force. We have a larger obligation to provide as much information to the Legislature who will put it through further scrutiny, discussion, debate, consideration, collection of public testimony, data and ultimately arrive at their conclusions.

Mr. Connor stated that he had a motion on the floor but before asking for a second, he suggested a five-minute recess.

Rep. Argenziano stated that the Guiding Principles she handed out earlier have the support of the Speaker of the House and Majority Leader. She also asked for the HCFA report to be addressed; that quotes from 10 state newspapers regarding nursing home insurance market be included in the record. [Staff did not receive a copy] In Alabama experts blame soaring liability insurance costs and say there is not enough federal and state assistance for caring for the elderly many of whom are poor. Oklahoma, State Rep. Chris Hastings said annual liability insurance for Oklahoma's nursing homes has increased from \$100 per bed to \$500 per bed in two years. In Texas, where they have tort reform, there is a nursing home and liability squeeze. She stated that the crisis is happening all over the nation.

The Chairman asked that before leaving the table and begin the process [of responding to the media] that if this is the direction that is chosen, we agree on the direction and deal with our own minority opinions in the most appropriate way. He stated that we represent individual entities but together we are a Task Force and have worked together for six long months and I hope that when we leave here we can leave here as a Task Force and then if necessary as we finish our process, begin our work as individuals which I know we are bound to do.

Mr. Connor repeated the motion.

Mr. Sherberg asked what process would be used to determine where consensus will be evident and where it will not.

Mr. Connor said that consensus would be determined after the report was circulated and Task Force members submitted their comments.

[The meeting recessed for five minutes.]

The Chairman reconvened the meeting and asked for a motion on how to proceed.

Mr. Sherberg asked for clarification that the draft report and backup material would be sent to Task Force members to indicate what we agree to and what we do not agree to or offer additional information. The additional information or opposing views would be added to the report and the Task Force member identified. Where it was unanimous, that would be stated and where there was conflicting opinions or add-ons, the report would state Mr. Connors, Mr. Sherberg stated this or that.

Mr. Connor clarified that the staff circulates the draft report and the Task Force has an opportunity to comment (e.g., on caps on damages). If there were different opinions on an issue or the staff does not agree, the opposition is stated.

Mr. Sherberg stated so we can footnote it at that point.

Mr. Connor agreed and stated that it becomes the final staff report submitted for information purposes to the legislature on whatever timetable they would recommend we take. The staff would be the arbitrator of the comments, in effect. It's their report. The staff circulates its report and Grofic doesn't like the way something is said. And Grofic says, I think it should be said this way and they agreed. Or they say, no we don't agree, but we'll put in your perspective on it.

The Chairman stated that he thought that the Task Force would have to take the staff report and make it the Task Force report. If we take their report to us today and then we look at it. We agree or we comment. Then it becomes a Task Force report.

Ms. Fierro seconded Mr. Connor's motion.

Rep. Argenziano asked for clarification that there would not be a vote today on this report. That this is the report that staff generated on behalf of the Task Force.

Dr. Calkin asked for clarification on the process (an amendment): that they would have a single opportunity to comment on the materials. Staff would compile the comments and objections and support or clarification and send them out to the Task Force.

Mr. Connor stated that one step was missing: there was a circulation with reply, then judgment by the staff which is final, then inclusion of the alternate points of view.

Dr. Calkin stated that she did not want the staff to have to assume the responsibility of her not voting. She wanted the thing sent out. She wanted to comment. She wanted to sign her name. She wanted to tell the legislatures what she thinks.

Mr. Connor explained why he opposed the proposed amendment because in some instances we still haven't received the draft. So we've had no opportunity to comment at all. I do believe that staff would benefit from one additional cut, one cut, from the committee who says we think you're off the mark here. We think you can improve it here. They review that. Make their determination. In other words, they get the benefit of that and then say, here's our next draft and if you don't like it then give me your alternate point of view and we'll include it.

The Chairman said that was what he had in mind. You can't work from it until there is a draft copy from which to work.

Dr. Calkin and **Mr. Connor** discussed the amendment and whether or not it eliminated a step.

Dr. Polivka proposed a timeline that would be compatible with the original motion:

12/22: staff will mail out a draft of the full report with recommendations

1/8: comments, critiques, alternative recommendations returned by Task Force members.

1/22: staff will organize the material within the format that was discussed.

1/29: conference call

He also clarified that most of the recommendations that are in the report came from Task Force members in one form or another over the last four to five weeks.

Mr. Connor clarified that so far staff haven't had a chance to hear our reactions to whatever the draft is. So we get this next draft. You get the benefit of comments. You then referee those comments. Message them however you think fit, is appropriate, integrate them as you see fit. And then in response to this second draft. In other words the second draft is your final, then you get, then when we dissent from that or express our countervailing point of view you put footnote six, but Connor feels there should be no caps. Calkin feels everything should be capped at two fifty. Is that what you have in view? On the second draft and if you don't like the second draft, your dissent gets reflected in the final. I'm talking about the two drafts to come. In other words, we're going to get a draft from you soon.

The Chairman summarized: As it stands right now, according to Dr. Polivka, there are some additional things that the staff needs to do to feel comfortable that each of you has what they consider

to be their final draft. Now giving them between now and whatever date Larry suggested they would compile that. That would give you for all intents and purpose then the draft from which we would finalize the process. Once you receive that, you have the opportunity then to call, e-mail, write, saying I have reviewed this and now I would like to give you my feelings about some of the information that is included within it. Larry and staff would have the ability then to say, this is where I want to make sure I'm right, we will register you as a yea or a nay in terms of what it is that you're telling me, but this is the recommendations as they will stand or and I keep saying recommendations. This is the information as it will stand.

Task Force Member stated: The point is to provide the opportunity for one cut of feedback. So they could either incorporate it or not. They would be the final arbitrator of that.

The Chairman agreed. And then if they didn't incorporate it, your contrary point of view would be reflected in the final product.

Rep. Argenziano asked if someone responds that she doesn't agree with or because you have overlooked another study, does she get to include the other study or just get one sentence, "no I don't like it."

Dr. Polivka stated that you get to include whatever you want to come back with. That according to Mr. Connor's recommendation, we will do some organizing of that material so that it is as readable and accessible as possible. But, you know, we are going to be as responsive as we can to everything that you send us.

Rep. Argenziano asked: as a legislator when I see the Task Force recommendations will they immediately see the comments from those who comment?

Dr. Polivka stated that it is his expectation that staff will put those comments and alternative recommendations next to the recommendation they're related to.

Mr. Grofic stated that he is concerned with who gets to lobby the staff to get their viewpoint put in as the final draft with everybody else's comments dissenting against that. Because it's going to be interpreted when it gets to the legislature as though the position whoever lobbied the best to get that draft changed in there is the way the Task Force really wanted it.

Mr. Connor stated that the Task Force has its opportunity for input. And ultimately the staff incorporates it or not as the draft report. To the extent they don't, the countervailing point of view gets put in there as a countervailing point of view. But it is the staff report. The staff is the arbiter.

Unknown Task Force member asked if the recommendations could be labeled in terms of whether it would require legislation or not.

Dr. Polivka stated that to the extent that staff can, with help from legislative staff, identify recommendations according to administrative action requiring legislation. Statutory action and budget issues.

The Chairman stated that some may require statutory language. Some may require a rule, but not statute. So again recognize that what we end up with in that document may not in essence be what ends up happening to it because a lot of these variables rely on one another before you make a determination

as to which is the appropriate. Some of them will be inescapable. It will be obvious that if you're going to do a certain thing it's going to require a law. Some of them may not be that obvious.

Unknown Task Force member stated that if the vast majority of the information is done, he/she accepts and have trust in the staff to what they're going to produce is going to be along the lines of things that we've gone over and I feel comfortable just taking that as the base and then any countervailing or dissenting opinions could go against whatever that report is and we can get to it and get done.

Mr. Connor stated that not all members have had the opportunity to react. They say yea or nay. If they say nay, then the countervailing point of view gets expressed. For example, we get our report back and it contains this sentence. "There's no clear relationship between quality and lawsuits." And I say, "Larry that's a nonsense statement." And he says, "sorry Ken that stays." Then I get a footnote or I get it put in there next to that however Connor feels that there is a clear relationship.

Mr. Freidin asked to move the question.

The Chairman asked for a final reiteration of the timeline.

Dr. Polivka stated that the next mail out will be the 22nd, Friday of this week. We would expect all comments, critiques, alternatives, suggestions, recommendations, options by the 8th of January, which is a Monday. We will then return to the Task Force the next draft of the report with the next set of comments, critiques, alternatives, recommendations, options by the 22nd of January. And then we would plan to have a conference call a week later with the Task Force to review it for the final time on the 29th.

Unknown Task Force member asked if it would be by the 29th in which your dissenting or alternate opinion has to be to you?

Dr. Polivka said no, the dissenting or alternative recommendation and such is needed by the 8th of January in response to the draft that we're sending out on the 22nd of this week of this month.

The Chairman stated that the question had been called. There is a motion and a second on the floor.

The motion passed: 15 ayes; 2 nays; the Chairman abstained; 1 absence.

The Chairman stated how much he appreciated the commitment to this incredibly important issue. The governor and he believe strongly that we've got to take a balanced approach to the issue of long-term health care. He is convinced that while we may have debated the logistics, that the body of information that we are about to proffer to the legislature gives them the unique opportunity not to have to start from scratch on a most complicated and controversial issue. Regardless of legislation that we're going to have to continue to oversee the appropriate monitoring, review in dealing with an industry that is critical to our most fragile and vulnerable citizens. His hope is that everything that we've done in the way of good work is going to enhance our ability to do that. But rest assured that we cannot close for renovation. We have got to continue to work every day to assure the highest quality, most affordable and accessible long-term health care for the people in the state of Florida. Their hard work is going to help us to do that and better stead in the future. He thanked them on behalf of all fifteen and a half million people for your service to this point. He knows that we're going to end up with a good piece of work and very helpful to the Florida legislature, who then has the awesome

responsibility of trying to turn it into positive change and impact for long-term health care for the future.

