The Long Term Care Litigation and Liability Insurance Crisis

A Proposal to the

Task Force on Availability and Affordability of Long Term Care

Submitted by

The Florida Association of Homes for the Aging

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November 7, 2000

The Honorable Frank Brogan
Lieutenant Governor
PL 05 Capitol
Tallahassee, FL 32399-0001

Dear Lt. Governor Brogan:

Attached is a copy of the Florida Association of Homes for the Aging proposal to address the availability and affordability of long-term care. It is divided into four parts: litigation reform, reimbursement/funding, quality of care and alternatives to nursing home care. The litigation reform is of paramount importance to our members who, as a group, deliver high quality care and services, staff well above the minimum required in rule, and spend on average of $18 more per resident day than Florida nursing homes in general. In spite of their outstanding track records, FAHA member nursing homes, assisted living facilities and continuing care retirement communities are plagued by resident rights' lawsuits and untenable increases in liability insurance premiums. The high cost of the lawsuits is having an effect on their ability to provide high quality services. Some have already notified residents that they will be dropping their extended congregate care license because affordable liability insurance is not available. Others have postponed plans to provide a broader array of long-term care services.

This transmittal includes as executive summary, a proposal for each of the four areas mentioned above, including suggested statutory language. Our statutory language for litigation reform is still being fine-tuned. Therefore, it will be submitted as an addendum to our proposal by November 10.

We appreciate the time and effort that you and other members of the Task Force have devoted to examining the many challenges that the state of Florida is facing related to the availability and affordability of long-term care services. Our sincerest thanks to Task Force members who took the time to visit nursing homes, assisted living facilities, and other long-term care organizations throughout the state. We are hopeful that newly-elected legislators will do the same so they too are aware of the gravity of the insurance crisis and the effect it is having on long-term care providers and the continuum of care that elder Floridians deserve.

If you have any questions about our proposal, please feel free to contact me.

Sincerely,

Raymond Johnson
Chair

RMJ/bms
Attachment

About FAHA

The Florida Association of Homes for the Aging (FAHA), a non-profit organization founded in 1963, represents over 280 long-term care facilities and senior housing communities statewide. Members include HUD housing complexes, continuing care retirement communities, assisted living facilities, and nursing homes -- most of which are sponsored by faith-based, fraternal, or community groups. Over 70,000 retirees reside in these communities and benefit from the services they provide.

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Executive Summary

The Long Term Care Litigation and Liability Insurance Crisis

Summary of the Problem and Its Impact on Care

What is unfair about current law and why are so many nursing homes and assisted living facilities being sued?

Nursing homes and assisted living facility providers are embroiled in a crisis that is affecting their ability to provide care to elder Floridians. The cause of the crisis is litigation and resulting exorbitant increases in liability insurance premiums. Litigation against long-term care providers is exploding with such rapidity that insurers and venture capital have disappeared in the state. The litigation epidemic is caused by Florida's statutory scheme of strict liability imposed by Chapter 400, Florida Statutes, the regulatory law for nursing homes and ALFs.

Chapter 400, Florida Statutes, grants residents certain statutory "rights". The statute also grants a civil legal remedy to enforce the rights if they are infringed upon or denied, regardless of the circumstances. This is called "strict liability". As a result, nursing homes and ALFs are held to a higher standard than any other health care provider. They have almost no ability to defend themselves if an accident or decline in health occurs.

It is this strict liability, not the rights themselves, that is causing the litigation crisis. Add huge attorney fees to the mix, and you are left with a recipe for over-litigation. No other business or health care provider is as vulnerable. Consequently, an army of Florida attorneys now specializes in nursing home and ALF litigation. Their bill boards and television advertisements offer free legal services when - not if - "your loved ones are victims of abuse or improper treatment in a nursing home or ALF."

The behavior of other health care providers is governed by negligence law rather than strict liability. Negligence law holds a wrongdoer responsible when they owe a duty to another, breach that duty, and the breach is the proximate cause of an injury or death.

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How has the unlimited right of any person or organization to sue on behalf of a nursing home and ALF resident affected providers and resident care?

- A Florida nursing home is three times more likely to have a claim/lawsuit filed against it than a nursing home in another state.
- According to data submitted to the Agency for Health Care Administration, 80 percent of Florida's nursing homes had claims/lawsuits filed against them during the last three years. In continuing care retirement centers, the average number of claims was five, per Department of Insurance data. There was no relationship between quality of care and the claims/lawsuits. Even the best facilities are being sued.
- The average per bed liability insurance premium for Florida nursing homes is $6,283 -- eight times the national average.
- Liability insurance premiums for Florida nursing homes increased an average of 409 percent over last year. Individual ALFs are also reporting exorbitant increases as well as cancellations of liability insurance coverage. In addition, 30 percent of the state's continuing care retirement communities (a group of providers known for high quality care) reported to the Florida Department of Insurance that they were notified of liability insurance cancellations or non-renewals during the past three years.
- According to the Florida Department of Insurance, 17 insurers are currently writing liability insurance coverage for long-term care facilities, but only four wrote more than four policies during the first half of 2000. Twenty-three companies that previously provided coverage in Florida said they no longer do.
- Medicaid does <u>not</u> pay for the full cost of caring for a nursing home resident. Approximately 74 percent of the nursing homes in Florida lose money when they serve a Medicaid resident. FAHA members spend an average of $18 more per day per resident than they are reimbursed. Consequently, the expenses incurred as a result of the lawsuits are passed on to private pay residents or paid for with reserves or contributions that should have been used to enhance resident care and staffing.
- The lawsuits and corresponding increases in liability insurance costs are affecting every level of long-term care – not just nursing homes. Non-profit providers who have always provided a full range of long-term care services must rethink their missions because most of their financial reserves are being used to pay for unanticipated costs related to lawsuits and liability insurance.

Is there any correlation between the exorbitant increases in liability insurance premiums and quality of care?

Based on data available through the Agency for Health Care Administration and the Department of Elder Affairs, FAHA member nursing homes outperform non-member nursing homes in quality of care, quality of life, and administrative indexes. They also have significantly higher nurse to resident staffing ratios and spend more on resident care than non-members. Nonetheless, they have experienced comparable increases in liability insurance premiums to

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Florida nursing homes as a group over the past two years (405 percent compared to 409 percent) and are equally affected by claims and lawsuits. Sixty-seven percent of FAHA members have had one or more claims filed against them compared to 83 percent for non-members. The data clearly indicate that there is **no** correlation between the quality of care provided in a nursing home and either the high cost of liability insurance or the increased prevalence of residents rights' litigation.

What should be done to give good providers the ability to defend themselves if they are sued for violating or infringing upon a resident's rights?

The Florida Association of Homes for the Aging proposal makes "negligence" the standard for resident rights' litigation filed under Chapter 400, Florida Statutes. Residents would retain all the rights they have today. They would also retain the ability to enforce their rights through the legal system. However, if a lawsuit were filed on behalf of a resident, the plaintiff would have to show that the nursing home or ALF was negligent. This makes the system fair to residents as well as providers. In addition, the FAHA proposal employs the identical presuit screening and arbitration process used in medical malpractice claims against hospitals and physicians. It also caps non-economic and punitive damage so that insurance companies are better able to predict their losses. Lastly, the proposal gives certain defenses to providers. These defenses are not a bar to an action by a resident, nor will they necessarily result in a provider "winning" a lawsuit. Rather, they give a nursing home or ALF that has been sued a chance to prove that care and services were provided in accordance with the wishes of the resident, facility policy, and prevailing standards of care.

In light of all of the evidence compiled by the Task Force on Availability and Affordability of Long-Term Care, the Florida Association of Homes for the Aging (FAHA) believes that any proposal that promises to resolve the current crisis in the long-term care community must address, at a minimum, the following three components: **Litigation Reform, Funding, and Quality of Care.**

Proposed Solutions

To address these components, our proposal:

- Creates a new part in Chapter 400, Florida Statutes, known as the "Long-Term Care Facility Negligence Act" to address claims and lawsuits against nursing homes and ALFs.
- Codifies negligence standards into Chapter 400, Florida Statutes, so they apply to all lawsuits against nursing homes and ALFs.
- Creates pre-suit notification requirements for lawsuits filed against nursing homes and ALFs.
- Creates an arbitration process that provides for an expedited, impartial means of early resolution of claims against nursing homes and ALFs. The process is identical to what is in effect for hospitals and physicians.
- Caps non-economic damages and limits add-on attorney fees to a percentage of the award when a case is settled through arbitration.

