IN THE SUPREME COURT OF FLORIDA
TALLAHASSEE, FLORIDA

ANGELA I. GESSA, ETC.,

Petitioner,

v.

MANOR CARE OF FLORIDA, INC., ET AL.,

Respondent.
_____/

CASE NO.: SC09-768
Lower Tribunal No(s): 2D07-1928
05-7548

FLORIDA HEALTH CARE ASSOCIATION'S AMICUS CURIAE BRIEF ON BEHALF OF RESPONDENT

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IDENTITY OF THE AMICUS CURIAE

Florida Health Care Association (FHCA) is a non-profit association of nursing homes and assisted living facilities and related companies and individuals. It represents approximately 500 nursing homes and a number of assisted living facilities. On December 31, 2009, FHCA sought leave to file an Amicus Curiae brief on behalf of Manor Care Of Florida, Inc. and the other defendants in this matter. This Court granted leave on January 4, 2010.

FHCA advocates for its members and the public they serve. It is interested in maintaining the reputation and goodwill of the many excellent providers who are its members. It provides education and assistance to enhance the quality of care rendered in Florida nursing homes.

SUMMARY OF ARGUMENT

When Angela Gessa was admitted to Manor Care of Carrollwood she freely executed an arbitration agreement. The presumption is that Mrs. Gessa, who had never been found mentally incompetent, read and understood the document she was signing.

The use of arbitration agreements by nursing home facilities in Florida is important as facilities strive to control their costs in a landscape of state and federal regulations and budgetary restraints in the Medicare/Medicaid systems.

Arbitration will certainly lessen the burden on the courts and provide for a swift resolution for the nursing home residents and the nursing home facilities.

ARGUMENT

FLORIDA HEALTH CARE ASSOCIATION'S AMICUS CURIAE BRIEF

I. AS A MATTER OF PUBLIC POLICY ARBITRATION AGREEMENTS BETWEEN NURSING HOMES AND RESIDENTS SHOULD BE ENFORCED

There is no legal requirement that nursing homes take specific residents and, likewise, there is no limitation in law as to the nursing home a resident can choose. In fact, the current average occupancy rate of the nursing homes in Florida is 87.36% so access is not an issue. http://www.fdhc.state.fl.us/MCHQ/CON_FA/Publications/Florida%20NH%20Utilization%20by%20District_Subdistrict%20-%20Jul%202008-Jun%202009.pdf. Ms. Gessa could have chosen any one of a number of other nursing homes.

But that was not her only option. She could have negotiated changes in the Manor Care contract with the admissions department. She did not.

Upon admission, facilities are required to give incoming residents a number of documents; hence the magnitude of the admission package. Included among those documents is the facility's discharge and transfer policy, bedhold policy, advance directives information and many other mandatory documents. Section 400.151, Fla. Stat. (2009); 59A-4.106, F.A.C.

The law is clear that a person is presumed to have read the agreement they are signing. Rocky Creek Retirement Properties, Inc. v. The Estate of Virginia B. Fox, by and through Bank of America, 19 So.3d 1105 (October 09, 2009). Thus one must presume that Ms. Gessa, and on the subsequent admission, her daughter, had all of the relevant information they needed to know and understand the provisions of the agreement.

In this case, Manor Care made certain that the arbitration agreement was highly visible. It was signed separately so one must presume it was read.

To permit Ms. Gessa to avoid the provisions of the arbitration agreement she entered into would create havoc in the long term care marketplace and put many contracts in questions. This is contrary to the public policy which resulted in the favoring of arbitration under both state and federal law. Sections 682.01-682.22, Fla. Stat. (2009); 9 U.S.C., §§ 1-16.

II. NURSING HOMES ARE ONE OF THE MOST HIGHLY REGULATED PROVIDERS IN THE COUNTRY

Nursing homes do not need punitive damages to prod them into providing appropriate care. Federal law imposes upon nursing homes a myriad of specific requirements, approximately 177. Some of these are proscriptive while others are based on community standards. For example 42 C.F.R 483.25 requires that a facility provide "necessary care and services" that result in a resident "attaining or

maintaining [his] highest practicable physical, mental and psychosocial well-being." The regulation does not specify how its requirements are to be met, but case law has held that in meeting that standard a facility must comply with professionally recognized standards of care. Heritage Manor or Columbia v. CMS, DAB CR995 (2003).