Rep. Argenziano thanked the Task Force and stated that she appreciated the work and input everybody put into this and she won't say it's not over and as she said in the very beginning of Task Force meetings, no matter what the recommendations are they're going to need to lobby the legislature for what each one of you believe in and feel is necessary. She can assure you that the comments that you add to the recommendations, as council chair of the health care committees, will get to those representatives. She gives that assurance today and knows that the governor wants to make sure that happens also and she thinks that it will. She thanks them for their input.

The Chairman stated as we walk out the door today, once we adjourn and become yet again individual members of the Task Force and citizens, he leaves you with this thought. That everyone will do and say what they believe is appropriate on this issue. But I want you to know as well any questions that you get from either the public or the press on this issue that you want to refer to either Dr. Polivka or to me as the chairman, feel free to do so. Those that you want to answer on your own you, of course, under the first amendment, have absolutely the right to do that. But you also have the right until we get where we need to go to continue to funnel those questions to Dr. Polivka and then we'll try to do the best we can to explain what we're up to as a Task Force.

Mr. Sherberg stated that people are going to be going out of business--ALFs today as you've noticed, have been given orders to produce insurance. It's not going to be pleasant out there and all I ask is that you all keep in mind for additional regulations or anything else that please put money with it because we cannot cut any more corners.

Dr. Polivka stated that the staff appreciated the Chairman's leadership since July. He has worked with Task Forces and long-term care from Governor Graham's days into the present and the Chairman provided the finest leadership over a 15 to 16 year period. It has just been outstanding. We, in this state, acted as if long-term care and frail elderly didn't exist from 1990 to 1998. We have finally begun to seek real attention focused on this issue and not just the nursing home crisis, but long-term care generally. I don't think we will go through such a period again for the foreseeable future in a large measure because of work of this Task Force and your leadership.

The meeting adjourned around 3:00 p.m.

Respectfully submitted,
Jennifer R. Salmon
Task Force Coordinator
February 1, 2001

Approved February 5, 2001

AGENDA

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

Senate Room 37, The Capitol, Tallahassee and Conference Call

BUSINESS MEETING FEBRUARY 5, 2001

This meeting will be tape-recorded and transcribed for the public record.

2:00 Conference Call Protocol

Lt. Governor Frank T. Brogan

- Please put your phone on MUTE unless you are making a comment (minimize distracting background noise like shuffling papers).
- Task Force members and staff are only participants who may speak.
- Please state your name (even if you are onsite) each time you speak.
- The conference call is being taped for the public record.

Task Force member introductions (*=on conference call)

Hon. Frank Brogan

Dr. Jesse Lipnick

Dr. Gema Hernandez*

Ms. Cherryl Chmielewski*

Mr. Bob Sharpe

Mr. Kenneth Connor

Mr. Philip Freidin*

Dr. Joy Calkin

Mr. Larry Sherberg

Mr. Ed Boyer*

Mr. David Grofic*

Mr. Robert Miller*

Mr. Walter Liptak*

Ms. Victoria Fierro

Mr. Ray Noga*

Hon. Nancy Argenziano

Dr. Jeff Dwyer*

Hon. John McKay

Mr. Rene Rodriguez*

Staff:

Dr. Larry Polivka

Dr. Chris Johnson*

Ms. Jennifer R. Salmon

Dr. Paul Duncan*

Dr. Kathryn Hyer*

Dr. Hongbin Chen

Ms. Mary Oakley*

Old Business

Lt. Governor Frank T. Brogan, Chairperson

Accept or amend minutes of the December 4-5, 2000 and December 18, 2000 meetings.

New Business

Lt. Governor Frank T. Brogan, Chairperson

Review Draft Final Staff Informational Report to the Task Force **Task Force Members**

4:00 Adjourn

TRANSCRIPT
Task Force on Availability and Affordability of Long-Term Care
BUSINESS MEETING
February 5, 2001, 2:00-4:00 p.m.
Telephone Conference Call, Senate Room 37, The Capitol

NOTE: *This transcript may contain errors or omissions due to quality of taping and transcription. Every effort was made to correct errors. We apologize for those that remain. This transcript is in lieu of minutes as a record of the meeting.*

Present (by phone): The Honorable Frank Brogan (Chairman), Dr. Gema Hernandez, Mr. Bob Sharpe, Mr. Philip Freidin, Mr. Walter Liptak, Mr. Rene Rodriguez, Mr. Raymond Noga, Dr. Jeff Dwyer, Ms. Cherryl Chmielewski, Mr. Ed Boyer, and Mr. Robert Miller.

Present (Senate Room 37): Mr. Larry Sherberg, Mr. David Grofic, Dr. Joy Calkin, Ms. Victoria Fierro, and The Honorable Nancy Argenziano.

Absent: Dr. Jesse Lipnick, Mr. Kenneth Connor, and The Honorable John McKay.

Staff present (by phone): Dr. Larry Polivka, Ms. Mary Oakley, and Dr. Kathryn Hyer.

Staff present (Senate Room 37): Ms. Jennifer Salmon.

Lt. Governor Brogan: I want to welcome everybody here today. Just a couple of preliminary housekeeping chores. We are doing this on a conference call communication, at least in terms of being able to speak and hear are incredible important and cumbersome based on the fact that we're not face-to-face. So I want to ask the people, especially in those rooms that have a number of people present, to please, if you will, hold the side-bar conversations down to a minimum. These things are very sensitive and while we'd love to be in on all those side-bars and hear exactly what you're saying, typically what we get is a dull roar which complicates. So if everybody can please, try to pay as much attention to the speakers as possible.

Obviously, since we're not face-to-face as well, identification of speakers is going to be a very important thing for the next period of time. So I will ask anyone who is on the Task Force, if you are attempting to speak to please, if you're in the Senate Room, let Jennifer know and she can be helpful. But any time someone is going to speak, if you will tell us your first and last name, task force members. We know who you are, but I think it will be helpful to others, who are on this conference call, since this is an advertised open to the Sunshine meeting. If you will identify yourself by first and last name.

And in just a moment we are going to do a quick roll call just to make sure that we have identified all of the Task Force members and the Staff members who are present today. I am going to, as I always do, bring everybody up to speed on what brings us here today. And to do that, I am going to digress to the day that we were born into law and let all of those know before my Task Force members and I introduce ourselves, that our present was created as a by-product of a piece of legislation that was created on the issue of availability and affordability of long-term health care during the last legislative process.

The legislature asked us to do several things: One was to meet regularly and we have done that. Two was to hold public hearings in the State of Florida. We have done that in a number of different venues. And then, ultimately, to supply to the legislature important information on the issue of long-term health care, so that they, in turn, could use that information for purposes of making change, budget consideration or identifying issues that they must deal with in order to create not just a long-term health care system for the 21st Century, but a more viable long-term health care system for the 21st Century.

We came together as a very cross-representative group of men and women appointed by a variety of people with a variety of designations. And when I ask my Task Force members to identify themselves, I'll also ask them not only to identify themselves by name, as they're used to doing, but also by designation that brings them to this particular Task Force.

The Task Force has been meeting for a little over six months in venues all over the State of Florida and I've got to tell you beforehand that this group has been a pleasure to work with. It's an enormously complicated issue. It also is not only complicated, but it is emotional based on the fact that we are talking about one of the most vulnerable and fragile populations in the State of Florida. Today and those who will be in that population in the future.

It is also made emotional by virtue of the fact that there are a large number of dynamic at work here on the system of long-term health care that have to do with quality issues, that have to do with issues of alternative care, that have to do with issues of liability and liability insurance. Issues of prescription drug and on and on. And have you talk about that kind of complexity and that kind of emotionalism, for those of you listening in and for those of you who observed the work of the Task Force, you know that the Task Force has done an incredible job of staying focused and being honorable to our commitment that ultimately, that we as Task Force members want from this is the greatest system of long-term health care that this State can provide.

So I want to thank first of all, all of our Task Force members for their service to the State of Florida and prior to this and I know after this, because even after today's meeting it is certainly not over and I also want to thank the members of Staff, Dr. Polivka, Jennifer Salmon, all the people at USF who were assigned to us in legislation. But, again, I think compiled what I hope will be by the time we are finished with it, the best treatise on the issue of long-term health care, that at least this State has ever seen and maybe one of the better such dissertations that you will find anywhere in the country.

Today what we hope to do is accomplish several things. One is discuss the draft that you have all received and the information therein. Two is to and at the same time discuss the format of the draft. The format is obviously a very important issue and we want to make sure that everyone has the opportunity to talk about the format that will ultimately become the report that we will hand over to the Florida legislature.

And then, ultimately, what I hope to accomplish is to have some ownership of this document. I think by the end of our conversation today, it is incredibly important that while we agreed at our last meeting that we were not going to vote on individual items within the document, that before our meeting is concluded today, we will see a motion that will, if worded appropriately, have us adopt the entire document in its entirety for informational purposes and, thus, dissemination to the leadership of the House and Senate.

You all worked very hard on this document and I think you not only have the right to, but I think you should have ownership of the final product before it goes to the House and Senate. So that was a very simple agenda for what no doubt will be a very important meeting and again, I want to thank all of you for joining us today. So with that, I'd like to turn my attention now to the members of the Task Force and if you will please, individually, introduce yourself by name and again, tell us of your special designation, because I want to give the folks who are listening in, as I always do, an idea of not only members of the Task Force, but how representative in nature this Task Force has been since its designation.

So with that I'll start in the Senate Room and, Jennifer, if you'll just point at somebody, we'll start across with anyone who is present in the Senate Room today.

TASK FORCE MEMBER INTRODUCTIONS

Ms Fierro: Good morning. This is Victoria Fierro. I'm the Consumer Representative appointed by the House of Representatives.

Dr Calkin: I'm Joy Calkin. I'm a representative of Florida Health Care Association and a nurse.

Mr. Grofic: I'm Dave Grofic. I'm the FAHA representative.

Ms. Salmon: We also have Larry Sherberg here, but he just stepped out.

Lt. Governor Brogan: That's because Larry is always humbled by the awesome praise that I heap upon this body that we know as the Task Force. And, of course, you have with you as you all can see, but I want the folks on conference call to know we also have Jennifer Salmon, who has helped to Staff us since the very beginning, who is also present in the Senate Room.

I also understood, and you all correct me if I'm wrong, Representative Argenziano, was she in the Senate Room as well.