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- Repeals exclusions from punitive damage caps for nursing homes and ALFs that were adopted by the Legislature in 1999 as part of a Tort Reform bill that applied to all other health care providers and businesses. The caps are for lawsuits that go to trial.
- Creates an affirmative defense when a managed risk program is in effect for a resident who requests specific changes in care, treatment, or services.
- Creates a two-year statute of limitations for lawsuits against nursing homes and ALFs -- identical to what is in law for other health care providers. The current statute of limitations is four years.
- To the extent that it is constitutionally permissible, applies the reforms proposed herein to all claims and lawsuits filed against nursing homes and assisted living facilities, including those that are not settled or adjudicated by the effective date of the bill.
- Requires the Agency for Health Care Administration to collect data from nursing homes and ALFs on the availability and affordability of liability insurance and to submit a report to the Legislature by January 1 of each year to determine whether or not regulatory, statutory, and funding changes have an effect over time on the crisis.
- Increases Medicaid reimbursement to reflect the actual cost of providing care for at least 80 percent of participating nursing homes so they have the resources to hire additional staff based on need and availability.
- Expands thresholds in current law to allow more opportunities for Medicaid-certified nursing homes to apply for interim rate adjustments to cover increases in liability insurance premiums.
- Strengthens quality assurance requirements for nursing homes and creates related training opportunities for facility-based quality assurance teams.
- Protects quality assurance and risk management records and communication for both nursing homes and assisted living facilities from discovery or introduction as evidence in a civil or administrative action.
- Creates an in-house pool of experts within the Agency for Health Care Administration to serve as receivers and monitors.
- Mandates increased staffing for both nurses and certified nursing assistants in facilities that have quality of care problems. The increased staffing would be required for a period of at least 12 months.

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Preservation of Affordable Long Term Care Alternatives

Summary of the Problem and Its Impact on Elder Floridians

What can be done to preserve the existing long term care alternatives in Florida and encourage the development of additional affordable alternatives?

In order to preserve long term care alternatives in Florida, it is necessary to create a more efficient system through which home and community based services are delivered to low-income elderly living in their own homes and to provide incentives and low-interest financing to encourage the development of new affordable assisted living facilities or the conversion of existing facilities to affordable assisted living.

Delivery of Home and Community-based Services in HUD Communities:
The largest single concentration of low-income elders in Florida - over 80,000 - occupy rent-subsidized apartment buildings. This group is predominantly women who are over the age of 75, and living alone. The residents are less likely to be well educated and less able to rely on family assistance. If the residents cannot maintain their independence, they are prime candidates for nursing homes.

Most HUD administrators are committed to helping their residents remain in their current apartments as long as they can arrange for necessary supportive services. Some elderly housing communities employ a Service Coordinator to coordinate supportive services in the community for residents. The primary function of a Service Coordinator is to link the elderly residents residing in their projects to the supportive services necessary for them to remain independent and in their own homes.

However, many HUD Service Coordinators and administrators encounter barriers in their efforts to link their residents with affordable supportive services. The current system through which services are made available to low-income elders residing in HUD housing communities is fragmented and inefficient. Additionally, may HUD administrators do not have money in their budgets to hire a Service Coordinator. With the right blend of services and support, affordable housing can be a viable "aging in place" alternative, but specific changes in state policy are necessary to ensure a seamless integration of housing and health care services.

Shortage of Affordable Assisted Living Facilities:
There is a critical shortage of affordable Assisted Living Facilities, which leaves most low-income elderly no choice but a Medicaid-funded nursing home bed. State and local low-interest financing options must be made available to encourage the production of new affordable assisted living facilities as well as the conversion of existing facilities to affordable assisted living and/or adult day care. State and local low-interest financing and/or Low Income Housing Tax Credits are necessary in order to make these converted facilities financially viable and truly affordable. In addition, in order to attract high-quality providers, reimbursement under the ALF Medicaid Waiver must keep pace with the cost of care. Unfortunately, reimbursement under the Waiver has not been adjusted annually to cover increases in costs.

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Proposed Solutions

In order to preserve and enhance the existing affordable long-term care alternatives and encourage the development of new affordable alternatives, FAHA proposes the following:

- Enhance the role of service coordinators in elderly housing communities so that they can complete assessments for their residents who are in need of supportive services.

- Assign workers funded through the Community Care for the Elderly and Home and Community Based Services waiver programs to housing communities so they can serve multiple residents in the same location.

- Allow service coordinators in elderly housing communities to refer residents with emergency needs directly to community care for the elderly services providers for priority consideration.

- Make funds available through the Florida Housing Finance Corporation to pay for additional service coordinators in affordable housing communities.

- Offer low-interest financing options for the conversion of existing facilities to affordable assisted living facilities or for the construction of new affordable assisted living facilities.

- Allow for exemptions of certain regulatory requirements for affordable assisted living conversion projects.

- Assign a designated number of Assisted Living Medicaid Waiver slots to new assisted living facilities that are willing to set aside at least 50 percent of the facility's beds as "affordable."

- Fund an annual price level increase for providers who are reimbursed through the Assisted Living Medicaid Waiver.

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Proposed Solutions

Litigation Reform - Proposal

In 1976, the Florida Legislature enacted a comprehensive nursing home bill of rights that was intended to improve care. In 1980, in response to a Dade County Grand Jury Report, the legislature strengthened the nursing home residents' bill of rights and created a civil enforcement provision that gave residents a cause of action to sue if their rights had been "deprived or infringed upon." In addition, a similar bill of rights and civil enforcement provision was passed in 1980 for residents of assisted living facilities. Almost anyone can sue a long-term care facility on behalf of a resident, including any person or organization acting on a resident's behalf. Any plaintiff who prevails is entitled to reasonable attorney's fees above and beyond contingency fees that are based on a percentage of the settlement or award. In addition, nursing home and ALFs are specifically excluded from the caps on non-economic and punitive damages that are applicable to all other heath care providers under the Medical Malpractice Act and the negligence law (Chapter 768, Florida Statutes).

The civil enforcement provisions that are part of Chapter 400, Florida Statutes, (the nursing home and ALF law) were enacted by the legislature to allow residents and their families to take legal action in the most egregious situations when the regulatory system failed to protect residents from harm. Not until the mid-1990's were the provisions widely used. Plaintiff's attorney's have since found that it is much easier and more lucrative to sue a nursing home or an ALF than a hospital, a physician, and most other businesses. Consequently, according to data submitted to the Agency for Health Care Administration, 80 percent of nursing homes have had a claim filed against them within the last three years. In continuing care retirement communities, the average number of claims was five, per Department of Insurance data. There is no correlation between the quality of care provided in a nursing home facility and the claims filed against it. Even facilities with outstanding regulatory track records have had claims filed against them. The same alarming trend is beginning to occur in ALFs.

Chapter 400, Florida Statutes, grants a civil legal remedy to enforce residents' rights if they are infringed upon or denied. The law is based on strict liability. No other health care provider is held to such a high standard. If an injury or accident occurs, the nursing home or assisted living facility in which it occurred is responsible, regardless of the circumstances. Florida law is often used unfairly to sue long-term care facilities for physical decline and accidents due to infirmities associated with advanced age or a disease. Plaintiff's attorneys portray these situations as abuse or neglect.

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The only way to address the inequities that have lead to the proliferation of lawsuits against long-term care facilities is to enact legislation that treats lawsuits and claims against them similarly to those filed against other health care providers and businesses.

Specifically, the law should be amended to:

- **Create a new part in Chapter 400, Florida Statutes, known as the "Long-Term Care Facility Negligence Act" to address claims and lawsuits against nursing homes and ALFs.**
- **Codify negligence standards into Chapter 400, Florida Statutes, so they apply to all lawsuits against nursing homes and ALFs.**
- **Create pre-suit notification requirements for lawsuits filed against nursing homes and ALFs.**
- **Create an arbitration process that provides for an expedited, impartial means of early resolution of claims against nursing homes and ALFs, comparable to what is in effect for hospitals and physicians.**
- **Cap non-economic damages and limit attorney fees to a percentage of the award when a case is settled through arbitration.**
- **Repeal exclusions from punitive damage caps for nursing homes and ALFs that were adopted by the Legislature in 1999 as part of a Tort Reform bill that applied to all other health care providers and businesses. The caps are for lawsuits that go to trial.**
- **Create an affirmative defense when a managed risk program is in effect for a resident who requests specific changes in care, treatment, or services.**
- **Create a two-year statute of limitations for lawsuits against nursing homes and ALFs -- identical to what is in law for other health care providers. The current statute of limitations is four years.**
- **To the extent that it is constitutionally permissible, apply the above reforms to all claims and lawsuits filed against nursing homes and ALFs, including those that are not settled or adjudicated by the effective date of the bill.**
- **Require the Agency for Health Care Administration to collect data from nursing homes and assisted living facilities on the availability and affordability of liability insurance and submit a report to the Legislature by January 1 of each year to determine whether or not regulatory, statutory or funding changes have had an effect over time on the crisis.**

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Litigation Reform - Proposed Statutory Change

Proposed bill will follow shortly. See Executive Summary for highlights.

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Reimbursement/Funding - Proposal

There are two distinct issues that need to be resolved in the Medicaid reimbursement area. First, under current regulations, the extraordinary increases in general and professional liability insurance premiums are not fully reimbursed under Medicaid. Only facilities with Medicaid caseloads in excess of 65 percent are entitled to request an interim rate increase; and these increases are granted only if the premium cost increase exceeds five percent of the facility's total operating costs. Additional limitations are imposed by other elements of the Florida's Nursing Home Reimbursement Plan. Consequently, on the average, only around 40 percent of Medicaid's portion of the liability insurance premium increases are reimbursed for those providers that qualify for the increase. Clearly, such inadequate funding puts pressure on other components of the reimbursement system, and dollars vital to the care of the residents are instead channeled into paying for insurance premium increases.

