SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

BILL: CS/CS/SB 1838

SPONSOR: Children and Families Committee, Health, Aging and Long-Term Care Committee and Senator Brown-Waite

SUBJECT: Long-Term Care

DATE: March 11, 2002 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Liem	Wilson	HC	Favorable/CS
2.	Barnes	Whiddon	CF	Favorable/CS
3.			AHS	
4.			AP	
5.				
6.				

I. Summary:

CS/CS/SB 1838 creates "The Consumer-Directed Care Act" under which persons who qualify to participate in one of the current Medicaid home and community-based waiver programs and who are able to direct their own care or to appoint a representative to act on their behalf are eligible to choose to participate in this program. The consumer-directed care program must allow persons to choose the providers of services and to direct the delivery of services to best meet their long-term care needs. Participants in the program will be given a monthly budget allowance to purchase home and community-based services, which may include services in an assisted living facility.

Consumers are permitted to hire family members, friends, or relatives as providers in this program. The bill requires all persons who render care under this program to complete background screening. Persons who are disqualified after the screening may request an exemption from the disqualification from the Agency for Health Care Administration (AHCA or agency).

The agency may apply for federal Medicaid waivers, or amendments to existing waivers, to implement the program. The agency and the Departments of Elderly Affairs (DOEA), Health (DOH), and Children and Family Services (DCF) will evaluate the program and report to the Legislature annually.

The bill provides legislative findings regarding the need for a more comprehensive strategy to meet the needs of an increasingly elderly population; requires AHCA, in consultation with the Department of Elderly Affairs, to develop a plan to reduce the number of Medicaid-funded nursing home days; establishes an Office of Long-Term Care Policy within DOEA; delineates the duties of the office; establishes an advisory board for the office; modifies the agency's duties

with respect to the certificate-of-need program to require that prior to issuing certificates of need to construct additional nursing homes, the agency must determine that such need cannot be met through enhanced home and community-based services; establishes statutory requirements for the Comprehensive Assessment and Review (CARES) nursing home pre-admission screening program; requires the department and agency to implement a program to assist individuals residing in nursing homes to move to less restrictive settings; makes changes to the State Long-Term Care Ombudsman Council; and specifies that a lease agreement required as a condition of bond financing or refinancing is not subject to the bond requirements pertaining to the sale or transfer of the ownership of a nursing facility.

The bill amends sections 408.034, 409.908, 409.912, 430.708, 641.386, 400.069, 400.0089, 400.0091, 400.179, of the Florida Statutes; and creates sections 409.221, 430.041, 430.7031, and two undesignated sections of the Florida Statutes.

II. Present Situation:

Long-Term Care Ombudsman Program

Long-term care ombudsmen are volunteer advocates for residents of nursing homes, board and care homes, assisted living facilities and similar adult care facilities. They provide an ongoing presence in long-term care facilities, monitoring resident care and facility conditions.

The Florida Long-Term Care Ombudsman Program (LTCOP) was initiated in 1975 under chapter 75-233, Laws of Florida. The Legislature's intent was to create a volunteer-based program to discover, investigate and remedy conditions that constitute a threat to the rights, health, safety or welfare of residents of long-term care facilities and to conduct investigations to further the enforcement of laws, rules and regulations that safeguard the health, safety and welfare of residents. The statutory authority for the LTCOP is found in part I of chapter 400, F.S.

In Florida, the LTCOP consists of a State Long-Term Care Ombudsman, State Long-Term Care Ombudsman Council and 14 district councils under sections 400.0063, 400.0067 and 400.0069, F.S. Each district council is comprised of 15 to 30 members under section 400.0069(4), F.S. The councils are required to conduct annual inspections of all long-term care facilities in the council's jurisdiction and to undertake complaint investigations as necessary under section 400.0073(4), F.S. The LTCOP maintains a toll-free complaint telephone line. Local councils meet monthly and the state council meets quarterly. The LTCOP is required to maintain a statewide uniform data collection and analysis system for long-term care statistics and to prepare an annual report incorporating such data under sections 400.0089 and 400.0067(2)(g), F.S. Comprehensive training must be provided to all ombudsmen under section 400.0091, F.S.

Long-term care facilities in Florida are comprised of nursing homes (744 facilities with 81,918 beds), assisted living facilities (2,566 facilities with 84,017 beds), and adult family care homes (351 facilities with 1,454 beds) for a total of 3,661 facilities and 167,389 beds. The LTCOP staffing is in constant flux, but typically approximates 260 (17.5 paid FTEs and the remainder volunteers). These ombudsmen accomplished 2,886 routine inspections (78.8 percent of the 3,661 facilities) and 8,040 complaint investigations during the 1999-2000 fiscal year. Based upon preliminary data, volume for the 2000-2001 year will be comparable to the previous year.