(No response)

Ms. Salmon: Correct. She may be on the conference call.

Lt. Governor Brogan: Okay. With that, let me just open it up to the other members of the conference call, who are Task Force members and if you will simply identify yourselves individually by name and designation, please.

Mr. Noga: This is Ray Noga, representing Investment Banking.

Lt. Governor Brogan: Welcome, Ray.

Dr. Dwyer: Jeff Dwyer, representing the State University System.

Dr. Hernandez: Gema Hernandez, Secretary to the Department of Elder Affairs.

Mr. Rodriguez: Rene Rodriguez, representing Appointee of the Secretary of Elder Affairs for Hospice Programs.

Mr. Liptak: Walter Liptak, representing the Long-Term Care.

Mr. Miller: Robert Miller, Consumer appointee.

Mr. Freidin: Phil Freidin, representing the Florida Bar.

Mr. Boyer: Ed Boyer, representing the Long-Term Care (inaudible) Council.

Ms. Chmielewski: Cherryl Chmielewski, AARP membership and long-term care experience.

Lt. Governor Brogan: Did we get everybody?

Mr. Sharpe: Bob Sharpe.

Lt. Governor Brogan: Did you all hear Bob?

Ms. Salmon: Yes. And we have the Representative here now, too.

Lt. Governor Brogan: Representative Argenziano, that's you?

Rep. Argenziano: Yes, I'm here.

Lt. Governor Brogan: Very good. And in the Senate Room, are you all sitting in front of a microphone?

Ms. Salmon: We each of microphones, can you hear us okay.

Lt. Governor Brogan: Okay. You're going to need to speak directly into them, because you are coming through, but you come through just a little bit weak, so I ask everybody to -- I may be speaking too loud. You can never tell on these things, but I believe on a conference call it's always better to speak too loud than not loudly enough to make sure that you're heard. So whenever you have the opportunity or the desire to speak, speak right up so we can make sure indeed you are registered with your comment.

Again, I want to thank you all for being here today. And at this point what I would like to do is turn my attention to Dr. Polivka and to Jennifer and give them an opportunity to explain to you how we got to this point in terms of the assimilation of all the materials that you have. Once they have done that, then we will open it up for discussion among the Task Force members and give you all an opportunity to talk about again, either the information that is included or not included, if that is your feeling within that document. And then, again, before we're finished we want to make sure the people are to the greatest degree possible comfortable with the format of the document before we put it into its final version for distribution to the House and Senate.

So, Jennifer, if you would help me out. Dr. Polivka had to run out of the room to get a document real quickly. Wait, he just walked back in. So I'm going to turn it over to him. And, Dr. Polivka, we're going to start with you and if you could spend just a couple of minutes recapping for all the members of the Task Force and the others on the call, how we compiled the information and included that into the format that they have for their consideration today.

Dr. Polivka: Thank you, Governor. The principle needs of material that was sent back to us by Task Force members since the last iteration of the report was to either incorporate it into the text of the material, primarily the recommendations or the summary of findings, which are included in the first 75, 80 pages of Volume I, are to be included as a footnote at the bottom of the page and to some extent we use our judgment in determining how much of the material was submitted that we put as footnotes was included there.

Since over the last few days we have made a change in that and our plan now is to include the full text of all responses, including those that go into the footnote, into any footnote, in the final version of the report, which we hope to get done by next week.

As you may -- you probably know, we sent an e-mail out last week indicating that we would give Task Force members until this Friday to submit any additional comments or make any additions to the text. We also included responses from Task Force members and side-by-side analyses particularly, of the section dealing with litigation and that was primarily an effort to derive a format where people could see the extent of the criticisms or suggestions for changes that we were getting from all of the parties on the Task Force and in some cases, of course, the criticisms are exactly the opposite of each other. But we wanted people to know the full graph of the critique that had been offered by Task Force members to those recommendations.

So, Governor, it's a matter of incorporating it into the text. It is in our judgment it was compatible with the analysis and research that we have done and we offered footnotes in cases where we did not think it was compatible with the work that we had done, but it would be known because that was the agreement in the meeting on the 18th. Already included in a side-by-side critique analysis of the recommendations. So there are three different ways of material coming back to the Task Force members to make its way into the report.

Lt. Governor Brogan: I will also say -- this is Frank Brogan again -- I will also say that we have tried to take all of the material forwarded by the individual members of the Task Force, not just for informational purposes, but some of it for recommended change or in some cases strongly recommended change to the format that was being utilized and have continued to take all of that and to the greatest degree possible tried to incorporate those changes into the final format.

Even from the time where you received what you received that you have in front of you today, we have already gotten some additional recommendations relative, as Larry mentioned, is the way we do some of the footnotes, the size of some of the information, the side-by-sides, et cetera. So, again, we are amenable. And I'm speaking on his behalf, I think, but we are amenable to trying to make whatever changes you all feel strongly about that will make this the best document possible within reason.

Some time, obviously, you have to call closure and you have to recognize that if you have a strong feeling one way or another and it just doesn't seem to scream out at you that way based on format. We're going to turn this over to some pretty smart people in the House and the Senate. And I have a funny feeling that if we do a good job of this, they're not going to be as overly sensitive to issues of format and footnoting, as some of us might think they would be.

But, again, we want to try to make this as accurate a reflection of what the members of the Task Force feel and try to do it in a way that does not give any particular bias on any of these issues, but be hopefully, enormously informational to the members of the House and the Senate.

Mr. Freidin: Governor, this is Phil Freidin. I have a question. What is it that we're going to vote on? I was not expecting to be voting on anything and looking through the Minutes of our last meeting, I didn't think we were going to take any votes. So could you explain to me what we're supposed to be voting on when this call is finished.

Lt. Governor Brogan: Yeah. The only thing that I would recommend that we vote on, Phil and members of the Task Force, as I mentioned earlier, is simply that if we're in a position to do it, an adoption of the document in its entirety for informational purposes to forward to the House and Senate. As I said earlier, I think everybody here has worked very hard on this thing over the last six months and while again, we're not going to be voting on individual recommendations up or down on any side of the equation, I still think it's important that we acknowledge that as a body of work representing virtually every perspectives on these important issues that you possibly can, that at least the Task Force should have ownership of the document, because they have indeed worked very hard on it.

And I think an appropriately worded motion that would not lead anyone to believe that by voting for this motion, they are voting to support any individual item or set of items in the document. There is a way to do this so that indeed we can give to the legislature the Task Force document for informational purposes without asking people to compromise their positions on some of these finer points.

Mr. Freidin: I would comment, just anticipating it might make a lot more sense to not take a vote than being able to come up with the language that satisfies everybody that whatever vote is taken today is not misinterpreted. I -- in order to adopt the document as a whole, it seems to me to be an unnecessary and perhaps interpreted in the wrong manner and I'm going to have a lot of concerns about that in that we clearly decided not to vote and, um, and I don't see the necessity for it. It can only add to confusion about what is actually happening. The document is going to be transmitted with everyone comments. Why does a vote need to be taken? What does it add to anything?

Lt. Governor Brogan: Well, again, at the risk of complicating and I'm not attempting to do so. I'm trying to be sensitive to some of the frustrations on the part of the Task Force members who simply feel or felt in communication with the Chairman that by no vote, no action being taken, not even on the document in its entirety, that indeed nowhere does it ever have the imprimatur of the Task Force on it that they concluded this body of work. I am not wed to that, folks. I'm really not.

Mr. Freidin: Now, Governor, we had a 15 to 2 vote to go the other way and not have anyone put -- what's that word "imprimatur" on it at that time and so now it seems to me after the fact, and after our jurisdiction is expired, do to so I think really would be a mistake and it would cause a lot of hostility that I'm not aware of that exists. People voted almost unanimously to do it this way. And now to go back, seems to me to be reversing that.

Lt. Governor Brogan: Well, again, I'm not wed to that. That was simply an attempt to give people an opportunity to say sine die. At some point we're going to have to do that. At some

point we are going to have to acknowledge the fact that our work is done and the document is now on its way to the legislature. Because one thing I don't want to have happen is have any member or individual members of the Task Force after this is forwarded on say, I wasn't finished with it yet. I think we need to be careful about that fact.

That at some point there needs to be some official acknowledgement by the members of the Task Force that the document in whatever final format it happens to be, is now going to be transmitted on to the leadership and that no one can then back up and say I had 20 other things that I wanted to put in there, but they didn't put them in there. And I'm just sort of caught in a dilemma as to how to do that. How to officially conclude our work and satisfy the legislature that the Task Force is forwarding this on, rather than a group of individuals who got together for six months.

Mr. Freidin: Well, I would think that the thing to do would be to send the report with a cover letter from either yourself or Larry, which says: Please see the Minutes of the meetings, which reflect what the Task Force decided to do or the last meeting, the 18th of December. And that would be simpler than trying to craft something, some final vote that I think can be certainly used politically in a way that perhaps none of us like. We decided the task and I think we ought to stick by that as opposed to sort of trying to do something that infers otherwise.

Lt. Governor Brogan: Well, I think it was several members of the Task Force's belief, and again, we'll talk about this more at the end of the conference call today.

Mr. Freidin: Okay.

Lt. Governor Brogan: But I think it was some of the people's feeling that what we decided not to do was take individual votes on individual items within the Task Force document and that I agreed with. That was one of the things that we talked about extensively. I don't know does anybody believe that what we were ultimately doing was agreeing not to ever take a position on the document in total and, therefore, the Task Force owned the document. But, again, we can talk about that before we conclude our business here today and I am wife open on the subject.

I just want you as Task Force members, to ultimate acknowledge the work and ultimately be able to represent it as having been forwarded by the Task Force versus simply suggesting that I provided input to something that is a compilation of individual ideas that -- anyway, I'm beating a dead horse so ...

Mr. Freidin: But, Governor, that's what it is, is a compilation of the Staff's opinion and a bunch of individual ideas. For good and for bad, that's what we decided on the 18th of December.

Lt. Governor Brogan: Well --

Mr. Freidin: I don't think we can make it into something more now.

Ms. Salmon: We have Joy Calkin here, who would like to speak.

Lt. Governor Brogan: Yeah, Joy.