The second reimbursement related proposal focuses on introducing some degree of stability into the reimbursement system. Under the current regulations, artificial restrictions (called targets) limit semi-annual rate increases and result in ever increasing numbers of nursing home providers not getting sufficient Medicaid reimbursement to cover the cost of care of their residents. In 1983, when the current plan was first implemented, approximately 65 percent of the nursing homes received a payment rate sufficiently high to pay for the care of their residents. Over the intervening years, even with the infusion of additional funds authorized by the last two Appropriations Bills, the percentage of providers not getting their cost covered is in excess of 74 percent.

FAHA proposes that the current reimbursement system be changed to:

- **Increase Medicaid reimbursement to reflect the actual cost of providing care for at least 80 percent of participating nursing homes so they have the resources to hire additional staff based on need and availability.**
- **Expand thresholds in current law to allow more opportunities for Medicaid-certified nursing homes to apply for interim rate adjustments to cover increases in liability insurance premiums.**

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Reimbursement/Funding - Proposed Statutory Change

409.908 Reimbursement of Medicaid providers.-- Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(1) Reimbursement to hospitals licensed under part I of chapter 395 must be made prospectively or on the basis of negotiation.

(a) Reimbursement for inpatient care is limited as provided for in s. 409.905(5), except for:

1. The raising of rate reimbursement caps, excluding rural hospitals.
2. Recognition of the costs of graduate medical education.
3. Other methodologies recognized in the General Appropriations Act.

During the years funds are transferred from the Board of Regents, any reimbursement supported by such funds shall be subject to certification by the Board of Regents that the hospital has complied with s. 381.0403. The agency is authorized to receive funds from state entities, including, but 1not limited to, the Board of Regents, local governments, and other local political subdivisions, for the purpose of making special exception payments, including federal matching funds, through the Medicaid inpatient reimbursement methodologies. Funds received from state entities or local governments for this purpose shall be separately accounted for and shall not be commingled with other state or local funds in any manner. Notwithstanding this section and s. 409.915, counties are exempt from contributing toward the cost of the special exception reimbursement for hospitals serving a disproportionate share of low-income persons and providing graduate medical education.

(b) Reimbursement for hospital outpatient care is limited to $1,500 per state fiscal year per recipient, except for:

1. Such care provided to a Medicaid recipient under age 21, in which case the only limitation is medical necessity.
2. Renal dialysis services.
3. Other exceptions made by the agency.

The agency is authorized to receive funds from state entities, including, but not limited to, the Board of Regents, local governments, and other local political subdivisions, for the purpose of making payments, including federal matching funds, through the Medicaid outpatient

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reimbursement methodologies. Funds received from state entities and local governments for this purpose shall be separately accounted for and shall not be commingled with other state or local funds in any manner.

(c) Hospitals that provide services to a disproportionate share of low-income Medicaid recipients, or that participate in the regional perinatal intensive care center program under chapter 383, or that participate in the statutory teaching hospital disproportionate share program may receive additional reimbursement. The total amount of payment for disproportionate share hospitals shall be fixed by the General Appropriations Act. The computation of these payments must be made in compliance with all federal regulations and the methodologies described in ss. 409.911, 409.9112, and 409.9113.

(d) The agency is authorized to limit inflationary increases for outpatient hospital services as directed by the General Appropriations Act.

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

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

(b) Subject to any limitations or directions provided for in the General Appropriations Act, the agency shall establish and implement a Florida Title XIX Long-Term Care Reimbursement Plan (Medicaid) for nursing home care in order to provide care and services in conformance with the applicable state and federal laws, rules, regulations, and quality and safety standards and to ensure that individuals eligible for medical assistance have reasonable geographic access to such care. ~~Under the plan, interim rate adjustments shall not be granted to reflect increases in the cost of general or professional liability insurance for nursing homes unless the following criteria are~~

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~~met: have at least a 65 percent Medicaid utilization in the most recent cost report submitted to the agency, and the increase in general or professional liability costs to the facility for the most recent policy period affects the total Medicaid per diem by at least 5 percent. This rate adjustment shall not result in the per diem exceeding the class ceiling. This provision shall apply only to fiscal year 2000-2001 and shall be implemented to the extent existing appropriations are available.~~ Under the plan, the agency shall segregate general and professional liability costs from all other cost components, and shall reimburse the Medicaid allowable portion of these costs without limitations. The agency shall adjust the operating and patient care cost component ceilings to reflect the removal of general and professional liability costs. The agency shall report to the Governor, the Speaker of the House of Representatives, and the President of the Senate by December 31, 2000, on the cost of liability insurance for Florida nursing homes for fiscal years 1999 and 2000 and the extent to which these costs are not being compensated by the Medicaid program. Medicaid-participating nursing homes shall be required to report to the agency information necessary to compile this report. Effective no earlier than the rate-setting period beginning April 1, 1999, the agency shall establish a case-mix reimbursement methodology for the rate of payment for long-term care services for nursing home residents. The agency shall compute a per diem rate for Medicaid residents, adjusted for case mix, which is based on a resident classification system that accounts for the relative resource utilization by different types of residents and which is based on level-of-care data and other appropriate data. The case-mix methodology developed by the agency shall take into account the medical, behavioral, and cognitive deficits of residents. In developing the reimbursement methodology, the agency shall evaluate and modify other aspects of the reimbursement plan as necessary to improve the overall effectiveness of the plan with respect to the costs of patient care, operating costs, and property costs. In the event adequate data are not available, the agency is authorized to adjust the patient's care component or the per diem rate to more adequately cover the cost of services provided in the patient's care component. The agency shall work with the Department of Elderly Affairs, the Florida Health Care Association, and the Florida Association of Homes for the Aging in developing the methodology. It is the intent of the Legislature that the reimbursement plan achieve the goal of providing access to health care for nursing home residents who require large amounts of care while encouraging diversion services as an alternative to nursing home care for residents who can be served within the community. The agency shall base the establishment of any maximum rate of payment, whether overall or component, on the available moneys as provided for in the General Appropriations Act. The agency may base the maximum rate of payment on the results of scientifically valid analysis and conclusions derived from objective statistical data pertinent to the particular maximum rate of payment. However, maximum payment rates established for direct patient care related expenses shall exceed the estimated case-mix adjusted cost of care for at least 80 percent of the nursing home facilities participating in the Medicaid program.

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Quality of Care - Proposal

Quality Assurance

The Florida Association of Homes for the Aging believes that quality-of-care is dependent upon a strong regulatory law, adequate funding, dedicated long-term care facility employees and a sufficient number of regulatory staff to carry out their responsibilities. FAHA's Quality of Care Proposal strengthens quality assurance programs already in place in nursing homes and builds on the Agency for Health Care Administration's responsibility to respond rapidly to facilities that have serious quality of care problems.

We believe that current law provides the Agency with sufficient enforcement authority to identify and deal with substandard providers. However, we do not believe that the Agency has the resources to hire sufficient number of survey staff to carry out its regulatory obligation.

The proposal does not include any major revisions to the survey process or specific recommendations related to the Agency's administrative budget. Instead, we believe the Task Force should call upon the Agency to identify any statutory changes or funding increases that would improve its ability to identify problem providers and monitor corrective action plans.

To promote continuous quality improvement in long-term care facilities, the following statutory changes should be made:

- **Require each nursing home to implement a quality assurance program directed by an interdisciplinary team that meets at least every other month. (Quarterly meetings are now required by federal law.)**
- **Protect quality assurance and risk management records and communication for both nursing homes and assisted living facilities from discovery or introduction as evidence in a civil or administrative action.**
- **Mandate the Agency for Health Care Administration to implement a continuous quality improvement educational program that consists of training modules for specific topics.**
- **Require the Agency to create a listserve that members of quality assurance committees can use to ask and respond to questions about best practices and quality of care issues.**
- **Create an in-house pool of experts within the Agency for Health Care Administration to serve as receivers and monitors.**

