HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HHSC 12-04 Quality Improvement Initiatives for Entities Regulated by the Agency for Health Care Administration
SPONSOR(S): Health & Human Services Committee; Gonzalez
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health & Human Services Committee	18 Y, 0 N	Shaw and Entress	Gormley
1) Appropriations Committee			

SUMMARY ANALYSIS

The bill implements quality improvement incentives and other measures for entities regulated by the Agency for Health Care Administration including assisted living facilities, nursing homes, hospitals and managed care plans.

The bill increases the quality of assisted living facilities (ALFs) by:

- Creating a licensure program for ALF administrators.
- Increasing training and competency testing requirements for ALFs administrators.
- Creating higher standards for licensure as a limited mental health ALF.
- Increasing penalties for ALFs that have Class I or Class II violations.
- Imposing a mandatory penalty of $10,000 when by a violation by an ALF results in a resident's death.
- Directs the Department of Children and Families to contract for mental health training for ALF staff.
- Provides that training for an ALF administrator can be through a public or private college, or through a contract with the Department of Elder Affairs and a statewide assisted living association.

The bill also encourages quality by establishing a pay-for-performance program for hospitals, skilled nursing facilities, and managed care plans servicing Medicaid patients which will be implemented in FY 2015-16. The program will examine certain outcome measures to rank the providers in each category. The highest ranked providers will receive a positive adjustments to rates up to 1 percent of current payment rates.

The bill has both positive and negative fiscal impacts to state government. See Fiscal Analysis and Economic Impact Statement.

The bill provides an effective date of July 1, 2012.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

An Assisted Living Facility (ALF) is a facility "… which undertakes through its ownership or management to provide housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.[1]" Through the use of long-term care, ALFs allow residents to age in place in a residential environment.[2]

Licensure

To operate, an ALF must be licensed by AHCA, be under the supervision of an administrator, comply with sanitation, fire safety and zoning requirements, and comply with staffing requirements.

Three specialty licenses[3] are available to an ALF: Limited Mental Health (LMH) License, Limited Nursing Services (LNS) License, and Extended Congregate Care (ECC) License. As of December 1, 2011, there were 2,985 ALFs in Florida, containing 68,190 private beds and 15,416 Optional State Supplementation (OSS) beds.[4] Of these facilities, 1,108 had LMH licenses, 1,083 had LNS licenses, and 267 had ECC licenses, totaling 1,350 facilities with specialty licenses.[5]

License Qualifications

An ALF must be licensed AHCA to operate in Florida[6], unless exempt from licensure.[7] To apply for a standard license, the facility must comply with part II of Chapter 408 (general healthcare licensing provisions) and must submit the following to AHCA:

- Information regarding all other facilities operated by the administrator;
- The name, social security number, education, and experience of the administrator;
- The location of the a facility with proof of zoning compliance;
- Proof of fire safety compliance; and
- Proof of passing a sanitation inspection.[8]

Administrator Qualifications

ALFs are required to be under the supervision of an administrator, who is "responsible for the operation and maintenance of the facility including management of all staff and the provision of adequate care to all residents…" To qualify as an administrator, an individual must meet certain qualifications, but is not required to obtain any type of license or certification. ALF administrators must:

- Be at least 21 years old;
- If employed after August 1, 1990, have a high school diploma (or equivalency) or have been employed as the administrator or operator of an ALF in Florida for 1 of the past 3 years in which the facility met minimum standards;
- If employed after October 30, 1995, have a high school diploma (or equivalency);

---

[1] S. 429.02(5), F.S.
[2] S. 429.01(2), F.S.
[3] See discussion below for details of the specialty licenses.
[4] Assisted Living Facility Directory, *available at:* http://ahca.myflorida.com/MCHQ/Long_Term_Care/Assisted_living/alf.shtml.
[5] Assisted Living Facility Directory, *available at:* http://ahca.myflorida.com/MCHQ/Long_Term_Care/Assisted_living/alf.shtml.
[6] S. 429.07(1), F.S.
[7] S. 429.04, F.S.
[8] S. 429.11, F.S.