Dr. Calkin: n alternative may be simply to call a question on the issue of whether -- whether to adopt for information and forward it to the House and Senate.

Mr. Freidin: I can't hear her. For some reason the sound is --

Lt. Governor Brogan: No, Joy, I couldn't hear you either. Do you want to try that again.

Dr. Calkin: I'm going to grab my microphone. Thank you. Mr. Chair, an option is simply to adopt the report for information and call a vote on that now. Then we'd have it clear and not hanging over our heads. I think probably people have thought about it. So I would recommend - I would simply move that we do as you suggest and try it. And if it fails, then fine.

Ms. Chmielewski: Governor --

Lt. Governor Brogan: Yes.

Ms. Chmielewski: This is Cheryl.

Lt. Governor Brogan: Yes, Cheryl.

Ms. Chmielewski: I'd like to go ahead and make a motion, a full motion, if I could, please.

Lt. Governor Brogan: Well, let me short circuit that.

Ms. Chmielewski: Okay.

Lt. Governor Brogan: Only by virtue of the fact that to ask people to move to adopt a document which isn't -- which we're about to discuss in terms of format and information contained therein, is probably a bit premature. We probably ought to go ahead and discuss it, the document that is, get final suggestions on the formatting, information that's contained within, but at some point entertain what it is that you're talking about, Cheryl. And I will ask both you and Joy if that's --

Ms. Chmielewski: As long as you call me when it's time to have that considered, please, sir.

Lt. Governor Brogan: Well, I would really -- by the end of today, as I said to Phil, by the end of this meeting, if we are all comfortable that we all have our information included, that the format issues will be worked out as recommended to Staff and that people seem satisfied generally, it would be appropriate at that point. Joy, is that satisfactory?

Dr. Calkin: I understand what you're saying, Mr. Chairman. You've made your ruling as a Chair and I'm not going to call you on the question.

Lt. Governor Brogan: All right. Let's move forward with the document itself then. Folks, I'd like to open it up for discussion relative to both things. And that is, the information contained within, as well as the formatting of the document. As I mentioned, some of the format questions were issues we've already gotten from individual members of the Task Force and will be making, but if you're not sure about that, being redundant is not a problem in this case, so everyone knows what those are.

So I will open the floor for discussion. Again, to be recognized, please give us both your first and last name so those who don't know you, will know who is speaking.

Ms. Salmon: We've got Vicky Fierro here.

Lt. Governor Brogan: Vicky.

Ms Fierro: Good morning, Governor. I would like to talk about the format of the report for a moment. I faxed a letter this morning to all the members of the Task Force. I hope you received a copy as well.

Lt. Governor Brogan: Yes.

Ms Fierro: My primary concern is that while I understood the vote that we took on the 18th of December was to send this entire body of information, including all the various prospective that we have received to date --

Mr. Freidin: Can I interrupt. We're getting some terrible interference. Is everyone getting that? I can't --

Ms. Salmon: I think we're getting communication from Mars.

Lt. Governor Brogan: All right. It seems to have stopped. Let's try it again, Vicky.

Ms Fierro: Can you hear me?

Lt. Governor Brogan: Yeah, go ahead, Vicky.

Ms Fierro: I'll resume. My concern is that the Executive Summary for this particular report and the title of the report still conveys this as a Staff Report. And the Executive Summary of this report contains a recommendation for the Litigation Reform, which was not approved, of course, by the Task Force. And, in fact, there was great opposition on that from various and sundry fronts. And so my recommendation is basically, I have seven items that I would like to have considered that I put in my letter earlier today.

The first one is that the report's title be changed from the Final Staff Information Report to the Final Report of the Task Force. The second one is since the Task Force did not make recommendations to the legislature, I believe that we should strike the word "recommendations" and include "options" in the report so that the legislature knows that these are not a selected group from which to choose, but a series of options that they can select from.

The third issue is that I really believe that the members' contributions to this report have ever bit as much importance as the contributions of Staff and should have the same weight in the report as Staff options. The fourth is that I believe that the Executive Summary should be rewritten, slightly modified, and I have prepared a draft which I have included with my letter to all the members.

Number five is the issue of the litigation Staff recommendations. I believe that both the options that were advanced by the nursing home industry, as well as those options advanced by the other

groups that were interested including the academy, should be included in the body of the report, but there was no decision on which is the more appropriate set of recommendations and the legislature should go forward to deal with that issue as they see as appropriate, but not with "staff recommendations" on that subject.

Number six, I believe that in the Executive Summary there is a set of Q and A's about tort reform and those Q and A's, I do not know who wrote them or what they represent, but they should be removed from that or at least a minimum put into the appendices.

And, finally, my last item, which I have forgotten what it is -- just a moment.

Lt. Governor Brogan: Vicky, that's comments, suggestions and opinions should be included in the report and have parity with suggested options.

Ms Fierro: Thank you. You must be reading my letter.

Lt. Governor Brogan: I have it in front of me. Let me just say first of all, and then I'm going to let him address it himself, but Dr. Polivka, I think, has addressed several of those in his preliminary comments. There's a couple that I'd like to address.

One is I have no problem with the title that you offer up, Vicky, in terms of the Informational Report of the Task Force on the Availability and Affordability of Long-Term Care in response to House Bill 1993. Not very sexy. Won't get us an academy award, but I think it's probably very appropriate and as Chairman, I have no problem with that one. I think you probably also are correct and I've talked to Dr. Polivka about inserting the word "options" in place of "recommendations" since largely that's what this document is about, providing information and options to the House and Senate to consider. So there again, I don't have a problem. And again, I'm just talking as a member and as a Chairman. And we'll certainly open it up to the other members of the Task Force.

On the issue of -- the last issue, I think that's the one he addressed about including the Task Force members comments and suggested options as well. And he has agreed that he can do that. It will make the document considerably more lengthy and one of the things that we had talked about members, and again we can talk about this under format before we're finished, one of the things we had talked about was instead of creating 100, you pick the number, 200, 1,000 page documents, that perhaps we could use the power of the computer and create a printed text of the summary report and then make available on the Internet everything else, which would be included as a part of the appendices.

So that if someone wanted to move beyond the Summary Report, they would know exactly where to go and they would have more information than they probably ever wanted. All formatted the same way we're sitting here talking about, but done on the Internet as opposed to what are rapidly becoming very, very lengthy documents. So that's just something for you to consider as well.

The issue of litigation Staff recommendation, my understanding is that, Vicky, there you're talking about the side-by-side that was done in the report. Can you talk a little bit more about that one.

Ms Fierro: No, sir, I'm speaking specifically on Page 19 -- let me get my report. I specifically refer your attention to Page 19 of the -- which is the first page of the Executive Summary and Page 21, which is the second page of the Executive Summary. It actually lists the bulleted points of recommendations for those legislative legal reforms.

Lt. Governor Brogan: Dr. Polivka wants to address that one.

Dr. Polivka: Vicky, are you suggesting here that we make an effort to incorporate in some kind of systematic way by categories, the recommendations of the groups that you mentioned, including nursing home representatives that would be presumably FAHA and the Health Care Association, the trial lawyers and others, that we present that in some kind of comparative fashion, and are you also saying here by using the term "replaced" that we leave out the Staff recommendations that was developed?

Ms Fierro: Yes, sir, I am.

Dr. Polivka: Well, Governor, I don't mind --

Ms Fierro: Well, Larry, at least if --

Dr. Polivka: -- a format that will present each of these issues by categories. But, I would object, frankly, to removing the Staff recommendations as a part of that -- of that format.

Ms. Salmon: Dave Grofic would like to say something.

Lt. Governor Brogan: Yes.

Mr. Grofic: I feel very comfortable with leaving in the word "recommendation" instead of "options." I think we've already fallen back from not taking votes to just having the report itself fill over in total and so that I don't know how we -- excuse me?

Lt. Governor Brogan: That's somebody cutting in. Go ahead.

Mr. Grofic: Okay. But how do we vote to decide whether we have recommendations or options? Because I'd like to just see it remain as recommendations.

Rep. Argenziano: I agree with David, Governor.

Ms. Salmon: Representative Argenziano.

Lt. Governor Brogan: Representative.

Rep. Argenziano: Thank you, Mr. Chairman. I have some problems with the word "recommendations" because I don't think we've really recommended anything. The Staff has. And if the legislature wanted Staff to come up with the recommendations, then it would be the Staff doing that. I think it's the Task Force recommendations that need to go to the legislature. So I'm not sure the word "recommendations" is appropriate. And one other thing, Mr. Chairman, I have a problem with -- this not the final -- this is still not the final version and I don't want to vote on something that I don't know what the final version will be. And one other thing,

regarding the Hillsborough litigation study that was done by Staff, all along there have been problems with some of that information and obtaining some of that information.

And now I just received this in my hand for the first time and the first line says that we discovered that the litigation study conducted in Hillsborough County did not identify all lawsuits and then it goes on to say that there were some major discrepancies. So I don't have enough time to make a vote today on something I don't know the final recommendation or even to call it a recommendation since it's not a consensus of the Task Force.

Lt. Governor Brogan: Other members.

Ms. Salmon: Mr. Grofic.

Mr. Grofic: I'd like to jump back in. I think that what the report provides is not all the detail and not all the options that was presented in the various forms from FAHA or other groups. And so by just changing the title and then sending it over without going back and expanding this greatly and having ten more meetings to get all the details so that everybody knows what all the different options potentially could be, then I think we've run the risk of just running this right into the ground.

Ms. Salmon: Ms. Fierro.

Ms Fierro: All the options have already been laid on the table. The FAHA and the Florida Health Association and the trial lawyers have all submitted these comments during the course of this process. What I want to avoid is that when this document gets transmitted and often times the only pages that will be read are the first few pages of the document by people reading the document, it leaves the impression on the very first page of the Executive Summary that there is a set of recommendations that this Task Force, as a body, recommended on litigation reform that was not recommended by this body as Representative Argenziano just commented on.