Other regulations are more proscriptive and require facilities to act above and beyond the community standard. For example certain regulations require that the facility staff prepare comprehensive assessments on forms required by CMS on a regular basis. 42 C.F.R. 483.20(b). Facilities are required to hold care planning sessions involving the physician. 42 C.F.R. 483.20(k)(2). Unlike the patient/physician relationship in the community, the regulations require that a third party, the facility, be actively involved in that relationship.

Facilities undergo surveys every 9-15 months by the Agency for Health Care Administration ("the Agency"), acting on its own behalf as the licensing agency and as the designated state agency with authority to survey on behalf of CMS for Medicaid and Medicare certification. § 1819(g)(2)(A), Social Security Act; 42 C.F.R. 488.20(a); 42 C.F.R. 488.308; Section 400.23(7), Fla. Stat. (2009); Premier v. CMS, DAB CR1602 (May 29, 2007). On occasion, CMS' own surveyors conduct the survey. In addition, facilities undergo surveys whenever a complaint is filed with the Agency or CMS. Section 400.19, Fla. Stat. (2009). Resurveys

occur if a facility is found not to be in substantial compliance during one of these. The State Ombudsman also has authority to review facilities. If the Ombudsman representative finds a problem it is referred to the Agency for a survey. Chapter 400 Part III, Fla. Stat. (2009).

If a facility has had recurring problems, more frequent surveys are conducted and are, in fact, mandated under certain circumstances. Section 400.19(3), Fla. Stat. (2009).

Nursing homes are constantly under the scrutiny of the regulatory agency which has a number of sources for receiving information to trigger an inspection.

When a facility is surveyed, a scope and severity is placed on any deficient practice found. Section 400.23(8), Fla. Stat. (2009). On the federal side, a scope and severity matrix has been developed by CMS and is included in the Appendix hereto. In the state system the deficiencies are designated Class I, II or III, with I being the most severe. Further a determination is made as to whether the deficiency is isolated, widespread or patterned. Section 400.23(8), Fla. Stat. (2009). "Substantial compliance" means that a facility has been found to have an issue with a regulation but at a level that is not likely to cause harm to a resident. A nursing home is a dynamic place and CMS does not expect perfection, but it does expect substantial compliance. 42 C.F.R 488.301. Deficiencies which are at this level do not have remedies attached at the federal level.

Deficiencies which put a facility out of substantial compliance are rated through a matrix (see Appendix). Remedies may be imposed. 42 C.F.R. 488.406. Some remedies are mandatory and others are discretionary with CMS. 42 C.F.R. 488.408; Alexandria Place v. CMS, DAB CR1391 (January 17, 2006).

A provider can appeal only if a remedy is imposed. 42 C.F.R. 498.3(d)(10)(ii). A provider has no right to challenge CMS' choice of remedies. 42 C.F.R. 488.408(g)(2). Appeals are brought first before an administrative law judge of the Departmental Appeals Board (DAB) and then to a DAB panel. The decision may be appealed to the federal courts.

The highest level of deficiency is immediate jeopardy. 42 C.F.R. 488.301. Fines, called civil money penalties, may be imposed for immediate jeopardy from $3050 per day to $10,000 **per day**. 42 C.F.R. 488.438(a)(1), (d)(2). At any level, the fine may begin to accrue even before the date the deficiency was discovered. In Britthaven of Goldsboro v. CMS, DAB 1960 (January 28, 2005), CMS imposed a remedy of $5,000 per day beginning the day that a resident was found to have received less than adequate care, a date some 24 days before the survey was conducted. Fines do not stop until the facility is back in substantial compliance although they may be reduced if the scope and severity of the deficiency is changed.