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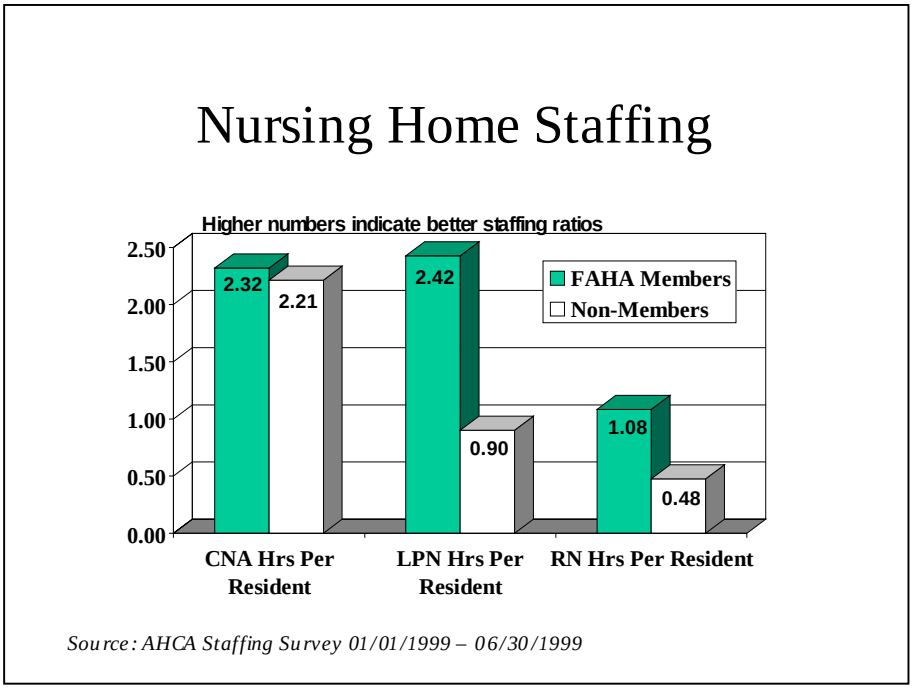
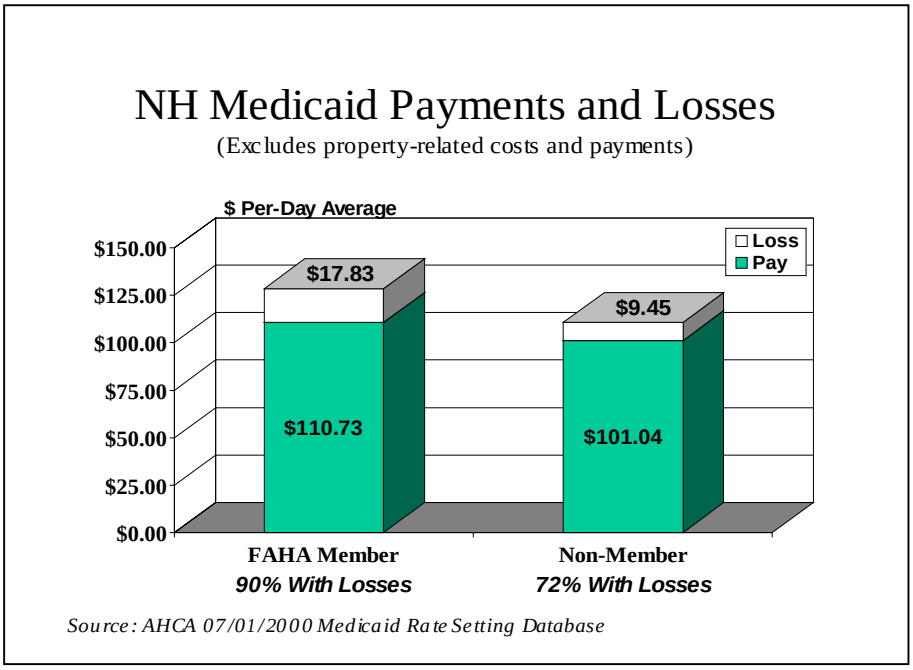
Staffing

An adequate number of qualified staff is essential to the delivery of care and services in a nursing home. However, data available through the Agency for Health Care Administration indicates that there is no correlation between inadequate staffing and exorbitant increases in liability insurance rates or the increased prevalence of claims and lawsuits against nursing homes. As the charts shown on the left and below indicate, members of the Florida Association of Homes for the Aging have significantly higher staffing ratios and, as a result, spend on average $18.07 more per patient day on resident care than nursing homes that are not members of the association.





Nonetheless, they have experienced increases in liability insurance over the past year that are comparable to those of non-members (405 percent compared to 410 percent), and 67 percent have had a claim or lawsuit filed against them over the past three years compared to 83 percent for non-members.

Most FAHA members staff above the minimum now required in rule, but they do so with great difficulty because of the serious shortage of both licensed nurses and certified nursing assistants in most areas of the state. This shortage is not unique to Florida or to long-term care providers. It is a critical problem that

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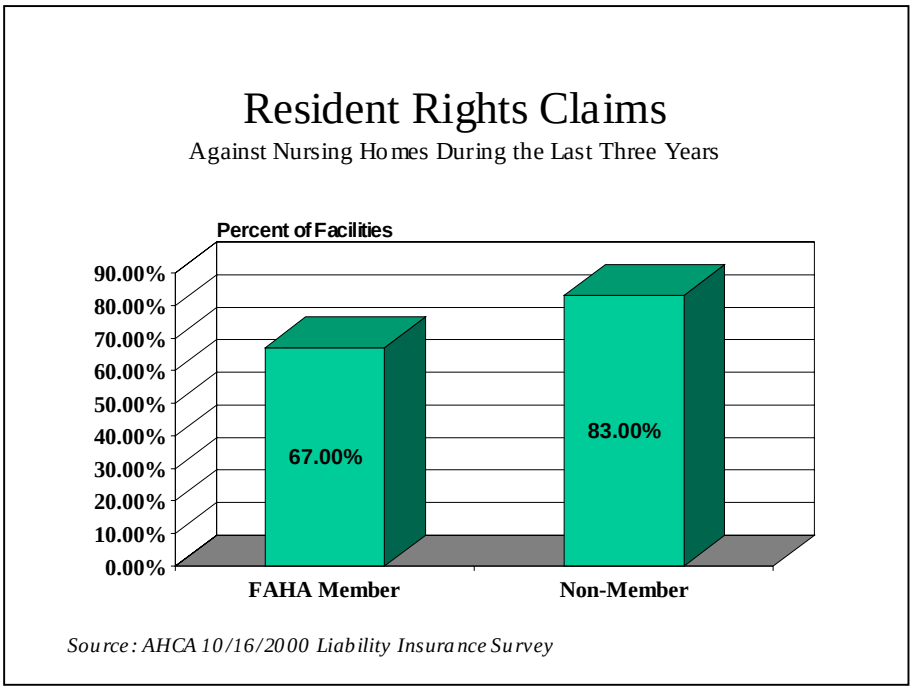
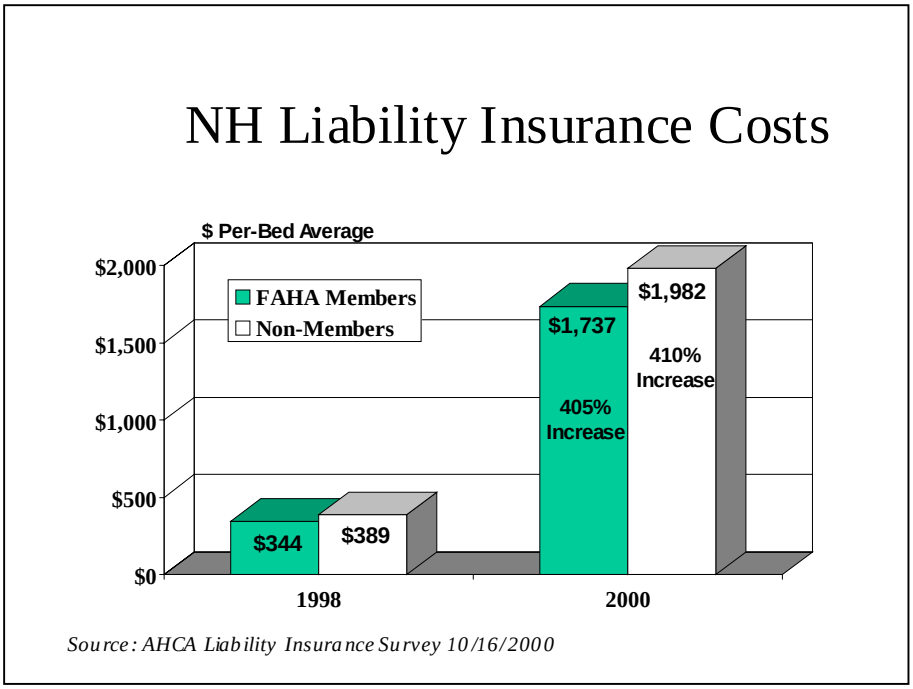
is affecting health care providers nationwide. If the Legislature were to mandate increased staffing for all nursing homes and assisted living facilities, it would be creating a requirement that, in many instances, would not be achievable.





Since nurses and certified nursing assistants are in short supply, an across the board mandate for higher staffing standards would be both unrealistic and unreasonable unless the Agency for Health Care Administration were also given the authority to grant hardship waivers to facilities that made a good-faith effort to comply but failed because of the nursing and certified nursing assistant shortage. Medicaid reimbursement would also have to be increased to cover the cost of additional staff and to allow facilities that already staff above the minimum to raise salaries and benefits to remain competitive as the overall demand for nurses and CNAs increases because of the mandated increase in staffing standards.

Instead of recommending increased staffing ratios for all nursing homes, the Florida Association of Homes for the Aging is recommending:

- **A higher staffing ratio to be imposed by the Agency for Health Care Administration if a facility has serious quality-of-care problems that lead to either a conditional rating or a**

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substandard quality-of-care designation. The minimum staffing now required for nursing home facilities is 1.7 CNA hours and .6 licensed nursing hours per resident day. The proposal raises the minimum staffing for problem providers to 2.0 CNA hours and .8 licensed nursing hours per resident day. The enriched staffing would be in effect for a minimum of 12 months and would increase to 2.2 CNA hours and 1.0 licensed nursing hours if similar problems were identified during the next survey cycle.

- **An expedited interim Medicaid rate request process to cover the additional expense.**
- **Authority for the Agency to adopt rules to document a facility's compliance with staffing increases required as a result of care-related problems and for evaluating the effect of mandated enhanced staffing on resident care.**

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Quality of Care - Proposed Statutory Change

Quality Assurance

400.118 Quality assurance; early warning system; monitoring; rapid response teams.

1) The agency shall establish an early warning system to detect conditions in nursing facilities that could be detrimental to the health, safety, and welfare of residents. The early warning system shall include, but not be limited to, analysis of financial and quality-of-care indicators that would predict the need for the agency to take action pursuant to the authority set forth in this part.