Lt. Governor Brogan: This is Frank Brogan again and I'm not trying to curtail the discussion on a fine point, which is the word "options" versus "recommendations," but I've got to say again, recommendations in my opinion, and I guess in this case I'm rising to the defense of a few, is the fact that indeed if we're going to bill this as recommendation, it would clearly or could be read by those who take this document as these are not only the findings of, but these are the official recommendations of the Task Force. In light of the fact that I think it's safe to say that some of these are not, on all sides of these issues, clearly the recommendations of the member of the Task Force, then I would defend the word "option" because again, I think if we're going to include some of the other -- the other looks at the litigation issue from some of the other groups and include them also for informational purposes, then what you are truly providing is a set of options on the issue of litigation for the members of the House and Senate.

You truly are not providing them with a list of recommendations. I hate to sound almost Clintonian on this point, but how you define the word "option" or how you define the word "recommendation" is indeed confounding and I don't want to get tied down to too fine a point and that's why I think the notion of "options" is probably, in my opinion, is probably a better reference because that is exactly what this document represents.

Ms. Salmon: Mr. Sherberg would like to speak.

Mr. Sherberg: Governor --

Lt. Governor Brogan: Yes, sir.

Mr. Sherberg: -- all throughout our seven months of journey here we've used these terms and I don't think that they were inappropriate at the time. Also in our last meeting, this is why we gave each member the time to push their own comments. And I think the comment section is stated. I mean, I don't have a problem with "options" versus "recommendations" but we have been going through and using these recommendations the entire time and I think we should continue.

Mr. Liptak: Walt Liptak. I think if the title is changed to an Information Report from the Task Force, then I think it would be inconsistent to use the word "recommendations" and I would agree that "options" is a better selection.

Lt. Governor Brogan: Other feelings.

Dr. Hernandez: This is Gema Hernandez from Elder Affairs. I believe that we need to perhaps use "options" and "opinions" of individual members of the Task Force. Because that's exactly the document that we have in front of us. The collection of opinions and in some cases options that the members of the Task Force offer, so people can explore them.

Lt. Governor Brogan: Other members.

Dr. Dwyer: Governor, this is Jeff Dwyer. I just wanted to make the suggestion that maybe when we get to the point of voting on something like this that we consider separating out the task. It's at least my impression that there was the sense of recommendation among many Task Force if not all Task Force members, on certain of the issues in quality of care and alternatives and I'd hate to see us throw the baby out with the bath water if the primary area of disagreement is litigation.

Lt. Governor Brogan: Jeff, you've hit on a very important point and one we talked about internally the other day. If you stop and think about our work task force members it's largely fallen into three specific areas. Area one, we began to discuss alternative care. We came up with a pretty broad consensus on the whole issue of proving more in-home care, community based care programs and I think -- and again, I'm not trying to speak for any member -- individual members of the Task Force. Somebody may be sitting up right now saying, not me. But for the most part, I think we did reach an accord on the issue of alternative care.

We then moved on to the issue of quality and, again, I think for the most part we satisfied ourselves as Task Force members that we would indeed agree even though through consensus, even though consensus doesn't mean we agree on every single point, we generally agreed with the approach that we took to quality of care. And, again, I'm not attempting to speak for individual Task Force members, just what I heard as Chairman globally on the issue of quality of care contained within the document. Then, obviously, we moved on to the issue of liability and we talked about litigation. Probably more clearly there is a split among members of the Task Force on the issue of litigation and liability.

So it was our determination that the best thing to do would be, again to compile a lot information on the issue of litigation to provide to the House and Senate and ultimately allow them to take their position on the issue. But as Jeff mentioned and I think he's exactly right, if you go back in time and think about the three individual pieces, there was much general consensus in total on the first, arguable and total consensus on the issue of quality.

And, again, I don't mean that there is not an item or items that individual members of the Task Force totally agree with. But when we got to the issue of liability is where it became difficult and that is where we agree to put information together for the House and the Senate. That's kind of the way I remember it as the Chairman.

Now whether it is possible then, based on Jeff's comment, to go back and break down the three individual components is something that we can certainly talk about.

Ms. Salmon: Representative Argenziano.

Rep. Argenziano : Mr. Chairman, the last meeting I had a copy of something. I don't know if you've ever gotten to see it. The Speaker was supportive of it and the House Majority Leader was supportive of it. And it was Principles on Litigation Reform. And the reason I brought that up was because I knew that there was not consensus on the litigation issue. And to keep everything else intact that we could agree on, I thought that if we addressed something such as at least guiding principles to litigation reform, I don't know any other member except Larry maybe, who got to read that that day. And I thought that would be a way out to save what the -- the rest of what we all could agree on. Is there a possibility of going back to something like that?

Lt. Governor Brogan: Well, there's two ways to approach it. That is one. Another way to approach it is to simply recognize the variety of different opinions on the issue of litigation reform. One is that there should be no litigation reform. Two, that there would be some litigation reform as carried out with the following recommendations. And then I would venture if you look at each of the consumer groups and the advocates out there, there's probably a different spin from each of them on what litigation reform might look like from no litigation reform all the way up to and including what some would consider to be the extreme litigation reform and everything in between.

And I think one way to look at this is including that within the document and that is taking several different versions of what we either heard in public testimony and believe me, received in writing or in e-mail from the different groups and include them all in the final document and then let the House and Senate use that as a buffet, an opportunity to select what, if any, litigation reform they believe that we need to have.

Rep. Argenziano : I'll follow up, Mr. Chairman. I guess I understand, except the problem is -- the problem that I have as an individual member of the Task Force, is that I'm not sure that I agree with any of the proposals in the Task Force recommendations. And the reason for that is because I keep seeking in my mind, I keep seeking the evidence --

(End of Tape 1 - Side A)

Rep. Argenziano : -- unnecessary lawsuits that are existing now and I don't think the Task Force has received that evidence to my satisfaction at this point. So I have a hard time trying to figure

out which plan to go with without having the full evidence in front of me of why we need to do this to begin with.

Lt. Governor Brogan: Well, I would suggest that indeed one of the versions that you may wish to support, which would end up in the document would be that there would be no litigation reform based on the reason that you just outlined. But I would also say that we have versions from several of the groups on all sides of this issue and to provide it, I think, would be a service to the members of the House and Senate, who do believe that there ought to be litigation reform.

If there are enough of them who don't believe there should be, they will decide that very quickly. If there are enough who decide there should be, rather than starting from a blank sheet of paper, I think they could benefit from the six months work that the Task Force did in compiling all of this information and putting it down into a format that they might find useful.

And, again, they might decide none. They might decide total or they might decide one from Column A, one Column B and one from Column C. But that's a part of the document. I go back to the issue of quality. We included in the quality component, not only those things that many people to consider to be carrots. We included those components that some people, many considered to be sticks. And we included them in there in totality to make certain that the House and Senate would have access to all of that information and all the variations on the theme. In the final analysis, the House may decide to go with only carrots and in the final analysis only six, I would suggest they'll probably go with hybrid. And I think it's no different on the issue of litigation. We have differing opinions from no litigation reform up to and including what some might consider to be draconian. And everything in between.

Rep. Argenziano : Mr. Chairman --

Lt. Governor Brogan: I think we've got the same responsibility of the House and Senate to provide that information to them and then allow them to decide what, if any, litigation reform they will select at the end of the day.

Rep. Argenziano : Mr. Chairman --

Lt. Governor Brogan: Including some that may not even be within our recommendations.

Rep. Argenziano : Mr. Chairman, I have to go back to something now, because I'm going to have to clarify this so that it's written in the transcript, so that if anybody wants to reproduce what I say, please get the transcript and let me clarify this. Mr. Chairman, no, I did not say I am not for any type of litigation. That would be obvious by looking at the guiding principles of litigation reform that I have submitted.

I do believe there are areas where litigation reform is absolutely essential. What I'm saying, and let me clarify this, and give me a moment, please because it may take a moment. But what I have not seen -- what I have seen is insurers coming into the State, coming before the Task Force Committee and saying that we are going to leave your State despite you having -- even if you do have litigation reform. And I see insurers leaving the rest of the nation for the same reason, I guess. They're just having problems in the nursing industry, whether it's lawsuits or whatever it is. But, they're leaving nationwide.

The told us that they would not necessarily come back into our market even if we did do a reform. And then I think the thing that I looked for the most, was finding or listening to those who testified on the -- let's see, I guess cases or actions that had no merit. That's what I'm looking for. If there is, and I repeated this many times, if there are lawsuits taking place in our nursing homes that are a part of -- God, you've heard me say this so many times -- a natural component of aging or that of -- a natural component of dying process, well, heck, I'd be the first one to write the legislation to protect those nursing homes from that type of litigation. But, unfortunately, as a Task Force member, I have not seen that evidence. I don't even see it in any of this writing in here. I don't have --

Lt. Governor Brogan: And, Representative, I'm very sensitive to that. Number one, I did not suggest, if you thought I did, I apologize, that you had a position staked out on this issue one way or the other. I was talking about in theoretical terms. That if any member of the Task Force doesn't believe that there ought to be litigation reform, they ought to have the opportunity to have that included. Up to and including, again, what some people might feel is extreme litigation reform, on those things in between.

I, for example, was a member of the Task Force, not just Chairman. And I, for one, as the Governor, believe that we need litigation reform. I will not push a particular litigation reform initiative, because I would venture to say that within all of the opinions and recommendations that have been delivered to us, probably somewhere in there is the version of litigation reform that the Governor and I feel is probably most appropriate to pursue. And that's exactly why I think that it would be helpful to the House and Senate to have that information, so that they would at least know what possibilities existed out there.

As it relates to the guarantee of the insurance industry, I would suggest you will get no more guarantee from the insurance industry on litigation reform and their return, as you will get from trial attorneys and their guarantee that they will pursue no litigation if we do all of the carrots and sticks in the systemic reform. And I don't mean that as glib comment. I mean that as fact. That people do not make guarantees simply because this is a business. It is the business of human beings and it's the business of many times frail and fragile human beings. And having said that, I don't think business people are in the position of making guarantees on -- all they can do is tell you, you know, what they can tell you in that regard.

So I'm going to make the case again that I think if I were a member of the House and Senate, and I'm not. If I were, it would be helpful to me to have the variations on the issue of litigation reform that people had discussed, considered and provided to the members of the Task Force and those that came from the Task Force themselves. And, Representative Argenziano, that would include, if you wanted to include it, what you provided to us on that particular day.