Medicaid

Medicaid is a medical assistance program that pays for health care for the poor and disabled. The federal government, the state, and the counties jointly fund the program. The federal government, through law and regulations, has established extensive requirements for the Medicaid Program. The agency is the single state agency responsible for the Florida Medicaid Program. The Department of Children and Family Services is responsible for determining Medicaid eligibility and managing Medicaid eligibility policy, with approval of any changes by AHCA.

The statutory provisions for the Medicaid Program appear in ss. 409.901 through 409.9205, F.S. Section 409.903, F.S., specifies categories of individuals who are required by federal law to be covered, if determined eligible, by the Medicaid Program (mandatory coverage groups). Section 409.904, F.S., specifies categories of individuals who the federal government gives state Medicaid programs the choice of covering (optional coverage groups). Payments for services to individuals in the optional categories are subject to the availability of monies and any limitations established by the General Appropriations Act or ch. 216, F.S.

Long-term Care

Long-term care generally means care that is provided on a continual basis to persons with chronic disabilities. Unlike acute illness, chronic conditions are essentially permanent. Regimens of medical and personal care can sometimes control chronic conditions and the level of disability can often be mitigated through the use of assistive devices and re-training in self-care activities. The presence of disability, however, is not synonymous with the need for long-term care.

Florida is home to nearly 3 million individuals over the age of 65 years. Of the ten places in the U.S. with 100,000 or more population having the highest median ages, five are in Florida: Cape Coral, St. Petersburg, Fort Lauderdale, Hollywood, and Clearwater. Clearwater had the highest median age at 41.8 years.

Over the past 10 years, the proportion of the population in Florida over age of 65 years declined from 18.3 to 17.6 percent. This decline was caused by a dip in the birthrate in the United States in the late 1920s and early 1930s. Despite the drop in the proportion of the elderly in Florida's population over the past 10 years, the number of Floridians over the age of 85 years increased by nearly 30 percent to 331,000. The current dip in the proportion of the elderly in Florida will be much more than offset when the "baby boom" generation begins to reach the age of 65 years in 2011, swelling the ranks of the elderly. Florida, more than other states, faces large increases in the number of "oldest old," i.e., people over the age of 85 years. By 2020, Florida will be experiencing the full effect of the aging of its "baby boomer" residents, with an estimated 97 percent growth in its population over the age of 85 years.

Home and Community-Based Services in Florida

Provision of supportive services to disabled persons can help them to remain in their own homes as an alternative to nursing home placement. Traditionally, the majority of the supportive

services needed are assistance with the activities of daily living such as assistance with bathing and dressing, light housekeeping, adult day care, home delivered meals, and home repair (construction of wheelchair ramps, installation of grab bars).

Generally, home and community-based programs require an assessment of an individual's functional deficits and a prescription for the supportive services required to substitute for the individual's ability to provide self-care. The assessment is performed by a "case manager," who arranges for the services, oversees delivery of the services, and modifies the plan of care as the individual's needs change. Under traditional waivers, services are provided by agencies or individuals who meet criteria established by the state and are enrolled as Medicaid providers.

Currently the state operates four Medicaid home and community-based waiver programs designed to delay or prevent institutional placement of frail elders, physically disabled adults, and persons with developmental disabilities. In each of those waiver programs, the consumers select a case manager to assist in developing a plan of care, identifying providers, selecting services, and arranging for care to be delivered.

Federal Research & Demonstration Project

The Florida Consumer-Directed Care project (CDC) is one of three national demonstration projects initiated to research issues and questions about Medicaid recipients managing their own care. Consumers in the project receive a monthly budget allowance and are expected to manage their own waiver services within that budget. Consumers or their representatives plan their own care, arrange for its delivery, and negotiate the costs. Under this program, the consumer is responsible for choosing essential and cost-effective services. Consumers arrange the type, duration, frequency, and timing of services to best meet their needs.

The CDC project is a "Cash and Counseling" grant program implemented under an 1115 Medicaid waiver granted by the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) and funded by the Robert Wood Johnson Foundation and the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Arkansas and New Jersey also participate in the Cash and Counseling grant program.