- Comply with level 2 background screening; and
- Complete the core training requirement.[9]

Administrators may supervise up to three ALFs. If an administrator supervises more than one ALF, they must appoint a manager who is 21 years old and has completed the core training requirement to each facility. This appointment must be in writing.[10]

<u>Licensure Violations</u>

AHCA is required to cite facilities for violations of facility standards according to the severity of the violation. Violations are categorized in four classes:

- Class I violations "present an imminent danger to the clients of the provider or a substantial probability that death or serious physical or emotional harm would result therefrom."
- Class II violations "directly threaten the physical or emotional health, safety, or security of the clients, other than class I violations."
- Class III violations "indirectly or potentially threaten the physical or emotional health, safety, or security of clients, other than class I or class II violations."
- Class IV violations "do not threaten the health, safety, or security of clients."[11]

ALFs which commit violations are subject to sanctions, including possible license revocation. AHCA is also required to impose a fine on facilities for violations as follows:

- A fine between $5,000 and $10,000 for each cited class I violation;
- A fine between $1,000 and $5,000 for each cited class II violation;
- A fine between $500 and $1,000 for each cited class III violation; and
- A fine between $100 and $200 for each cited class IV violation.[12]

AHCA may impose a moratorium, or a requirement that the ALF not accept any new residents,[13] "if the agency determines that any condition related to the provider or licensee presents a threat to the health, safety, or welfare of a client."[14] AHCA must also revoke the license of an ALF which has been cited for two or more similar class I violations within the last two years.[15] AHCA may deny or revoke a license for the following acts performed by any facility employee:

- An intentional or negligent act seriously affecting the health, safety, or welfare of a resident of the facility;
- The determination by AHCA that the owner lacks the financial ability to provide continuing adequate care to residents;
- Misappropriation or conversion of the property of a resident of the facility;
- Failure to follow the criteria and procedures provided under part I of chapter 394 relating to the transportation, voluntary admission, and involuntary examination of a facility resident;
- A citation of any of the following deficiencies as specified in s. 429.19, F.S.,:
    - One or more cited class I deficiencies.
    - Three or more cited class II deficiencies.
    - Five or more cited class III deficiencies that have been cited on a single survey and have not been corrected within the times specified.
- Failure to comply with the background screening standards of this part, s. 408.809(1), F.S., or ch. 435;
- Violation of a moratorium;

[9] Rule 58A-5.019, F.A.C.
[10] Rule 58A-5.019, F.A.C.
[11] S. 408.813, F.S.
[12] S. 429.19, F.S.
[13] S. 408.803(10), F.S.
[14] S. 408.814, F.S.
[15] S. 429.14 (4), F.S.

- Failure of the license applicant, the licensee during relicensure, or a licensee that holds a provisional license to meet the minimum license requirements of this part, or related rules, at the time of license application or renewal;
- An intentional or negligent life-threatening act in violation of the uniform firesafety standards for assisted living facilities or other firesafety standards that threatens the health, safety, or welfare of a resident of a facility, as communicated to the agency by the local authority having jurisdiction or the State Fire Marshal;
- Knowingly operating any unlicensed facility or providing without a license any service that must be licensed under this chapter or ch. 400;
- Any act constituting a ground upon which application for a license may be denied.[16]

AHCA may also deny or revoke a facility license if the administrator of an owner-operator facility makes fraudulent statements regarding the correction of a violation.[17]

In cases where AHCA revokes a facility's license because of a threat to health, safety, or welfare of a resident, the Division of Administrative Hearings of the Department of Management Services must review the revocation within 120 days after receipt of the facility's request for a hearing.[18]

Inspections

All facilities must be inspected by AHCA biennially, for license renewal.[19] AHCA must also conduct a biennial survey to ensure compliance with facility standards and resident rights.[20] An abbreviated version of this survey may be conducted if the applicant does not have any of the following:
- Class I or class II violations or uncorrected class III violations;
- Confirmed long-term care ombudsman council complaints; or
- Confirmed licensing complaints within the two licensing periods immediately preceding the current renewal date.[21]

AHCA must conduct at least one monitoring visit of each facility that had a Class I or II violation of or three uncorrected class III violations in the previous year during years that the survey is not done.[22]

Specialty Facilities

A number of optional specialty licenses are available in addition to the general ALF license. These licenses include a Limited Mental Health License (LMH), Extended Congregate Care License (ECC), and Limited Nursing Services License (LNS).

Limited Mental Health License

A mental health resident is "an individual who receives social security disability income due to a mental disorder as determined by the Social Security Administration or receives supplemental security income due to a mental disorder as determined by the Social Security Administration and receives optional state supplementation."[23] A LMH license is required for any facility serving 3 or more mental health residents.[24] To obtain this license, the facility may not have any current uncorrected deficiencies or violations and facility administrator, as well as staff providing direct care to residents must complete 6

[16] S. 429.14 (1), F.S.
[17] S. 429.19, F.S.
[18] S. 429.14 (5), F.S.
[19] S. 408.811, F.S.
[20] S. 429.28, F.S.
[21] Rule 58A-5.033, F.A.C.
[22] S. 429.28, F.S
[23] S. 429.02, F.S
[24] S. 429.075, F.S.

hours of training related to LMH duties, which is either provided by or approved by DCF.[25] A LMH license can be obtained during initial licensure, during relicensure, or upon request of the licensee.[26]