Rep. Argenziano: Mr. Chairman, I'll just go over this briefly. Because I am a member of the legislature, I'm going to include what I think is, at the time, I guess, with my colleagues too, but what I meant, and with all due respect, I understand what you're saying. But I am desperately seeking a reason as to why. I have a very logical and analytical mind. And if I can't find in front of me -- what I'm saying to the insurance companies -- I'm looking at as evidence brought forth before the Task Force and I'm listening to them say, well, we're leaving anyway. And I'm looking for evidence of why we need to do this.

And I understand. I've heard the testimony. But I would love to see and I guess maybe I should have been an attorney somewhere in another life or maybe I was, I don't know, but I'd love to see that. Because if it's really happening, then I would love to be the first person to sign on to a bill that says -- and I have no doubt that it's happening in certain areas, but it has not been before me. And I'm wondering, are we just doing tort reform because it sounds good or because the insurers are leaving. That was my point. I don't have it in front of me and I'm not sure if I'm articulating it well now. I wish I could. And I'm not sure I'm getting my drift across. It's great that the Governor thinks that there needs to be tort reform, but is it for meritorious cases or just tort reform because we need to keep the insurance companies here. That's the answer I need.

Lt. Governor Brogan: I understand and I will say this. The Governor not only believes that we need litigation reform, he also believes that we do need the systemic reform largely that's laid out within the draft documents that you have. He also believes that we do need the alternative care opportunities and I think to treat the one piece, the litigation reform differently than we're treating the other pieces, which is to suggest that we need systemic reform across the board, not one in lieu of the other, but all together, I think is doing a disservice. And I really think that we need to keep this total picture in mind at the end of the day, that it isn't just about systemic reform, alternative reform or litigation reform. It is about an entire package that we are talking here.

And, so, again, if we want to use a sheet of simple principles on litigation reform, we ought to use the simple sheet of principles on quality of care and on alternative care as well and we can synthesize six months work down to a one-page document. I think what the House and Senate was looking for was considerably more in terms of their ability to read, decipher and ultimately decide what systemic reform would look like across the board on this issue.

Ms. Salmon: Mr. Sherberg.

Mr. Sherberg: Governor, I don't know when we're winding down, but I guess first of all I'd like to thank

Dr. Polivka, Dr. Salmon, Florida Policy Exchange Center of Aging, Dr. Hyer, et cetera, et cetera. Mary Oakley for all the help in trying to make us more educated individuals for the State of Florida and for ourselves. Also, I'd like to kind of concur with Representative Argenziano on her guiding principles and make the statement that I think that these books or manuals are for what we decided are for informational purposes only. And should be passed along to the legislature with that in mind. That they have and they will represent their constituents properly. Our constituents, our needs and our residents' needs.

But at the same time, our report now is an informational packet for them to use as a resource manual; is that correct, sir?

Lt. Governor Brogan: Well, that is largely what I think we decided at the last meeting. And I know a lot of water has gone under the bridge since that meeting and I'm sensitive to what Phil Freidin was saying about a final vote. But all I can do is take us back to the last meeting when we generally agreed that we would be providing and I agree it is, a massive amount of information to the House and Senate for their consideration. Bringing to them a variety of perspectives on all of these issues, knowing at the end of the day that House and Senate as they are elected to do, will make the final decision as to what the systemic reform will look like across the board.

And as I said to the press, and I really was not attempting to belittle the process, all of the Task Force reports that go to the House and Senate over time, and some of which contain votes, some which do not, I don't ever remember seeing a Task Force report that was taken item by item by the members of the House and Senate, and because it had attached in it or to it a majority vote of the members of that Task Force, it was automatically given immediate statutory prominence. Up or down.

And that's why I say that I think it's important that this be considered one of the most important and one of the most all inclusive dissertations on the issue of long-term health care that the State has ever seen and then trust that we have elected, and I think we have, good people both sides of the aisle, House and Senate, who are capable of deciphering it, taking additional testimony as we know they will, ultimately dialoguing with their colleagues, debating the point and committee on the floor, and ultimately, creating their own version of long-term health systemic reform as it relates to statute and budget.

So, again, I know we can bogged down significantly on content, on format, on font size. But, ultimately, I think we remember that we ought to keep our eye on the ball, which is providing the House and Senate the amount of information that they're going to need to do that. My point is if there is information not included in this document and someone wants to see it included in this document, we will once again put an all call. Let us know what it is, provide it to us and I think you will find that we can incorporate it into the final draft that we ultimately send on to the House and Senate.

It's not a matter of being exclusive. We're trying to be inclusive here with this information. It is not a matter of using format as a scalpel for purpose of trying to make one point over another point. That's why we're having this conversation today. We want your input on the format. We want your input on the information that will ultimately go within this document. And to the best of everybody's ability, we'll try to accommodate that to the point where we can hand it off to the House and Senate and the people in the Task Force will feel good about it.

Dr. Polivka?

Dr. Polivka: Governor, just back to Ms. Fierro's seven requests. Just to be clear from my prospective, Staff prospective, we wouldn't have any difficulty with any of the recommendations, except the one asking that the Staff recommendations on litigation be replaced by these other -- the other contributions from the nursing home administration trial lawyers and others. I think that the Staff recommendation should be a part of that array. That would include all of that -- all of the recommendations from those other parties in addition to the ones that we have made. That would be my only difference with the suggestions that Ms. Fierro has made.

Ms Fierro: Lieutenant Governor, this is Vicky Fierro.

Lt. Governor Brogan: Yes, Vicky.

Ms Fierro: My recommendation was that all of the presenting options under that litigation be included, both the ones that came from nursing home industry and the ones that came from the trial. The ones that came from the Staff are actually a subset of those other sets of

recommendations. So if all of the recommendations are provided, the ones that the Staff were talking about are included. It's simply a subset of those other two sets of recommendations.

Dr. Polivka: There are at least three major differences between our recommendation to those offered by anybody else. Particularly, if you're referring to those that came from the provider side and they have to do with accounts and they have to do with the provisions for allowing children in the case of no spouse over 25 to help standing in Court. And they have to do with permitting people to sue both the pending suffering of a patient who may have died, as well as the person bringing the case.

Ms Fierro: And, Larry, I'm comfortable if it makes you -- if you feel better about having the Staff recommendations included with the other sets of recommendations. I simply don't want them included in the Executive Summary as if they stand alone or leave the impression that these were the ones the Task Force had endorsed.

Lt. Governor Brogan: That's fair enough. He's shaking his head to that as well. So, fair enough Vicky.

Ms. Salmon: Governor, this is Jennifer Salmon. Can I just suggest, because we did this at the December 4th and 5th meeting, we already set up a side-by-side with FAHA and the trial attorneys, which is really sort of the two very different points of views. If we could just do sort of a three-way and put the Staff recommendations, because I agree with Larry, that what we did try to do is to pull from both of those. And then you're getting the three major ones. There were a lot of recommendations. It becomes a huge report and the web site has all of the recommendations up on the web site.

Lt. Governor Brogan: That's fine. And I think, Vicky, and you can correct me if I'm wrong, I think Vicky's point here is just to make sure that when a member looks, she can see or he can see clearly the different sets of opinions on this thing and from whence they came. Vicky, am I characterizing that right?

Ms Fierro: Yes, sir. But I would add the caveat that I want to make sure that not one set more than the other has the approval or the appearance of the approval of the Task Force.

Lt. Governor Brogan: So noted. Yes.

Dr. Polivka: Governor, I would like to include the side-by-side critique of the Staff recommendations, because I have heard from many Task Force members and others, they feel as if that side-by-side critique has offered them insight into the issues that they have not gotten in any other way.

Ms. Salmon: Larry, what page.

Dr. Polivka: I would like permission to keep that as a part of the text.

Lt. Governor Brogan: In conjunction with what we just talked about?

Dr. Polivka: Yes.

Lt. Governor Brogan: You-all have any problem with that out there?

Dr. Calkin: We're looking at it and Mr. Chairman, if I could --

Lt. Governor Brogan: It's simply a format issue of including also, not in lieu of, but also the side-by-side, which many of the members of the Task Force found to be very insightful and very helpful.

Ms. Salmon: Dr. Calkin would like to speak.

Lt. Governor Brogan: Say again.

Dr. Calkin: Mr. Chair, it's Joy.

Lt. Governor Brogan: Joy, yes, I'm sorry.

Dr. Calkin: I guess there are a couple of things, since you're asking for feedback, that I'd like to just state in process. First of all, I should be clear that the provider groups do not agree with the Staff recommendations. The provider groups do not agree with the Staff recommendations. So let there be no lack of clarity about the fact that we -- these are not the report -- this is not the report of the providers nor did it have -- on the matter of litigation.

There are a very significant number of pieces both within litigation, within funding that area critical within the quality of care that are critical to our task. Let me tell you, coming in and observing us here in Florida for the last four years, the legislators in this State, and Representative Argenziano, who has been extraordinarily helpful in this, have provided funding in the hope that there would be an improvement in the care delivered in nursing homes.

Of that, eighteen and a half dollars, eleven and a half is going right out the door on the other end into litigation. We have a problem in Florida. Dealing with the continuing of care alone is not going to help. It matters. Dealing with the quality of care is going to help and it matters. Dealing with funding is going to help and it matters. But what matters equally much is the issue of considering litigation.

Now in the process here before us, Mr. Chair, with that by way of background and my apologies, I want to be clear that there are some of us who believe that the report the way it was presented should move forward. You have not asked us as a group to comment on that and I am doing that now. I wish, Mr. Chair, to formally recommend the report in its current form be forwarded to the legislature. Let the question go up or down. If it goes one way, fine. We'll fix it. If it goes another way, fine. We won't fix it. But whatever it is no one is going to have all their oars in this to the depth they would want to. And I understand that. This is a process that wants rational and political.

But I'm here to tell you our Staff, and our residents, and our families and our insurers and so all believe that this whole package needs to be considered. We may be wrong, but at least we will have been informative. And so I would ask you, Mr. Chair, by way of motion to approve the report in its current form and put it forward. And I agree in advance, by the way, that if the side-by-sides need to go through, I think that that makes perfect sense. And, by the way, I think that

includes Representative Argenziano's question. She has raised those issues and they are part of the record.

Lt. Governor Brogan: Joy, let me see if I can get my arms around your motion. I was with you to the point where you said I move the current document.