(2)(a) The agency shall establish within each district office one or more quality-of-care monitors, based on the number of nursing facilities in the district, to monitor all nursing facilities in the district on a regular, unannounced, a periodic basis, including nights, evenings, weekends, and holidays. Priority for monitoring visits shall be given to nursing facilities with a history of patient care deficiencies. Quality-of-care monitors shall be registered nurses who are trained and experienced in nursing facility regulation, standards of practice in long-term care, and evaluation of patient care. Individuals in these positions shall not be deployed by the agency as a part of the district survey team in the conduct of routine, scheduled surveys, but shall function solely and independently as quality-of-care monitors. Quality-of-care monitors shall assess the overall quality of life in the nursing facility and shall assess specific conditions in the facility directly related to patient care. The quality-of-care monitor shall include in an assessment visit observation of the care and services rendered to residents and formal and informal interviews with residents, family members, facility staff, resident guests, volunteers, other regulatory staff, and representatives of a long-term care ombudsman council or Florida advocacy council.

(b) Findings of a monitoring visit, both positive and negative, shall be provided orally and in writing to the facility administrator or, in the absence of the facility administrator, to the administrator on duty or the director of nursing. The quality-of-care monitor may recommend to the facility administrator procedural and policy changes and staff training, as needed, to improve the care or quality of life of facility residents. Conditions observed by the quality-of-care monitor which threaten the health or safety of a resident shall be reported immediately to the agency area office supervisor for appropriate regulatory action and, as appropriate or as required by law, to law enforcement, adult protective services, or other responsible agencies.

(c) Any record, whether written or oral, or any written or oral communication generated pursuant to paragraph (a) or paragraph (b) shall not be subject to discovery or introduction into evidence in any civil or administrative action against a nursing facility arising out of matters which are the subject of quality-of-care monitoring, and a person who was in attendance at a monitoring visit or evaluation may not be permitted or required to testify in any such civil or administrative action as to any evidence or other matters produced or presented during the monitoring visits or evaluations. However, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil or administrative action merely because they were presented during monitoring visits or evaluations, and any person who participates in such activities may not be prevented from

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testifying as to matters within his or her knowledge, but such witness may not be asked about his or her participation in such activities. The exclusion from the discovery or introduction of evidence in any civil or administrative action provided for herein shall not apply when the quality-of-care monitor makes a report to the appropriate authorities regarding a threat to the health or safety of a resident.

(3) (a) Each nursing home facility must implement a quality assurance program to monitor and evaluate the quality of resident care and services, pursue methods to improve the quality of care and services, and resolve identified problems. The quality assurance program must be directed by an interdisciplinary committee consisting of, at minimum, the licensed administrator, medical director, director of nursing, a certified nursing assistant, and one other discipline that may vary depending on the topic under review. Quality assurance meetings must be held at least every other month. Through the survey process, the agency shall verify that each facility has a quality assurance program that addresses quality concerns and that the quality assurance committee meets regularly. In conjunction with the quality assurance program, a facility may also implement a risk management program that further improves its ability to identify and address potential problems and enhances its ability to obtain affordable liability insurance.

(b) Any records or communication, whether written or oral, generated pursuant to this subsection shall not be subject to discovery or introduced into evidence in any civil or administrative action against a nursing home facility arising out of matters which are discussed or under review by the quality assurance committee or individual participating in the risk management program. A person who was in attendance at quality assurance or risk management meetings may not be permitted or required to testify in any such civil or administrative action as to any evidence or other matters produced or presented during or as part of the quality assurance or risk management assessment or evaluation process. However, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil or administrative action merely because they were assessed or evaluated as part of the quality assurance or risk management program, but such witness may not be asked about his or her participation in such activities. The exclusion from the discovery or introduction of evidence in any civil or administrative action provided for herein shall not apply when an individual who participated in either the quality assurance or risk management program makes a report to the appropriate authorities regarding a threat to the health or safety of a resident.

(c) To ensure effective facility-based quality assurance programs, the agency, in conjunction with the Florida Association of Homes for the Aging and the Florida Health Care Association, shall implement a statewide continuous quality improvement educational program. The program shall provide nursing home facility staff with information about the most current best practice guidelines and practical strategies to improve the quality of resident care and services. At a minimum, the agency shall develop training modules for the following topics: resident assessment, continence, skin care, behavior management, falls, restorative care and nutrition. Each training module shall consist of a seminar with a follow-up workshop to share case studies and ideas for addressing difficult problems. Seminars shall be conducted for at least two modules per year. The agency shall create a listserve that members of quality assurance committees may use to share information and to ask and respond to questions related to quality

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improvement, best practices, and problem solving techniques. The quality-of-care monitors created in subsection (2)(a) shall attend and participate in the training so they have the expertise to review the quality assurance programs of individual nursing home facilities and provide suggestions and recommendations related to the implementation of best practice guidelines to improve care and services. $_____ is appropriated to the Agency to develop the training modules and listserve.

~~(3)~~(5) The agency shall also create teams of experts that can function as rapid response teams to visit nursing facilities identified through the agency's early warning system. Rapid response teams may visit facilities that request the agency's assistance. The rapid response teams shall not be deployed for the purpose of helping a facility prepare for a regular survey.

In addition, the agency shall establish an in-house pool of qualified individuals to serve as receivers pursuant to s. 400.126 or as monitors to oversee the operation of facilities licensed under this part that have serious care related problems until the problems are corrected to the satisfaction of the agency, the facility is sold, or the facility is closed and residents are relocated. Such individuals may also serve as quality-of-care monitors, members of the rapid response teams, or trainers. At the discretion of the executive director of the agency, these individuals may perform other regulatory functions unrelated to the survey process. All expenses and costs incurred by the resident protection trust fund for the services of a receiver or monitor to oversee the operation of a nursing home facility shall be reimbursed by the licensee pursuant to s. 400.126(10).

400.4275 Business practice; personnel records; liability insurance; quality assurance. -- The assisted living facility shall be administered on a sound financial basis that is consistent with good business practices.

(3) The administrator or owner of a facility shall maintain liability insurance coverage that is in force at all times. The legislature recognizes the importance of facility based risk management and quality assurance programs to monitor and improve care and services and to enhance the ability of a licensee to obtain affordable liability insurance. In order for assisted living facilities to aggressively use such programs, any records or communication, whether written or oral, generated pursuant to this subsection shall not be subject to discovery or introduced into evidence for any civil or administrative action against a facility arising out of matters which are discussed or under review by individuals participating in either the risk management or quality assurance program. In addition, any person who was in attendance at a risk management or quality assurance program meeting may not be permitted or required to testify in any such civil or administrative action as to any evidence or other matters produced or presented during or as part of a risk management or quality assurance assessment or evaluation process. For the purpose of this subsection, a “risk management program” means an ongoing effort to systematically identify, evaluate, and manage activities that could create potential financial or legal risks for a facility. A “quality assurance program” means an interdisciplinary approach to monitor, evaluate and improve the quality of resident care and services and develop methods to resolve problems or potential problems.

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Staffing

400.23 Rules; evaluation and deficiencies; licensure status --.

(3)(a) The agency shall adopt rules providing for the minimum staffing requirements for nursing homes. These requirements shall include, for each nursing home facility, a minimum certified nursing assistant staffing and a minimum licensed nursing staffing per resident per day, including evening and night shifts and weekends. Agency rules shall specify requirements for documentation of compliance with staffing standards, sanctions for violation of such standards, and requirements for daily posting of the names of staff on duty for the benefit of facility residents and the public. The agency shall recognize the use of licensed nurses for compliance with minimum staffing requirements for certified nursing assistants, provided that the facility otherwise meets the minimum staffing requirements for licensed nurses and that the licensed nurses so recognized are performing the duties of a certified nursing assistant. Unless otherwise approved by the agency, licensed nurses counted towards the minimum staffing requirements for certified nursing assistants must exclusively perform the duties of a certified nursing assistant for the entire shift and shall not also be counted towards the minimum staffing requirements for licensed nurses. If the agency approved a facility's request to use a licensed nurse to perform both licensed nursing and certified nursing assistant duties, the facility must allocate the amount of staff time specifically spent on certified nursing assistant duties for the purpose of documenting compliance with minimum staffing requirements for certified and licensed nursing staff. In no event may the hours of a licensed nurse with dual job responsibilities be counted twice.

(b) Any nursing home facility that violates a care related licensure requirement that is directly attributable to insufficient staffing and results in a conditional license under this part or a substandard quality of care designation under the Omnibus Reconciliation Act of 1987 (Pub. L. No. 100-203), as amended, shall at a minimum be required to provide 2.0 hours per resident day of certified nursing assistant staffing and .8 hours per resident day of licensed nursing staffing. Such nursing home facility shall continue to meet the enhanced staffing requirements for twelve consecutive months from the date that the agency imposes corrective action. If during the next annual survey, a nursing home facility that is required to comply with the staffing standards prescribed in this paragraph again receives a conditional license or a substandard quality of care designation directly related to insufficient staffing, the agency shall require the nursing home facility to increase its staffing to 2.2 hours per resident day for certified nursing assistants and 1.0 hours for licensed nurses. The nursing home facility may request an interim Medicaid rate, to be processed by the agency within 30 days, to cover the additional expense. The agency shall adopt rules providing for a procedure for documenting a facility's compliance with this paragraph and for evaluating the effect of mandated enhanced staffing on resident care.