There are two ranges of fines for deficiencies. One is reserved for immediate jeopardy level deficiencies as set out above and the lower level is for less serious deficiencies. 42 C.F.R. 488.438(a)(1), (d)(2); 42 C.F.R. 488.438(a)(2). Facilities can only challenge the scope and severity of the deficiency if a successful challenge would change the range of civil money penalties. 42 C.F.R. 498.3(b)(14), (d)(10)(i); Meadville Convalescent Home v. CMS, DAB CR434 (April 4, 2006). The net effect is that, with few exceptions, only the scope and severity of immediate jeopardy is appealable. Britthaven of Havelock v. CMS, DAB No. 2078 (2007). A provider must show that the finding of immediate jeopardy was clearly erroneous. 42 C.F.R 498.60(c).

The federal administrative law judges apply this standard rigidly. In the Britthaven case cited above, Judge Steven T. Kessel explained it thus:

> "[U]nder the clearly erroneous standard, we cannot meddle with a prior decision…simply because we have doubts about its wisdom or think we would have reached a different result. To be clearly erroneous, a decision must strike us as more than just maybe or probably wrong; it must …strike us as wrong with the force of a five-week-old unrefrigerated dead fish," quoting Parts and Elec. v. Sterling, 866 F.2d 228, 233 (7th Cir. 1988).

Termination from the Medicare and Medicaid programs is a remedy available to CMS for any deficiency which is not substantial compliance. In Beverly Health & Rehabilitation – Springhill v. HCFA, DAB CR553 (1998), *aff'd* DAB No. 1696 (1999), a facility challenged immediate jeopardy level deficiencies

which it believed led to its termination. The administrative law judge overturned the jeopardy deficiencies. However, the facility had not challenged several lower level deficiencies. The judge held that CMS has the authority to terminate for any non-compliance so long as it is at "D" level or higher on the matrix and the termination was upheld.

Termination is mandatory if a facility does not achieve substantial compliance within a 6-month period. 42 C.F.R. 488.412(a). A denial of payment for new admissions (DPNA) is permissive and becomes mandatory after 90-days of substantial noncompliance. 42 C.F.R 488.417. A DPNA precludes the facility from being paid for any new Medicare or Medicaid residents while the DPNA is in effect.

The ability of CMS to substantially affect the financial picture of a nursing home provider through fines, DPNA's, and termination makes the need for punitive damages less important in this setting.

In addition to federal remedies, the Agency can also impose remedies for non-compliance. Florida has adopted federal regulations for its licensed facilities. In addition, Florida has added others particular to our state. Each facility undergoes a licensure survey, usually contemporaneously with the federal survey. The state also has remedies which it can impose, including moratorium,

receivership, fines and even delicensing. Section 400.121, Fla. Stat. (2009). This is a strong incentive for a facility to remain in compliance.

III. FACILITIES SHOULD BE ABLE TO REDUCE RISK THROUGH CONTRACTUAL AGREEMENTS

Given the economic environment, a facility should be able to make its choice as to whether it wishes to limit non-economic damages.

There is already a system in place for remedying wrongs committed by a nursing home. In fact, there is a complex remedial system in both state and federal law which serves to encourage compliance with state and federal regulations which enhance quality of care.

Immediate jeopardy is defined as a noncompliance which has the likelihood of "causing serious injury, harm, impairment, or death to a resident." Actual harm need not occur to trigger immediate jeopardy. 42 C.F.R. 488.301.

CMS must look at certain factors in determining a fine including:

^Culpability of the facility, although culpability cannot be used to mitigate the fine

^The facility's history of compliance

^The seriousness of the deficiencies

^The facility's financial condition

42 C.F.R. 488.438(f)

A review of the case law relative to these elements did not show a single case where the facility's financial condition was shown to be a factor in reducing the fine. CMS takes its responsibility very seriously in imposing fines to bring a facility back into compliance.

In fact, a number of cases have resulted in fines of several hundred thousand dollars. See Premier.