Consumer-directed care for elders and physically disabled adults is available in Brevard, Broward, Charlotte, Collier, Dade, Hillsborough, Lee, Manatee, Martin, Okeechobee, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Sarasota, Seminole and St. Lucie Counties. The CDC is available statewide for developmentally disabled adults and children.

Because this is a research program, the participants are randomly assigned either to a "control" or an "experimental" group. In the control group, the consumers receive services under the existing Medicaid waiver program. In the experimental group, the consumer or a representative develops a purchasing plan and manages the funds; a "Fiscal Intermediary" (FI) provides bookkeeping assistance/oversight; a consultant provides training, technical assistance and support; the consumer decides which allowable services best meet his or her needs; the consumer may hire and direct employees and independent contractors (who may be family members or friends) and/or agency providers; and the consumer assesses the quality of services received.

Allowable purchases include: personal care; homemaking; consumable medical and personal care supplies; adaptive devices; wheelchair ramps; grab bars; home repairs and maintenance; errands/shopping services; and pest control/yard work.

Under the 1115 Medicaid waiver, Florida may enroll 6,000 participants in CDC. Only 3,000 are needed for evaluation purposes. Experimental group consumers are guaranteed a minimum of 2 years participation in CDC. Enrollment began in May 2000. As of January 10, 2002, a total of 2,664 individuals (658 elders, 1,002 adults, and 1,004 children) had been assigned to the experimental group or control group. Of the individuals assigned to the experimental group, approximately 59 percent are now receiving funds. The remaining experimental group participants are in various phases of the CDC purchasing plan development and approval process.

Enrollment for evaluation purposes is expected to close during the 2nd quarter of 2002. The Department of Elderly Affairs and AHCA are investigating the expansion of CDC availability statewide for elders and physically disabled adults.

The 1115 Medicaid waiver protocol requires the transition of CDC participants to a permanent Medicaid consumer direction program, should one be established. The experimental group would be enrolled directly in the permanent program, and the control group would have first priority for enrollment. The protocol requires control group members to complete 1 year in the CDC project and then have first priority in transitioning to a permanent program. The Centers for Medicare and Medicaid Services may be unwilling to approve a waiver for the Consumer-Directed Care Program if this protocol provision is not followed.

If a permanent program is not available, the 1115 Medicaid waiver protocol requires an experimental group phase out process at the end of 2 years of participation. The first phase out would be effective August 1, 2002.

Based upon the DOEA's experience with the demonstration project and preliminary feedback, the CDC evaluation is expected to show positive outcomes in quality of care and consumer satisfaction.

Nursing Home Capacity in Florida

Florida regulates the number of nursing home beds in the state via the Certificate-Of-Need (CON) program. The CON program is a regulatory process that requires health care providers to obtain state approval before offering new or expanded services. Need for additional nursing home beds is determined in 33 separate market areas. The factors considered in the nursing home CON formula are the elderly population in an area, existing nursing home beds per elder population, and the existing nursing home occupancy rate in the area. For many years, the CON program has produced a ratio of nursing home beds to elders and to disabled elders in Florida that has been one of the lowest in the nation.

The 2001 Legislature imposed a 5-year moratorium on the issuance of new certificates of need for nursing home beds with the exception of non-Medicaid beds in Continuing Care Retirement Facilities. The intent of the moratorium is to enable the state to shift its emphasis from nursing

home care to care that is community-based and more in keeping with the wishes of the state's elderly citizens. The agency has imposed the moratorium and is no longer issuing certificates of need for nursing home beds, however, as of October 2001, there were 2,285 beds that had been approved but not yet built.

Nursing Home Preadmission Screening

The CARES program (Comprehensive Assessment and Review for Long-term Care Services) is Florida's gatekeeper to prevent inappropriate Medicaid payment for nursing home care. Pre-admission screening for nursing home care is a federally-mandated function of the Medicaid program to ensure that elder and disabled applicants for Medicaid-reimbursed nursing home care are medically appropriate for such care. The CARES program identifies an individual's need for long-term care, establishes an individual's medical eligibility to receive Medicaid funding for long-term care, and recommends the least restrictive and most appropriate placement.

Prior to 1989, the CARES program was operated by the Medicaid program office within the Department of Health and Rehabilitative Services (HRS). In 1989, management of the CARES program was transferred to the Aging and Adult Services program office in an attempt to better integrate the nursing home pre-admission screening function with the state entity that managed the state's elder services network. When DOEA was created in 1992, CARES remained at HRS. In 1995, funding and staff for the CARES program was transferred in the General Appropriations Act to the Department of Elderly Affairs, which operates the CARES program under an interagency agreement with AHCA.