~~(b)~~ (c)The agency shall adopt rules to allow properly trained staff of a nursing facility, in addition to certified nursing assistants and licensed nurses, to assist residents with eating. The rules shall specify the minimum training requirements and shall specify the physiological conditions or disorders of residents which would necessitate that the eating assistance be provided by nursing personnel of the facility. Nonnursing staff providing eating assistance to

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residents under the provisions of this subsection shall not count towards compliance with minimum staffing standards.

~~(c)~~ (d)Licensed practical nurses licensed under chapter 464 who are providing nursing services in nursing home facilities under this part may supervise the activities of other licensed practical nurses, certified nursing assistants, and other unlicensed personnel providing services in such facilities in accordance with rules adopted by the Board of Nursing.

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Long-Term Care Alternatives - Proposal

FAHA is the only statewide association in Florida that represents non-profit providers of low- to moderate-income retirement housing financed or insured though the United States Department of Housing and Urban Development (HUD.) Approximately 160 of our members own and/or manage one or more buildings financed through HUD or another government program at below-market interest rates for the purpose of creating affordable housing for elder Floridians. An estimated 80,000 low-income elders live in these apartment buildings. The majority of these residents are over the age of 75, female and living alone.

Unfortunately, there is little coordination between government-financed affordable housing for elders and Florida's home- and community-based service system. Since service providers often incorrectly assume that the sponsors of affordable housing communities provide supervision and services, residents generally are not given priority consideration when they apply for services that delay nursing home placement. Because most residents have limited incomes and little savings, they cannot afford to move into an assisted living facility. As a result, when a resident needs in-home services, their needs often go unmet or they end up in a nursing home where their care is paid for by Medicaid.

In order to promote the creation of additional affordable alternatives to nursing homes, and in order to better serve the low-income elders currently residing in affordable apartment buildings throughout out the state, we propose the following enhancements of the current system:

Enhanced Role for Service Coordinators in Elderly Housing Communities

Service Coordinators are currently assessing their residents and making calls to lead agencies when they determine that supportive services are necessary. The current system requires that a request for an assessment be made to the lead agency. When that resident gets to the top of the waiting list, the lead agency then sends out someone to perform another assessment of the same client so that the appropriate services can be requested. The resident then has to wait until the requested services can be provided (based on available funds and personnel.) This system is redundant and protracted and many times, residents are told they must receive more services than they need or want in order to be eligible for the primary service they are requesting.

FAHA proposes to amend current law to allow Service Coordinators in HUD elderly housing communities to complete the DOEA assessment form for their residents who are in need of supportive services and allow the Service Coordinators to request additional services as needed based on their evaluation of the resident's condition.

Assignment of CCE and HCBS Waiver Workers to Housing Communities

Most elderly housing communities have a significant number of residents who receive services through the HCBS or CCE waiver programs. On a given day, it is not uncommon for six or seven workers to go to the same facility to provide the same service to six or seven different residents. This policy of assigning workers on a random basis to individual residents often results in different caregivers each day for the same resident, as the workers' schedules and caseloads vary

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from day to day. Assigning one worker to a facility would provide more stability for the residents and decrease the probability of no-shows and tardiness, both of which can be very disconcerting to elderly residents and expensive.

FAHA proposes to amend current law to allow individual workers to be assigned to affordable housing communities where sufficient need for a volume of such services has been demonstrated. Workers would report to the housing community each day, but their salary would be paid through the local lead agency. Workers would only provide services to those residents whose eligibility had been established.

Emergency Intervention Services

Many residents are forced to go without vital services for several days, while their requests for services is processed. This can lead to falls and accidents, if a resident needs personal care assistance. Some residents risk eviction from their apartment, if the service needed is housekeeping, and the resident is in violation of his/her lease due to the condition of his/her apartment.

Service Coordinators in HUD-financed facilities for the elderly should be able to request short-term emergency services for elderly residents who are waiting for their eligibility determinations to be processed. Such services would be approved at the discretion of the local lead agency based on adequate verification of the emergency.

State Funding for Service Coordinators

There are limited funds available through HUD for Service Coordinators, and each year, the number of applications for funding far exceeds the awards made. Consequently, many facilities do without a Service Coordinator, as they cannot afford to include the expense in their project budget. Additional state funding is needed so residents of HUD facilities get the support they need to access the services available in the community so they can safely age in place.

Funds should be made available through the Florida Housing Finance Corporation or other sources to fund salaries of additional Service Coordinators in HUD communities serving elderly residents.

Preservation of Affordable Assisted Living

Recently, some ALFs with extended congregate care licenses have had their liability insurance policies cancelled because they are ECC providers. Quotes from other insurance companies are unaffordable. As a result, some providers are electing to drop their ECC license. Without ECC-licensed ALFs, Assisted Living Medicaid Waiver funds will not be available to residents with limited incomes. Since many ECC residents cannot afford to pay full rate in an ALF, they will have to be transferred to nursing homes. The closure of ECC beds will result in a “reverse diversion” of the low-income elderly.

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ALFs with ECC licenses must be protected from exorbitant liability insurance premiums. Chapter 400 must be amended to place limits on liability claims paid by ALFs, and the corresponding attorney's fees awarded with those claims. In addition, the risk management and quality assurance programs implemented by ALF providers to improve their ability to purchase liability insurance must be protected from discovery in a civil or administrative action. (See litigation proposal.)

In addition, the reimbursement for providers participating in the Assisted Living Waiver should be adjusted annually to cover increases in expenses, including liability insurance costs. Otherwise, it will be impossible for good providers to offer this important level of care. Currently, the Legislature does not provide for an automatic price level increase in ALF reimbursement as it does for nursing homes. This is a risky and short-sighted policy since providers need adequate funding to employ and retain sufficient qualified staff to deliver good care.

Assisted Living Conversion Financing

HUD began an Assisted Living Conversion Program in FY2000, but the total funding was only $50 million nationwide, and the application process was onerous. There are many facilities that would be interested in converting some of their units to assisted living, if the funding were available. Funding should be contingent upon a provider's willingness to sign a long term use agreement confirming their commitment to provide affordable shelter and services to low-income elders for a designated period of time. This would go a long way towards increasing the supply of affordable assisted living beds.

Low-interest financing should be made available through the Florida Housing Finance Corporation to fund the conversion of existing HUD facilities to affordable assisted living. This will enable many residents to remain in the complex they call home, but with a higher level of service.

Waiver of Certain Regulatory Requirements for Affordable Assisted Living Conversions

Many providers are discouraged from undertaking projects to convert nursing homes or HUD facilities to affordable assisted living, as the cost of conversion is more expensive than new construction. This is due in large part to the stringent physical plant requirements in the ALF rule. By relaxing some of those requirements, with the least possible impact on resident privacy and quality of life, more providers might consider conversions.

The ALF rule should be amended to provide exemptions from certain physical plant requirements for assisted living conversion projects, in order to control construction costs and thus ensure the project's ultimate affordability. Regulatory waivers should be contingent upon a provider's willingness to sign a long term use agreement confirming their commitment to provide affordable shelter and services to low-income elders for a designated period of time.

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Assignment of Medicaid Waiver Slots for New Projects

Many non-profit sponsors interested in developing affordable assisted living facilities experience difficulty in procuring financing without a commitment from Medicaid that there will be ALF waiver slots available for the residents of that facility when it is built. Without concrete assurances that the income projected from rent will be adequate as a result of the Medicaid Waiver, most lenders will not extend financing to providers. This has the effect of discouraging construction of new affordable assisted living beds

The Medicaid waiver regulations should be amended to allow a designated number of slots to be assigned to new projects that are willing to sign a long-term use agreement in which the owner commits to set aside a specific percentage of the facility's beds as "affordable." Standards of "affordability" can be based on HUD's definitions of low-income and the resident's share of cost will not exceed 30 percent of a low-income resident's income.

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Long-Term Care Alternatives - Proposed Statutory Change

Enhanced Role for Service Coordinators in Elderly Housing Communities
Assignment of CCE and HCBS Waiver Workers to Housing Communities
Emergency Intervention Services

430.204 Community-care-for-the-elderly core services; departmental powers and duties.--
(1) The department shall fund, through each area agency on aging, at least one community care service system the primary purpose of which is the prevention of unnecessary institutionalization of functionally impaired elderly persons through the provision of community-based core services. Whenever feasible, an area agency on aging shall be the contracting agency of preference to engage only in the planning and funding of community-care-for-the-elderly core services for functionally impaired elderly persons.

(2) All existing community resources available to functionally impaired elderly persons shall be coordinated into a community care service system to provide a continuum of care to such persons as their needs change. Additional services may be provided, but may not be funded from the community-care-for-the-elderly core service funds. Agencies contracting with the department shall ensure that all other funding sources available have been used prior to utilizing community-care-for-the-elderly funds. The department and agencies contracting with the department may accept gifts and grants in order to provide services within a community care service area.

(3) The use of volunteers shall be maximized to provide a range of services for the functionally impaired elderly person. The department shall provide or arrange for the provision of training and supervision of volunteers to ensure the delivery of quality services. The department or contracting agency may provide appropriate insurance coverage to protect volunteers from personal liability while acting within the scope of their volunteer assignments under a community care service area. The coverage may also include excess automobile liability protection.