Further, at the federal level CMS need only show a prima facie case that the facility was out of compliance and the burden shifts to the provider to establish that it was in substantial compliance by a preponderance of the evidence. Hillman Rehabilitation Center v. CMS, DAB No. 1611 (1997); aff'd Hillman Rehabilitation Center v. U.S., No. 98-3789 (GEB) (D.N.J. May 13, 1999); Batavia Nursing and Convalescent Inn, DAB No. 1911 (2004).

This heavy burden has resulted in only a handful of the hundreds of cases tried in front of administrative law judges or the Departmental Appeals Board being decided in favor of the facility. Thus most of the penalties imposed stand.

At both the federal and state level sanctions can be imposed while the provider awaits a hearing. Sections 400.121, 400.23(8)(a)-(c), Fla. Stat. (2009). Moratoriums on the state side are imposed almost immediately when a serious deficient practice is found to exist. This can have a significant impact on a

provider as the provider cannot admit any residents during the pendency of a moratorium. Section 408.814, Fla. Stat. (2009).

On the federal side a provider need not pay a CMP while a hearing is pending but any other sanction, including termination, goes into effect immediately. Thus success at the federal level on a termination is a Pyrrhic victory, as by the time the hearing is held and a decision rendered the provider has suffered severe financial consequences. See Beverly Health & Rehabilitation – Springhill.

The sanction process at both the state and federal level is sufficient incentive for a facility to provide quality of care. Given that the regulations require compliance above and beyond the community standards, nursing homes are in a different position than most other health care providers. They can receive tremendous fines for a failure to follow the proscriptions of the Medicare and Medicaid programs, which fines can continue for as many days as the provider is out of compliance. This is an incentive to provide good care, identify issues as they arise and find quick solutions.

Adding punitive damages to this mix only increases the cost of care in the State of Florida. The strong incentive to use punitive damages to encourage a litigant to follow community standards is just not there. The incentive is already there through the survey process.

Further, the care for the vast majority of residents in Florida is funded by the Medicare and Medicaid programs. The Agency for Health Care Administration reports 78.2% of nursing home residents receive care paid for by public funding. http://www.ahcancal.org/research_data/oscar_data/NursingFacilityPatientCharacteristics/patients_payer_Dec2009.pdf. Thus when punitive damages are paid they are paid through those sources. To pay out dollars in fines and punitive damages punishes a facility twice and takes money away from places where it is needed to improve the quality of care.

IV. IN LIGHT OF THE DIRE ECONOMIC STRAITS OF THE MEDICAL SYSTEM AND GOVERNMENTAL BUDGETS, ARBITRATION IS ESSENTIAL

Medicaid is a joint federal and state payment system by which nursing homes and other health care providers are paid for providing services to those meeting the indigent standards of the state system. Once eligible for Medicaid, the resident typically pays a small portion of the monthly charge, based upon income. Federal law sets out certain parameters which must be met by each state and, within that framework, the states are free to adopt their own plans. § 1902, Social Security Act [42 U.S.C. § 1396a]. Florida has adopted its Medicaid system through the Title XIX Long Term Care Plan. 59G-6.010, F.A.C. The Plan is promulgated through rulemaking and must be approved by the Centers for

Medicare and Medicaid Services ("CMS") of the Department of Health and Human Services ("HHS"). Section 409.919, Fla. Stat. (2009).

In a nutshell, under the Medicaid program, a provider is reimbursed based on historical costs with certain targets and ceilings. At this time, 57.8% of residents in Florida's nursing homes receive some portion of payment for their care through the Medicaid program. http://www.ahcancal.org/research_data/oscar_data/NursingFacilityPatientCharacteristics/patients_payer_Dec2009.pdf.

Medicaid dollars flow from both Florida and the federal government. Currently, Florida pays 32 1/3% of the Medicaid payment and the federal government pays 67.64%. http://edr.state.fl.us/conferences/Medicaid/fmap.

There is a deficit in the Florida Medicaid line item this year estimated to be $1.7 billion. http://edr.state.fl.us/conferences/medicaid/fmap.pdf; http://edr.state.fl.us/conferences/medicaid/medsummary.pdf.