Florida statutes do not contain an authorization or requirement for operations of the CARES program.

The University of South Florida has been contracted by AHCA to develop a data system which matches Medicaid data to nursing home pre-admission screening data kept in the DOEA CARES management information system. In an analysis of this data for other purposes, the university was unable to find evidence that CARES evaluations had been performed for between 15 to 25 percent of the Medicaid residents of nursing homes. According to CARES staff, the event which triggers CARES staff performing an evaluation of a nursing home resident's need for nursing home care is an eligibility determination by DCF staff. In the instance of an individual who is eligible for Medicaid due to receiving assistance under the Federal SSI program, DCF staff do not perform an eligibility determination; consequently there is no trigger for CARES to perform the required preadmission screening. There is not currently a mechanism in the Medicaid payment system to ensure that the required screening has been performed prior to payment.

Transitioning People Out of Nursing Homes

CARES approval for Medicaid payment of nursing home care is based on criteria defined in state rules. An individual may be admitted as a "skilled" resident if the recipient requires services that are medically complex and supervised by a physician. A resident may also be admitted as either "intermediate level I" or "intermediate level II." A resident at intermediate level I is incapacitated mentally or physically and receives extensive health-related care. Intermediate level II care is limited health-related care required by an individual who is mildly incapacitated

or ill to a degree to require medical supervision. In Florida, approximately 1/3 of the Medicaid funded nursing home residents are at a skilled level of care; approximately 2/3 of Medicaid funded residents are at intermediate level I. Less than half a percent of Medicaid-funded residents are at intermediate level II.

If CARES staff believe that an individual's stay in a nursing home will be short-term, the team recommends a "temporary nursing home" level of care. In fiscal year 2000-2001, DOEA reports that CARES issued approximately 4,600 temporary level of care recommendations. Department staff report that many of these temporary placements have lengths of stay that resemble permanent placements (for example nearly 60 percent of the temporary placements are in a nursing home for more than 6 months, and nearly 40 percent remain in a nursing home for a year or more). This is due, in part, to a lack of intervention to ensure that the resources of the home and community-based services system are used as soon as the individual is rehabilitated to assist the person in returning home or to an alternative setting as soon as possible.

The 2001 General Appropriations Act, however, provided $3.49 million for the Assisted Living Medicaid waiver program to transition residents in nursing homes at the intermediate level II of care to assisted living facilities. In implementing this policy DOEA found that there were far fewer individuals at the intermediate level II of care than anticipated, and therefore began to take a closer look at individuals currently at the "temporary" level of care, but who had nonetheless remained in nursing homes. As of October 1, 2001, DOEA has been able to arrange alternative placements for 84 individuals. All of the residents moved to the assisted living waiver program had been in a nursing home at least 60 days; the average length of stay prior to transition was 263 days. The full time equivalent of these 84 individuals in nursing homes, at Florida's average per diem rate would have been approximately $3 million. The cost of care in the Assisted Living Waiver for this population for a year will be $820,000.

Staff at DOEA report that several factors must be in place in order for an individual who has been in a long-term nursing home placement to move to a less intense care setting. First, someone must be available to follow up on the resident immediately after the nursing home placement, offer an alternative, and take responsibility for working with the individual, his family and the facility to prepare a transition plan. Second, an alternative placement (either in a less intensive assisted living facility or one of the state's community care programs) must be available. Third, the state must ensure that dedicated funds are available to support the cost of the alternative placement.

III. Effect of Proposed Changes:

Section 1. Creates s. 409.221, F.S., to establish the consumer-directed care program. The section is titled the "Florida Consumer-Directed Care Act." The bill provides legislative findings regarding community-based care and consumer choice and control in selecting services and providers. The intent of the Legislature is to nurture the autonomy of Floridians who have disabilities by providing long-term care services in the least restrictive, appropriate setting. The Legislature further intends to give such individuals more choices in and greater control over the long-term care services they receive.

AHCA is required to establish the consumer-directed care program, upon federal approval, and to establish interagency cooperative agreements with and work with DOEA, the Department of Health (DOH), and DCF to implement and administer the program. The program must allow enrolled persons to choose the providers of services and to direct the delivery of services, to best meet their long-term care needs. The program must operate within the funds appropriated by the Legislature.

Persons who are enrolled in one of the Medicaid home and community-based waiver programs and are able to direct their own care, or to designate an eligible representative, may choose to participate in the program. The bill defines the terms "budget allowance," "consultant," "consumer," "fiscal intermediary," "provider," and "representative" for the purposes of s. 409.221, F.S.