(4) The department or contracting agency shall contract for the provision of the core services required by a community care service area.

Such services may include the completion of assessments by Service Coordinators serving the residents of housing projects for the elderly that are financed, insured or subsidized by the United States Department of Housing and Urban Development.

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430.205 Community care service system.--
(1) The department, through the area agency on aging, shall fund in each planning and service area at least one community care service system that provides case management and other in-home and community services as needed to help the older person maintain independence and prevent or delay more costly institutional care.

(2) The department, through the area agency on aging, shall allow Service Coordinators in housing projects for the elderly that are financed, insured or subsidized by the United States Department of Housing and Urban Development to complete assessments for the residents of their facilities who are deemed to be in need of supportive services. Local lead agencies shall give these assessments the same priority as assessments completed by other contracted providers. Service Coordinators may also make subsequent requests to increase or decrease the services being received as appropriate.

~~(2)~~ (3) Core services and other support services may be furnished by public or private agencies or organizations. Each community care service system must be under the direction of a lead agency that coordinates the activities of individual contracting agencies providing community-care-for-the-elderly services. When practicable, the activities of a community care service area must be directed from a multiservice senior center and coordinated with other services offered therein. This subsection does not require programs in existence prior to the effective date of this act to be relocated.

(4) As an alternative to sending multiple workers to a multifamily housing facility to meet the needs of the elderly residents, and in the interest of developing a more efficient service delivery system, local lead agencies may assign individual workers to a multifamily housing facility to service the residents of that facility. These workers shall provide services to residents of the facilities whose eligibility for such services has been determined by the lead agency and whose requests for services have been approved by the lead agency. These workers shall be considered contract employees of the lead agency, but shall work on-site at the multifamily housing facility or at two or more multifamily facilities that are located in the same geographic area.

~~(3)~~ (5) The department shall define each core service that is to be provided or coordinated within a community care service area and establish rules and minimum standards for the delivery of core services. The department may conduct or contract for demonstration projects to determine the desirability of new concepts of organization, administration, or service delivery designed to prevent the institutionalization of functionally impaired elderly persons. Evaluations shall be made of the cost-avoidance of such demonstration projects, the ability of the projects to reduce the rate of placement of functionally impaired elderly persons in institutions, and the impact of projects on the use of institutional services and facilities.

~~(4)~~ (6) A preservice and inservice training program for community-care-for-the-elderly service providers and staff may be designed and implemented to help assure the delivery of quality services. The department shall specify in rules the training standards and requirements for the community-care-for-the-elderly service providers and staff. Training must be sufficient to ensure that quality services are provided to clients and that appropriate skills are developed to conduct the program.

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~~(5)~~ (7) Any person who has been classified as a functionally impaired elderly person is eligible to receive community-care-for-the-elderly core services. Those elderly persons who are determined by protective investigations to be vulnerable adults in need of services, pursuant to s. 415.104(3)(b), or to be victims of abuse, neglect, or exploitation who are in need of immediate services to prevent further harm and are referred by the adult protective services program **or by the Service Coordinator in a housing project for the elderly financed, insured or subsidized by the United States Department of Housing and Urban Development** , shall be given primary consideration for receiving community-care-for-the-elderly services. As used in this subsection, "primary consideration" means that an assessment and services must commence within 72 hours after referral to the department or as established in accordance with department contracts by local protocols developed between department service providers and the adult protective services program.

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Assisted Living Conversion Financing

420.0003 State housing strategy.--

(1) LEGISLATIVE INTENT.--It is the intent of this act to begin the process of articulating a state housing strategy that will carry the state towards the goal of assuring that by the year 2010 each Floridian shall have decent and affordable housing. This strategy must involve state, regional, and local governments working in partnership with communities and the private sector and must involve financial as well as regulatory commitment to accomplish this goal.

(2) GOAL.--By the year 2010, this state shall ensure that decent and affordable housing is available for all of its residents.

(3) POLICIES.--

(a) *Housing need.*--The continuum of need for decent and affordable housing shall be addressed, with an emphasis on assisting the neediest persons.

1. State housing programs shall promote the self-sufficiency and economic dignity of the people in this state, including elderly persons.

2. The housing requirements of special needs populations shall be addressed through programs that promote decentralization and deinstitutionalization.

3. All housing initiatives and programs shall be nondiscriminatory.

4. The geographic distribution of resources shall provide for the development of housing in rural and urban areas.

(b) *Public-private partnerships.*-- Cost-effective, public-private partnerships shall be emphasized to produce and preserve affordable housing.

1. Data shall be developed and maintained on the affordable housing activities of local governments, community-based organizations, and private developers.

2. The state shall assist local governments and community-based organizations by providing training and technical assistance.

3. The state shall provide incentives for public sector and private sector development of affordable housing.

4. The department shall coordinate state programs with local activities and with federal initiatives.

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5. The state shall provide incentives for public sector and private sector development of affordable assisted living facilities and conversion of existing facilities to affordable assisted living facilities.

(c) *Preservation of housing stock.*--The existing stock of affordable housing shall be preserved and improved.

1. Units of housing for low-income and elderly persons shall be preserved and improved through rehabilitation programs.

2. Neighborhood revitalization efforts shall be expanded in order to promote suitable living environments for individuals and families.

3. The state should encourage the Federal Government to continue the availability of federally subsidized units subject to mortgage prepayment and rent subsidy contract expiration.

(d) *Public housing.*--The important contribution of public housing to the well-being of low-income citizens shall be acknowledged through state and local government efforts to provide services and assistance through existing programs to public housing facilities and their tenants. Such services may include, but are not limited to, transportation, education, law enforcement, and health services. Any state or local government funds allocated to enhance public housing must be used to supplement, not supplant, federal support.

(e) *Housing production or rehabilitation programs.*--New programs for housing production or rehabilitation shall be developed in accordance with the following general guidelines as appropriate for the purpose of the specific program:

1. State and local governments shall provide incentives to encourage the private sector to be the primary delivery vehicle for the development of affordable housing.

2. State funds should be heavily leveraged to achieve the maximum local and private commitment of funds while achieving the program objectives.

3. To the maximum extent possible, state funds should be expended to provide housing units rather than to support program administration.

4. State money should be used, when possible, as loans rather than grants.

5. State funds should be available only to local governments that provide incentives or financial assistance for housing.

6. State funds should be made available only for projects which are consistent with the local government comprehensive plan.

7. State funding for housing should not be made available to local governments whose comprehensive plans have been found not in compliance with chapter 163 and who have not

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entered into a stipulated settlement agreement with the Department of Community Affairs to bring the plan into compliance.

8. Mixed income projects should be encouraged, to avoid a concentration of low-income residents in one area or project.

9. Distribution of state housing funds should be flexible and consider the regional and local needs, resources, and capabilities of housing producers.

10. State funding for housing should be made available to owners of affordable housing projects for the elderly that are financed, insured or subsidized by the United States Department of Housing and Urban Development or other similar government agencies for the hiring of Service Coordinators whose purpose is to link the elderly residents residing in their facilities to the supportive services necessary for them to remain independent and in their own homes. Any state or local funds allocated for this purpose must be used to supplement, not supplant, federal support.

~~10.~~ 11. Income levels used to determine program eligibility should be adjusted for family size in determining the eligibility of specific beneficiaries.

~~11.~~ 12. To the maximum extent possible, state-owned lands that are appropriate for the development of affordable housing shall be made available for that purpose.

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420.9075 Local housing assistance plans; partnerships.--

(1)(a) Each county or eligible municipality participating in the State Housing Initiatives Partnership Program shall develop and implement a local housing assistance plan created to make affordable residential units available to persons of very low income, low income, or moderate income and to persons who have special housing needs, including, but not limited to, homeless people, the elderly, and migrant farm workers. The plans are intended to increase the availability of affordable residential units by combining local resources and cost-saving measures into a local housing partnership and using private and public funds to reduce the cost of housing.

(b) Local housing assistance plans may allocate funds to:

1. Implement local housing assistance strategies for the provision of affordable housing.

2. Supplement funds available to the corporation to provide enhanced funding of state housing programs within the county or the eligible municipality.

3. Provide the local matching share of federal affordable housing grants or programs.

4. Fund emergency repairs, including, but not limited to, repairs performed by existing service providers under weatherization assistance programs under ss. 409.509-409.5093.

5. Further the housing element of the local government comprehensive plan adopted pursuant to s. 163.3184, specific to affordable housing.

6. Fund the construction of affordable assisted living facilities or the conversion of existing facilities to affordable assisted living facilities.

7. Provide funds to non-profit owners of affordable housing projects for the elderly that are financed, insured or subsidized by the United States Department of Housing and Urban Development to hire Service Coordinators whose purpose is to link the elderly residents residing in their facilities to the supportive services necessary for them to remain independent and in their own homes. Any state or local funds allocated for this purpose must be used to supplement, not supplant, federal support.

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420.9076 Adoption of affordable housing incentive strategies; committees.--

(1) Each county or eligible municipality participating in the State Housing Initiatives Partnership Program, including a municipality receiving program funds through the county, or an eligible municipality must, within 12 months after the original adoption of the local housing assistance plan, amend the plan to include local housing incentive strategies as defined in s. 420.9071(16).