Dr. Calkin: That's correct.

Lt. Governor Brogan: Then did I understand that you are agreeing in your motion to include the side-by-side and Representative Argenziano's material?

Dr. Calkin: I thought Representative Argenziano's material was part of the report, but there are a number of special reports that can be included. But, I am specifically recommending that we vote -- I will recommend that we vote on the cream one and on the green one. And then if one of my colleagues wants to make an amendment to that motion, that's fine, Mr. Chair. So I'll just do it simple.

Ms. Salmon: Mr. Chairman --

Lt. Governor Brogan: So then noting the fact that Representative Argenziano's material is in there and representative and if it is not, please shout out --

Dr. Calkin: It should be put in there.

Rep. Argenziano: Mr. Chairman, let me ask you, are we limiting the debate now or can I speak on some other things that I have some questions on or are we just going to the end of this.

Mr. Sherberg: Point of order, sir.

Lt. Governor Brogan: Yeah, hang on one second here. Representative Argenziano, I didn't get your comments. Please, again.

Rep. Argenziano: Are we ending the conversations here on our questions, are we ending questioning by going to that motion now, if I have further questions?

Lt. Governor Brogan: Well, all I have on the floor thus far is a motion, but I need a clarification to the motion before I think anybody can even consider a second.

Dr. Calkin: I'm sorry, Mr. Chair. My intention would not be to exclude the information from Representative Argenziano or the suggestions of my colleague with regard to the side-by-side. My intention is to understand where the other members of the Task Force are, who are on the phone, from whom I have not heard and I want to know how they would vote on sending this package forward as we said we would do when we met in December. That's all I'm asking, Mr. Chair. Thank you. I don't know that I have a second by the way.

Lt. Governor Brogan: I just want to make sure I understand at the fear of being redundant. You are moving or would entertain the motion that we accept the document in the form that it was distributed today and that it include, if it does not, the set of principles of Representative

Argenziano, as well as the side-by-side, which I understand is included in the total document as well.

Dr. Calkin: Indeed. I think that Jennifer and Vicky have just been discussing this and I think you have a solution.

Lt. Governor Brogan: Okay.

Dr. Calkin: That the three of them should be side-by-side.

Ms Fierro: Mr. Chairman, didn't we at the last meeting say we were not going to vote to send this information.

Dr. Calkin: I reviewed the Minutes and I would be glad to have you rule on that, Mr. Chair. It's my review of the Minutes that that was not the case.

Ms Fierro: I don't remember us saying we were going to vote. I think we need a review, because I don't remember anybody saying that they were going to vote on sending information.

Lt. Governor Brogan: Yeah. I've got to tell you just one person's feeling and I stated that up front. It was always my belief that what we had agreed to was that we were not going to vote on 120 individual recommended items up or down. But it was never my belief that ultimately we would not be voting to accept this document for purposes of forwarding it on to the legislature. And, again, I tried to make that clear at the onset. Not for purposes of a motion that would give any -- lend any notion that people were adopting any individual items in there, but they were simply adopting the document for informational purposes.

Now some people are concerned, obviously, that based on format by such a motion, they might be considered de facto to be voting on some of the individual items contained within, but again, as I said earlier, I think with a carefully worded motion, even a very carefully lengthy motion, it is quite possible to let the House and Senate know and include it in the cover letter that that is not the intent, but simply an intent to adopt the entire process for purposes of forwarding it on to the House and Senate for their consideration. And like Joy, I do want to hear from as many members of the Task Force as choose to speak.

Mr. Freidin: Governor, it's Phil Freidin again.

Lt. Governor Brogan: Philip.

Mr. Freidin: Looking at the Minutes of the last meeting, it seems like we got off on the path of not voting based upon Ken Connor's observation that we had not complied with the legislative mandate of putting these matters into legislative language. And as he made the point and others did throughout, the devil is often in the details. And felt that we did not have the jurisdiction, or the power or the ability to vote adopting any of these provisions and I think that's what everyone basically agreed with. Having said that, I fail to see any reason to vote on anything today.

And I fail to understand why it accomplishes anything other than confusing the issue of what we have not done by a 15 to 2 vote. And I don't understand what -- you said it several times and that it tells the legislature that this is our work, but it really isn't our work, it's a compilation -- it's a

compilation of materials that have been assembled. We've never really reached a consensus on anything. And it would be misleading, I think to reach a consensus now, unless the motion was so nonsensical as to make no sense, such as a motion to say we're reaching consensus but there was no consensus. And it seems to me that it would be an unnecessary, and misleading and confusing notion and I don't know why the legislature gains anything by that vote. They're going to get the materials and they'll see what happens. And that's my thought.

Mr. Boyer: Governor, this is Ed Boyer. May I speak?

Lt. Governor Brogan: Yes, please.

Mr. Boyer: Thank you. I agree with Phil. What we did in December we did, when we had authority to do it. I question whether we really have authority to do a vote now. I may be wrong, but it sounds like (inaudible). What we're doing is sort of a wrap-up and I don't see any sense in going back and re-voting on things now, because what we decided to do, we decided to do in December and we're now doing that. And I do see any reason to go back now and start motions and votes on the nature of what Dr. Calkin is asking for.

Dr. Calkin: Mr. Chair, if I may. I was not making a motion to go back to the Task Force at all. In fact, Mr. Connor and I, you may remember, had some discussion about the motion that he was making. So as far as I can tell from the record, there is a set of concerns that were expressed. Some of which were reflected. Secondly, it was not stated that -- it was stated quite clearly that the individual pieces would not be dealt with. And, thirdly, I think we might have different understandings about therefore, whether we can vote to send the report forward. This is simply in the final analysis, we agreed that we couldn't agree on some matters. That we could agree on a lot of others. We were divided, actually, I think within the Task Force and a number of people were willing to move forward. A number of people tried to stop the Task Force from going forward.

Lt. Governor Brogan: Let me ask a question. Is there anybody on this conference call who disagrees with Vicky Fierro's belief that this document should be titled "The Informational Report of the Task Force on the Availability and Affordability of Long-Term Care in Response to House Bill 1993"?

Dr. Calkin: This is Calkin. I can live with that.

Lt. Governor Brogan: Anybody disagree with that?

(Replies of "No")

Lt. Governor Brogan: I guess what I'm getting in a secondhand way is the fact that by your silence, you just voted on this. I'm not -- I'm not going to repeat that anywhere, but it sounds like I'm whipping a dead horse on this thing.

Ms. Chmielewski: Governor --

Lt. Governor Brogan: I want this document to belong to the Task Force. If you want to vote on it, fine. If you don't want to vote on it, that's fine too.

Ms. Chmielewski: Governor --

Lt. Governor Brogan: Yes.

Ms. Chmielewski: This is Cheryl.

Lt. Governor Brogan: Cheryl.

Ms. Chmielewski: Are we just trying to come up with something worded something to this effect, that given the areas of disagreement and agreement, that are all well and thoroughly documented in the Staff Information Report to the Task Force, including the issues that were brought up today, Representative's principles and Vicky's concerns that we might move to accept the report and forward it as the final report? Is that essentially what we're looking to do?

Lt. Governor Brogan: That's generally what I had in mind.

Ms. Chmielewski: Well, could I so move that we do that?

Mr. Sherberg: Second it.

Lt. Governor Brogan: Okay. We've got a motion and a second on the floor. I'm sorry, Cheryl, would you repeat the wording of that, if you've got it written down.

Ms. Chmielewski: Yes, I do. If I can read my scribbling here. Given that the areas of disagreement and agreement are well and thoroughly documented in the Staff's Information Report to the Task Force, including the information requested to date, regarding Representative Argenziano's principles and Vicky Fierro's concerns, I would move to accept the report as it is and forward it as the final report.

Lt. Governor Brogan: All right. I have a motion and a second. Discussion.

Mr. Sherberg: Point of order, Mr. Chairman. This is Larry Sherberg. We still have a motion on the floor by Joy Calkin. Either she needs to drop it or we need --

Lt. Governor Brogan: I don't think it received a second.

Mr. Sherberg: Okay.

Mr. Boyer: For clarification, Governor, this is Ed Boyer. I assume she's talking about Ms. Fierro's points number 1 through 7 in her letter.

Lt. Governor Brogan: Yes, sir. And on -- and as Dr. Polivka mentioned we can accommodate all of those on number -- I'm just looking through now -- Number 5, we will include the side-by-side for information as well as the different versions on the litigation reform.

Mr. Freidin: Governor, it's Phil Freidin. Has our power to vote, as Ed Boyer suggests, expired?

Lt. Governor Brogan: I --

Ms. Salmon: This is Jennifer. The last day is March 1st, I believe, of 2001, that this Task Force expires on.

Mr. Freidin: I thought the report to the legislature by the end of December.

Ms. Salmon: That's right, but you voted in December to delay that.

Mr. Freidin: Well, I'm asking whether we have the power to do that, I guess is the question, in light of the fact that we are created by statute.

Lt. Governor Brogan: Are you going to sue, if we do?

(Laughter)

Lt. Governor Brogan: Gosh, we're cutting a pretty fine point on this thing here.

Mr. Freidin: Well, Governor, actually, I -- you can always get a good laugh at a lawyer's expense about a lawsuit and I appreciate that. But I don't think it's cutting it fine to say that some time in December, for whatever reason, and you were involved in it and one of the prime movers. This Commission or Task Force decided to basically terminate without concluding its work. And I don't think it's simply a fine point and then there's an attempt now to say, well now we're voting and now there's some areas of agreement. I'm not sure there ever were any areas of agreement because we never actually discussed any issues with any finality, let alone take them to a vote.

So, Cheryl's motion which contains language about areas of agreement is not necessarily true. A final report --

Ms. Chmielewski: I also said disagreement.

Mr. Freidin: I know, but I'm not sure that there are any areas of agreement is all I'm saying.

Ms. Chmielewski: And it's purely a move to accept the report as it is, Phil. I wasn't trying to make a major motion here.