Consumers enrolled in the program shall be given a monthly budget allowance directly from an AHCA-approved fiscal intermediary. Each department must develop purchasing guidelines, approved by AHCA, to assist consumers in using the budget allowance to purchase needed, cost-effective services. Enrolled consumers must use the monthly budget allowance only to pay for home and community-based services that meet their long-term care needs and are cost efficient. The bill provides a list of services consumers can purchase, but does not limit the allowable services to those on the list.

The bill describes the roles and responsibilities of the consumers, the agencies involved in the program, and the fiscal intermediary. Consumers must be allowed to choose the providers of services and how services are to be provided. A consumer's neighbor, friend, spouse, or relative may be a provider. The consumer's roles and responsibilities are listed and differentiated according to whether the consumer is the employer of record or not the employer of record.

All persons who render care through the program must comply with the background screening requirements of s. 435.05, F.S. Persons excluded from employment may request an exemption from disqualification. AHCA must reimburse, as allowable, the costs of background screening of caregivers who actually become employed by consumers.

AHCA, DOEA, DOH and DCF may adopt and enforce rules to implement the bill. AHCA is required to ensure compliance with federal regulations and apply for necessary federal waivers or waiver amendments needed to implement the program. The program is to be implemented upon federal approval. AHCA, DOEA, DOH and DCF are required to review and assess the implementation of the program. By January 15 of each year, AHCA must submit a report to the Legislature that includes each department's review of the program, and contains recommendations for improvements.

Section 2. Provides legislative findings and intent regarding the need for a more comprehensive strategy for meeting the long-term care needs of an increasingly elderly population.

Section 3. Requires AHCA, in consultation with DOEA, by December 1, 2002, to submit a plan to reduce the number of nursing home bed days purchased by the state Medicaid program and to replace such nursing home care with care provided in less costly alternative settings. The plan is to include specific statutory and operational changes to achieve the reductions and must include

an evaluation of the cost-effectiveness and relative strengths and weaknesses of programs that are alternatives to nursing homes.

Section 4. Amends s. 408.034, F.S., modifying the methodology by which AHCA determines need for additional community nursing facility beds to require that prior to determining that there is a need for additional community nursing facility beds, the agency must determine that the need cannot be met through the provision, enhancement, or expansion of home and community-based services. As part of this determination, the agency must examine nursing home placement patterns and demographic patterns of persons entering nursing homes and the effectiveness of existing home and community-based service delivery systems in meeting the long-term care needs of the population. The agency is to recommend changes to the existing home and community-based delivery system to lessen the need for additional nursing home beds.

Section 5. Amends s. 409.912, F.S., to allow AHCA to contract with an entity on a risk sharing basis, to provide in-home physician services for the purpose of testing the cost effectiveness of enhanced home-based medical care to Medicaid recipients with degenerative neurological diseases and other diseases or disabling conditions associated with high costs to Medicaid.

The bill adds requirements for the CARES nursing facility-preadmission screening program to ensure that Medicaid payment for nursing facility care is made only for individuals who require such care and to ensure that long-term care services are provided in the most appropriate setting. The agency must operate the CARES program through an interagency agreement with the Department of Elderly Affairs. Prior to making payment for nursing facility services for a Medicaid recipient, the agency must verify that the nursing facility preadmission screening program has determined that the person requires nursing facility care and cannot be safely served in the community-based programs. The agency is to submit a report to the Legislature and to the Office of Long-Term Care Policy describing the rate of diversion to alternatives, staffing needed to improve the diversion rate, reasons the program is unable to place individuals in less restrictive settings, barriers to appropriate placement, including those due to operations of other agencies or state-funded programs, and statutory changes necessary to ensure that individuals in need of long-term care services receive such care in the least restrictive environment.

The bill does not move the CARES program from DOEA to AHCA. Since the General Appropriations Act provides staff and budget authority for this function in the DOEA budget entity, DOEA would continue to be responsible for this activity.