(2) The governing board of a county or municipality shall appoint the members of the affordable housing advisory committee by resolution. Pursuant to the terms of any interlocal agreement, a county and municipality may create and jointly appoint an advisory committee to prepare a joint plan. The ordinance adopted pursuant to s. 420.9072 which creates the advisory committee or the resolution appointing the advisory committee members must provide for nine committee members and their terms. The committee must include:

(a) One citizen who is actively engaged in the residential home building industry in connection with affordable housing.

(b) One citizen who is actively engaged in the banking or mortgage banking industry in connection with affordable housing.

(c) One citizen who is a representative of those areas of labor actively engaged in home building in connection with affordable housing.

(d) One citizen who is actively engaged as an advocate for low-income persons in connection with affordable housing.

(e) One citizen who is actively engaged as a for-profit provider of affordable housing.

(f) One citizen who is actively engaged as a not-for-profit provider of affordable housing.

(g) One citizen who is actively engaged as a real estate professional in connection with affordable housing.

(h) One citizen who actively serves on the local planning agency pursuant to s. 163.3174.

(i) One citizen who resides within the jurisdiction of the local governing body making the appointments.

If a county or eligible municipality whether due to its small size, the presence of a conflict of interest by prospective appointees, or other reasonable factor, is unable to appoint a citizen actively engaged in these activities in connection with affordable housing, a citizen engaged in the activity without regard to affordable housing may be appointed.

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(3) All meetings of the advisory committee are public meetings, and all committee records are public records. Staff, administrative, and facility support to the advisory committee shall be provided by the appointing county or eligible municipality.

(4) The advisory committee shall review the established policies and procedures, ordinances, land development regulations, and adopted local government comprehensive plan of the appointing local government and shall recommend specific initiatives to encourage or facilitate affordable housing while protecting the ability of the property to appreciate in value. Such recommendations may include the modification or repeal of existing policies, procedures, ordinances, regulations, or plan provisions; the creation of exceptions applicable to affordable housing; or the adoption of new policies, procedures, regulations, ordinances, or plan provisions. At a minimum, each advisory committee shall make recommendations on affordable housing incentives in the following areas:

(a) The processing of approvals of development orders or permits, as defined in s. 163.3164(7) and (8), for affordable housing projects is expedited to a greater degree than other projects.

(b) The modification of impact-fee requirements, including reduction or waiver of fees and alternative methods of fee payment for affordable housing.

(c) The allowance of increased density levels for affordable housing.

(d) The reservation of infrastructure capacity for housing for very-low-income persons and low-income persons.

(e) The allowance of affordable accessory residential units in residential zoning districts.

(f) The reduction of parking and setback requirements for affordable housing.

(g) The allowance of zero-lot-line configurations for affordable housing.

(h) The modification of street requirements for affordable housing.

(i) The establishment of a process by which a local government considers, before adoption, policies, procedures, ordinances, regulations, or plan provisions that increase the cost of housing.

(j) The preparation of a printed inventory of locally owned public lands suitable for affordable housing.

(k) The allocation of a certain percentage of funds for the construction of new affordable assisted living facilities, or the conversion of existing buildings to affordable assisted living facilities.

The advisory committee recommendations must also include other affordable housing incentives identified by the advisory committee.

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(5) The approval by the advisory committee of its local housing incentive strategies recommendations must be made by affirmative vote of a majority of the membership of the advisory committee taken at a public hearing. Notice of the time, date, and place of the public hearing of the advisory committee to adopt final local housing incentive strategies recommendations must be published in a newspaper of general paid circulation in the county. Such notice must contain a short and concise summary of the local housing incentives strategies recommendations to be considered by the advisory committee. The notice must state the public place where a copy of the tentative advisory committee recommendations can be obtained by interested persons.

(6) Within 90 days after the date of receipt of the local housing incentive strategies recommendations from the advisory committee, the governing body of the appointing local government shall adopt an amendment to its local housing assistance plan to incorporate the local housing incentive strategies it will implement within its jurisdiction. The amendment must include, at a minimum, the local housing incentive strategies as defined in s. 420.9071(16).

(7) The governing board of the county or the eligible municipality shall notify the corporation by certified mail of its adoption of an amendment of its local housing assistance plan to incorporate local housing incentive strategies. The notice must include a copy of the approved amended plan.

(a) If the corporation fails to receive timely the approved amended local housing assistance plan to incorporate local housing incentive strategies, a notice of termination of its share of the local housing distribution shall be sent by certified mail by the corporation to the affected county or eligible municipality. The notice of termination must specify a date of termination of the funding if the affected county or eligible municipality has not adopted an amended local housing assistance plan to incorporate local housing incentive strategies. If the county or the eligible municipality has not adopted an amended local housing assistance plan to incorporate local housing incentive strategies by the termination date specified in the notice of termination, the local distribution share terminates; and any uncommitted local distribution funds held by the affected county or eligible municipality in its local housing assistance trust fund shall be transferred to the Local Government Housing Trust Fund to the credit of the corporation to administer the local government housing program pursuant to s. 420.9078.

(b) If a county fails to timely adopt an amended local housing assistance plan to incorporate local housing incentive strategies but an eligible municipality receiving a local housing distribution pursuant to an interlocal agreement within the county does timely adopt an amended local housing assistance plan to incorporate local housing incentive strategies, the corporation, after receipt of a notice of termination, shall thereafter distribute directly to the participating eligible municipality its share calculated in the manner provided in s. 420.9072.

(c) Any county or eligible municipality whose local distribution share has been terminated may subsequently elect to receive directly its local distribution share by adopting an amended local housing assistance plan to incorporate local housing incentive strategies in the manner and according to the procedure provided in this section and by adopting an ordinance in the manner required in s. 420.9072.

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Waiver of Certain Regulatory Requirements for Affordable Assisted Living Conversions

400.407 License required; fee, display.--

(1) A license issued by the agency is required for an assisted living facility operating in this state.
(2) Separate licenses shall be required for facilities maintained in separate premises, even though operated under the same management. A separate license shall not be required for separate buildings on the same grounds.
(3) Any license granted by the agency must state the maximum resident capacity of the facility, the type of care for which the license is granted, the date the license is issued, the expiration date of the license, and any other information deemed necessary by the agency. Licenses shall be issued for one or more of the following categories of care: standard, extended congregate care, limited nursing services, or limited mental health.

(a) A standard license shall be issued to facilities providing one or more of the services identified in s. 400.402. Such facilities may also employ or contract with a person licensed under part I of chapter 464 to administer medications and perform other tasks as specified in s. 400.4255.

(b) An extended congregate care license shall be issued to facilities providing, directly or through contract, services beyond those authorized in paragraph (a), including acts performed pursuant to part I of chapter 464 by persons licensed thereunder, and supportive services defined by rule to persons who otherwise would be disqualified from continued residence in a facility licensed under this part.

In order for extended congregate care services to be provided in a facility licensed under this part, the agency must first determine that all requirements established in law and rule are met and must specifically designate, on the facility's license, that such services may be provided and whether the designation applies to all or part of a facility. Such designation may be made at the time of initial licensure or biennial relicensure, or upon request in writing by a licensee under this part. Notification of approval or denial of such request shall be made within 90 days after receipt of such request and all necessary documentation. Facility owners wishing to provide affordable extended congregate care services shall be eligible to apply for exemptions from certain physical plant requirements if such exemptions will result in a material reduction in construction costs without compromising the resident's privacy or quality of life. Exemption applications shall be evaluated on an individual basis by the Department of Elder Affairs. These exemptions may apply to existing facilities as well as new construction. Existing facilities qualifying to provide extended congregate care services must have maintained a standard license and may not have been subject to administrative sanctions during the previous 2 years, or since initial licensure if the facility has been licensed for less than 2 years, for any of the following reasons:

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Assignment of Medicaid Waiver Slots for New Projects

The following statements are proposed for inclusion as proviso in the General Appropriations Bill:

Whereas, a critical shortage of affordable assisted living facilities currently exists in Florida, causing many frail elderly individuals to be placed in nursing homes prematurely, and whereas potential sponsors and developers of new affordable assisted living facilities have encountered difficulty in securing financing for their projects due to their inability to demonstrate to lenders that sufficient revenue streams will be available to them once the project is completed because they cannot guarantee the availability of Medicaid Assisted Living for the Elderly Waiver slots for their residents.

Therefore, the Department of Elder Affairs shall allow sponsors and developers of affordable assisted living facilities to apply for a certain number of Assisted Living for the Elderly Waiver slots to be assigned to their facility for their residents. Acceptance of these applications shall be contingent upon the sponsor's or developer's willingness to make a long-term commitment to set aside a minimum of 50 percent of the facility's total beds to serve low-income individuals. Low-income individuals are defined as those earning less than 50 percent of the median income for the area in which the assisted living facility is located.

The number of Medicaid Assisted Living Waiver slots assigned to specific facilities shall be adjusted by the Department of Elder Affairs 180 days after the opening of the facility, and any unused slots at that point shall be available to the general population in accordance with Medicaid spending authority. However, the number of slots awarded to residents of individual facilities within the 180 days shall be reassigned to the facility annually to ensure that the facility has the continued ability to subsidize monthly fees to pay operating costs and meet its debt service.

NOTE: Suggested statutory language is not included in this proposal that would allow for automatic annual increases in the Assisted Living Medicaid Waiver as we are recommending.

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