Mr. Freidin: Let me finish. This is not a final report and that's a misnomer. It's an unfinal report. And I understand your point of view, Governor, but I'm saying we deliberately, and you were part of it, said we're not going any further. I was prepared, I came here to Jacksonville to discuss and vote. The motion that was made, which you agreed with, took me by surprise. When it took me by surprise, I didn't understand where it was going, but basically, it seemed like everyone was convinced after you convinced us that we really didn't have the authority to go forward with out legislative language and that things were incomplete.

And I'm simply saying that the actions today seem to me to be unnecessary and outside the area of where we were when we were all there ready to discuss what we did and did not agree upon. And I'm just concerned that there's something about using language, like "final report" or "areas of agreement" or whether they are recommendations or options. I'm concerned about all of that being voted on after the time that the legislature gave us to work on this, being nullifying what we all agreed to do in December.

Lt. Governor Brogan: Phil, somebody on Staff just handed me the information that the recommendations of the Task Force must include proposed -- let's see -- the Task Force shall expire on March 1st, 2001. I think we have a life span that takes us to March 1st, 2001.

Mr. Freidin: Well, I feel I can breath easier.

Dr. Calkin: Mr. Chairman, before we go further with the motion, I would just like to reiterate that I feel uncomfortable saying anything about -- we did not -- we did not talk about the redesign of DEOA. We didn't talk about the LTCS or whatever the heck it is in the thing, that may actually hurt small nursing homes. I mean, I can't find -- I can't put my name to say that I agree with sending something that we didn't even discuss. So I'm having problems with it and I just need to go on record with that.

Lt. Governor Brogan: Anybody else?

Mr. Liptak: Governor, this is Walt Liptak. Maybe I'm not viewing this in the same light as everyone or a couple of the people. But I don't see this as a major issue. I think all that has been put forth as a motion is a way of sending this report, this Informational Report on to the legislature as essentially the Task Force's acceptance of the Staff report. So, I guess I don't see the problems that some of the Task Force is bringing forward.

Lt. Governor Brogan: Well, for some of us and I'm not trying to put words into Phil's mouth. Believe me, I'm not. But I'm trying to be sensitive to his concern and if his concern or anyone's concern on this issue is that if we're not careful about how we do this, someone in the legislative process is going to stand up on the floor of the house, hold up that document and say, here's my position on the issue of long-term health care and everything that I'm saying is supported by the document that was given to me by the long-term health care Task Force. I understand that.

Having been Commissioner of Education, however, I know that all you have to do is pass a member of the House, wave at them, have them wave a document back at you from across the lobby and they'll still stand up on the floor of the House and say, I showed this to the Commissioner of Education and he waved back and nodded at me knowing that he supports what I'm doing. I'm trying to keep us out of the realm of just being so paranoid on this issue, that we're trying to out think the members of the House and Senate. And I don't mean paranoid in a bad way. I mean in a good way.

And I think that if we have an appropriately worded motion, that simply adopts the document for informational purposes, to forward it to the House and Senate to allow them to do their job, it gives at least the Task Force the knowledge that we have concluded this phase of our work. And I trust that once this phase is concluded we get to the every man for himself portion of the program, where everybody will be out there hustling the hallways, pushing their position. But I think it's simply something we ought to consider when it comes to six months hard work and recognizing that some of us disagree with all of it, some of us some of it, and some of us none of what's in that document.

That it is a compilation of six months hard work and I think ought to be forwarded on in that vein. That is all I am attempting to do. There is no veiled attempt here to put a special seal on anything included within that document other than the total body of work that we put together.

Mr. Liptak: I think that's well said, and I certainly would support that.

Mr. Grofic: Governor, this is Dave Grofic, I call the question.

Lt. Governor Brogan: David, I didn't hear. I'm sorry.

Mr. Grofic: Can I call the question?

Lt. Governor Brogan: We've got a motion on the floor and we've got a second. The question has been called. All those in favor of the motion, please signify by saying Aye and since we are voice, I'm going to ask for a roll call vote. Gema Hernandez?

Dr. Hernandez: Aye.

Lt. Governor Brogan: Bob Sharpe?

Mr. Sharpe : Yes.

Lt. Governor Brogan: Phil Freidin?

Mr. Freidin: No.

Lt. Governor Brogan: Larry Sherberg?

Mr. Sherberg: Yes.

Lt. Governor Brogan: David Grofic?

Mr. Grofic: Yes.

Lt. Governor Brogan: Walter Liptak?

Mr. Liptak: Aye.

Lt. Governor Brogan: Ray Noga?

Mr. Noga: Aye.

Lt. Governor Brogan: Jeff Dwyer?

Dr. Dwyer: Yes.

Lt. Governor Brogan: Rene Rodriguez?

Mr. Rodriguez: Yes.

Lt. Governor Brogan:: Jesse Lipnick? Oh, he's not with us today. Cherryl Chmielewski?

Ms. Chmielewski: Yes.

Lt. Governor Brogan: Ken Connor is not with us today. Dr. Calkin?

Dr. Calkin: Yes.

Lt. Governor Brogan: Ed Boyer?

Mr. Boyer: No.

Lt. Governor Brogan: Robert Miller?

Mr. Miller: Yes.

Lt. Governor Brogan: Vicky Fierro?

Ms Fierro:No.

Lt. Governor Brogan: Nancy Argenziano?

Hon. Argenziano: No.

Lt. Governor Brogan: John McKay is not with us today. By your vote -- can we tally?

Unidentified Speaker: Eleven to four.

Unidentified Speaker: Ten to four.

Lt. Governor Brogan: It is eleven to four. Frank Brogan, Aye. So it is now eleven to four -- is it twelve?

Unidentified Speaker: Twelve to four.

Lt. Governor Brogan: By your vote, twelve to four, the motion passes. Ladies and gentlemen, we will accommodate the changes that were brought to us today. Vicky's changes and I think they were good ones. We'll incorporate that as was the discussion today and we will then, as Dr -- talked about, get this document out to you as quickly as we can. We hope by next week. We will also put a cover letter on it of course. And let me assure you, I'm going to help to draft the cover letter. And I want you all as individual members of the Task Force to know, as the person who will sign it, I will do my best to make it abundantly clear that this is for informational purpose.

And these are my words and not necessarily the ones that will end up in the letter, but something akin to the notion that there are a lot of different perspectives contained within this document. Probably if you ask the members they didn't agree on every single piece that went in here. Not one of us. But I will do my best to craft a letter that will give anyone who reads past it, through the document, the knowledge that they really should not hold it up on the floor of the House and Senate and make their position based on what the Task Force recommended they do.

If they want to glean information from it, that's why it is there, to make their case. But if anyone is in a position to suggest that they're making their case based on the recommendation of us, as a Task Force, they will be doing it over a cover letter that very politely and respectfully indicates that that is not the case. And I will get you a copy of that as soon as I -- as soon as I can put it together.

Ms Fierro: Governor --

Lt. Governor Brogan: I thank you very much for the time, not just today, but for the six months hard work on this thing. I want to thank the Staff and all on this call. All the people who testified, the people who did presentations -- the people who provided us research documentation and --

Ms Fierro: Governor --

Lt. Governor Brogan: but most of all, you as Task Force members. I am convinced that ultimately, the House and Senate will do the right thing, whatever that end up being, because we're in a position where we need to do that on behalf of the people of the State of Florida.

Ms. Salmon: : Ms. Fierro.

Lt. Governor Brogan: Yes. Vicky, did you have a comment?

Ms. Fierro: Governor, I just wanted to be sure. Are we officially done as a Task Force and are we relieved now from the Sunshine Provisions?

Lt. Governor Brogan: I would suggest that is true.

Ms. Salmon: Governor, can we vote on the Minutes that we will mail to people over the weekend, the December 18th meeting.

Lt. Governor Brogan: Thank you, Jennifer. Vicky, the answer is now, no. We're not --

Mr. Sherberg: Governor, this is Larry Sherberg, so moved.

Lt. Governor Brogan: I have a motion on the Minutes.

Dr. Calkin: Second from Joy.

Lt. Governor Brogan: Second. Discussion?

Unidentified Speaker: Aye.

Lt. Governor Brogan:: All those in favor of the motion, please signify by saying Aye.

(Chorus of Ayes)

Lt. Governor Brogan: Opposed like sign?

(No response)

Lt. Governor Brogan: Minutes passed.

Ms. Salmon: That's the 12/18 Minutes. The 12/4 Minutes just came today. I don't expect to hear a motion on that, but I wanted people to have them.

Unidentified Speaker: So moved.

Lt. Governor Brogan: I have a motion on the 12/4 Minutes. Second?

Dr. Calkin: Second.

Lt. Governor Brogan: And a second. Any discussion on the 12/4 Minutes?

(No response)

Lt. Governor Brogan: Hearing none, all those in favor of the motion to approve the Minutes of 12/4, please signify by saying Aye.

(Chorus of Ayes)

Lt. Governor Brogan: Opposed like sign?

(No response)

Lt. Governor Brogan: Dr. Polivka?

Dr. Polivka: Governor, I wanted to express appreciation -- my appreciation and that of my staff of the work of the Task Force. We have very much enjoyed working with you. There have been difficult moments, but it has been -- it has been for the most part extremely rewarding and gratifying. And -- and I particularly appreciate the extraordinary alert and effective leadership that you provided. I've been involved with at least half a dozen Task Forces over the last 30 years and I've never seen leadership such as you have provided. So on the part of the Staff, a heart felt appreciation.

Lt. Governor Brogan: Thank you, Doctor. And that's to the Staff again. And thanks to each and every one of you and I know that we'll be seeing most of you here in Tallahassee over the next three months and look forward to working with you. Any additional comments or questions, don't hesitate, as you never do, to contact my office or that of Dr. Polivka. And thanks for coming together on the conference call today.

Mr. Sherberg: Governor --

Ms. Salmon: Larry Sherberg.

Lt. Governor Brogan: Larry.

Mr. Sherberg: I just want to thank you personally, for leading this delicate situation and your thoughtfulness, your caring and your humor has gotten us through many, many moments and I, personally, want to just thank you for your leadership.

Unidentified Speaker: I second the motion.

Lt. Governor Brogan: I'd go ahead and take a vote on that, but -- but I'm fearful as to how it would come out. So having said that, I will simply accept that and thank you all very much. It's really been a pleasure working with you. Each and every one of you. You are good people. You are fine people. And you are committed to this issue.

(Meeting concluded)