Section 6. Creates s. 430.041, F.S., to establish the Office of Long-Term Care Policy in the Department of Elderly Affairs. The department is to provide administrative support and service to the Office of Long-Term Care Policy. The director of the office is to be appointed by, and serve at the pleasure of, the Governor but shall be under the direct supervision of the Secretary of Elderly Affairs and not subject to supervision by any other employee of the department. The office is to evaluate the state's long-term care system and to make recommendations to increase the availability and use of non-institutional settings to provide care to the elderly and ensure coordination among the agencies responsible for the long-term care continuum. The office will have an advisory council and the chair will be the Director of the Office of Long-Term-Care Policy. The council will consist of a member of the Senate and of the House of Representatives, appointed by the President of the Senate and the Speaker of the House of Representatives,

respectively; the Secretaries of AHCA, DOEA, Children and Family Services, and Health; the Executive Director of the Department of Veterans' Affairs; a representative of the Florida Association of Area Agencies on Aging, appointed by the Governor, three people with broad knowledge and experience in the delivery of long-term care services, appointed by the Governor, and two representatives of people using long-term care, appointed by the Governor from groups representing elderly persons. Each state agency represented on the advisory council will make at least one employee available to work with the office. All state agencies and universities will assist the office in carrying out its duties. The office is to submit a preliminary report of its findings and recommendations on improving the long-term care continuum to the advisory council by December 1, 2002. The office must submit its final report and each subsequent annual update of the report to the Governor and the Legislature within 30 days after receiving input from the advisory council.

Section 7. Creates s. 430.7031, F.S., to establish the Nursing Home Transition Program to assist individuals in nursing homes to regain independence and to move to less costly settings. DOEA and the agency are to work together to identify long-stay residents who could be moved out of nursing homes, and to provide services to assist these individuals to move to less expensive and less restrictive care. The two agencies are to modify existing service delivery systems or develop new systems, and are required to offer long-stay residents priority placement in all home and community-based care programs. DOEA and the agency may seek federal waivers necessary to administer the program.

Section 8. Amends s. 409.908, F.S., to make conforming statutory cross-reference changes.

Section 9. Amends s. 430.708, F.S., to make conforming statutory cross-reference changes.

Section 10. Amends s. 641.386, F.S., to make conforming statutory cross-reference changes.

Section 11. Amends s. 400.0069, F.S., which governs local long-term care ombudsman councils to increase the maximum number of council members from 30 to 40.

Section 12. Amends s. 400.0089, F.S., to require the State Long-Term Care Ombudsman Council to publish quarterly reports regarding the number and types of complaints received by the long-term care ombudsman program which will supplement the more comprehensive annual report required by this section.

Section 13. Amends s. 400.0091, F.S., to require volunteers and appropriate employees of the Office of the State Long-Term Care Ombudsman to be given a minimum of 20 hours of training upon employment or enrollment as a volunteer. After the initial training, employees and volunteers must be given a minimum of 10 hours of training annually. The training must cover guardianships and powers of attorney, medication administration, care and medication of residents with dementia and Alzheimer's disease, accounting for residents' funds, discharge rights and responsibilities, and cultural sensitivity.

Section 14. Amends s. 400.179, F.S., to specify that a lease agreement required as a condition of bond financing or refinancing under s. 154.213, F.S., or s. 159.30, F.S., is not subject to the bond

requirements of s. 400.179(5)(d), F.S., pertaining to the sale or transfer of the ownership of a nursing facility.

Section 15. Provides an effective date of July 1, 2002

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

B. Public Records/Open Meetings Issues:

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

C. Trust Funds Restrictions:

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

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill will potentially decrease revenues to currently enrolled Medicaid waiver providers if consumers choose to receive their home and community-based services from other entities.

The provisions of this bill will increase the requirements that must be met prior to allowing the construction of additional nursing homes. Enhanced nursing home pre-admission screening and a requirement that individuals be referred to alternatives to nursing homes that can safely and cost-effectively meet their long-term-care needs may mean decreased revenues to nursing homes. The nursing home transition program will decrease revenues to nursing homes by removing those residents who can be cared for in other settings. It is likely that this program will increase revenues to assisted living facilities and other providers of community-based long-term-care services.

C. Government Sector Impact:

Funds for the Consumer-Directed Care program are transferred from existing Medicaid waiver programs. For implementing the Consumer-Directed Care program, AHCA reports that a total of five FTEs would be needed: two FTEs for program development, monitoring, and administration and three FTEs for the additional workload associated

with the background screening function. The agency reports that it would need new general revenue funds for FY 2002-2003 ($293,139.50) and for FY 2003-2004 ($283,602.50) in order to match federal funds for establishing these new positions.

The bill states that DOEA will provide administrative support and services to the Office of Long-Term Care Policy.

The nursing home transition program should produce substantial savings in Medicaid nursing home spending for each person removed from nursing homes and served in other settings.

The Office of the State Long-Term Care Ombudsman will be able to implement the provisions of the bill that affect the Ombudsman program within the existing resources of the office.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.