Medicare is a federal program which pays for skilled nursing home care as well as many other medical expenses. Medicare is available to all Americans age 65 and over. To qualify for Medicare nursing home services, a person must need skilled nursing home care, such as rehabilitation or artificial feeding services. There is a cap on the number of days a person may receive Medicare payment. At this time, 20.4% of nursing home residents in Florida receive care paid for by the Medicare program. http://www.ahcancal.org/research_data/oscar_data/

NursingFacilityPatientCharacteristics/patients_payer_Dec2009.pdf. Medicare is also operating at a deficit. It is most likely that Medicare payment rates will be cut.

In spite of the economy, Florida nursing homes have increased staffing requirements over the last few years to the point that Florida has one of the highest staffing ratios in the country. Chapter 400, Fla. Stat. (2009). Nursing homes must currently supply 2.9 hours per day of direct CNA care for the average resident. Section 400.23(3)(a). Staff costs money. Yet while this requirement has added expense to the nursing home budget, it has had the benefit of increasing the quality of care for Florida nursing home residents. The money to meet the increased staffing can be gained through decreasing costs associated with litigation. Arbitration serves judicial economy. http://www.ahcancal.org/research_data/oscar_data/Nursing%20Facility%20Operational%20Characteristics/Direct_Care_Staff_Dec2009.pdf.

Given this bleak economic climate, arbitration is even more essential. Arbitration saves costs to the system and fosters speedy resolution to resident's concerns.

V. QUICK RESOLUTION OF DISPUTES BENEFITS THE RESIDENT AS WELL AS THE NURSING HOME

It is axiomatic that the elderly residents of Florida nursing homes would benefit from swift resolution of a dispute over an injury which was incurred in a nursing home. If the nursing home staff was negligent, than prompt and decisive closure would be in both parties' best interests. Tying the matter up in the court system for many months and even years means that the injured party is not likely to see relief in her lifetime. She will never be made whole. Her heirs will enjoy the payment rightfully belonging to her as the injured party.

VI. NURSING HOMES MUST USE THEIR RESOURCES JUDICIOUSLY

Even with increased staffing, residents cannot receive one-on-one care 24 hours a day. In fact, this reality is reflected in the staffing ratios mandated by law. If there was an expectation of one-on-one staffing for even a small number of the residents in any given nursing home, the ratio of staff to resident would be substantially higher and the cost prohibitive.

Nursing homes are an important part of the long term continuum of care as evidenced by their very existence. They provide rehabilitative services to residents who have suffered fractures, strokes and the like.

Residents suffering from various types of dementia are also often best served in the nursing home setting. These individuals may be difficult or impossible to

handle in the home environment. They may be at great risk for falls or elopement so need to be in a structured, safe environment. Nursing homes provide this service.

While all of us would like to spend our golden years at home and die peacefully in our sleep, this is often not the reality. Many people who need 24-hour nursing supervision must have their needs met in the nursing home setting. Only if nursing homes remain financially viable can this occur. Permitting the use of arbitration in litigating negligence matters provides a small piece of the financial viability puzzle.

One cannot overlook the nursing home environment. Families often are unhappy that they have had to place their loved one in a nursing home. Many times their expectations are unrealistic. They may feel guilt that they have put their parent in a home when they had promised to always care for them.

Residents likewise may experience trauma. Even a person admitted for rehab may for the first time realize that they do have mortality which makes that person unhappy and leads to depression. See Senior Series, Moving Your Loved One to a Nursing Home, Ohio State Department of Aging, SS-187-R08 (in Appendix).

CONCLUSION

It is respectfully requested that the Court affirm the decision of the Second District Court of Appeal.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this ____ day of February, 2010, a true and correct copy of the foregoing has been furnished by U.S. Mail to:

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CERTIFICATE OF COMPLIANCE

I CERTIFY that this Amicus Curiae Brief complies with the font requirements of Rule 9.210 of the Florida Rules of Appellate Procedure and is in the required font of Times New Roman 14.

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APPENDIX

1. Remedy Scale Based on Scope and Severity (matrix)

2. Senior Series, Moving Your Loved One to a Nursing Home, Ohio State Department of Aging, SS-187-R08