Facilities with LMH licenses have a number of responsibilities not required by other types of ALFs. Each mental health resident in an ALF with a LMH license is assigned a case manager, "who is responsible for coordinating the development of and implementation of the community living support plan."[27] A community living support plan" includes information about the supports, services, and special needs of the resident which enable the resident to live in the assisted living facility and a method by which facility staff can recognize and respond to the signs and symptoms particular to that resident which indicate the need for professional services," and is written by the mental health resident, the case manager, and the ALF administrator.[28] A cooperative agreement is also only required in facilities with a LMH license. This is a written agreement between a mental health care provider and an ALF administrator to "specify directions for accessing emergency and after-hours care for the mental health resident."[29] The community living support plan and the cooperative agreement are required for all mental health residents in a facility with a LMH license and may be combined in one document.[30]

Extended Congregate Care License

The ECC specialty license allows an ALF to provide, directly or through contract, services performed by licensed nurses and supportive services to individuals who would otherwise be disqualified from continued residency in an ALF.[31] In order for ECC services to be provided, AHCA must first determine that all requirements in law and rule are met. ECC licensure is regulated pursuant to s. 429.07, F.S., and Rule 58A-5, F.A.C.

The primary purpose of ECC services is to allow residents, as their acuity level rises, to remain in a familiar setting. An ALF licensed to provide ECC services may also admit an individual who exceeds the admission criteria for a facility with a standard license, if the individual is determined appropriate for admission to the ECC facility. A licensed facility must adopt its own requirements within guidelines for continued residency set forth by rule. However, the facility may not serve residents who require 24-hour supervision.

Limited Nursing Services License

Limited nursing services are services beyond those provided by standard licensed ALFs.

Facilities licensed to provide limited nursing services must employ or contract with a nurse to provide necessary services to facility residents.[32] Licensed LNS facilities must maintain written progress reports on each resident receiving LNS. A registered nurse representing AHCA must visit these facilities at least twice a year to monitor residents and determine compliance.[33] A nursing assessment must be conducted at least monthly on each resident receiving limited nursing services.[34]

<u>Training and Examination</u>

Administrators and managers must complete a core training program and pass a competency test with a score of 75.[35] The competency tests must be developed by DOEA, in conjunction with AHCA and providers. Administrators who attended training prior to July 1, 1997, and managers who attended

---

[25] S. 429.075, F.S.
[26] S. 429.075, F.S.
[27] S. 394.4574, F.S.
[28] S. 429.02(7), F.S.
[29] S. 429.02 (8), F.S.
[30] S. 429.07(3)(a), F.S
[31] S. 429.07(3)(b), F.S.
[32] Rule 58A-5.031(2), F.A.C.
[33] S. 429.07(2)(c), F.S.
[34] S. 429.07(2)(c), F.S.
[35] Rule 58A-5.0191, F.A.C.

training prior to April 20, 1998, are not required to take the competency exam.[36] However, all administrators and managers must complete 12 hours of continuing education training for ALFs every 2 years.[37]

The core training must be 26 hours long and this must be completed within 3 months of employment.[38] The training for administrators and managers must be conducted by trainers registered with DOEA, who have the required experience and credentials.[39] The core training program must cover the following topics:

- State ALF laws and rules;
- Resident rights and identifying and reporting abuse, neglect, and exploitations;
- Special needs of elderly persons, persons with mental illness, and persons with developmental disabilities;
- Nutrition and food service;
- Medication management;
- Firesafety requirements; and
- Care of people with Alzheimer's disease and related disorders.[40]

Staff must receive in-service training, covering topics in the following areas, unless exempt:

- 1 hour of infection control training;
- 1 hour of incident reporting/emergency operations of the facility;
- 1 hour of resident rights/abuse reporting;
- 3 hours of resident behavior and needs/assistance of activities of daily living; and
- Elopement response policies and procedures.[41]

Those who have completed the core training and certified nursing assistants, nurses, and home health aides are exempt from portions of these training requirements. Administrators and staff must complete the following a course on HIV/AIDS and a CPR course, unless exempt. Additional training requirements apply to staff that prepare or serve food, assist with medication, those responsible for food organizing service, and employees in facilities with specialty licenses.[42]

To qualify as a trainer, a person must meet the following requirements:

- Complete the core training requirements;
- Successfully pass the competency test;
- Comply with the continuing education requirements of 12 hours every 2 years;
- Qualify in experience in one of the following ways:
    - Hold 4-year degree and have experience working in a management position in an ALF for 3 years after being core certified;
    - Worked in a management position in an ALF for 5 years after being core certified and 1 year teach experience as an educator or staff trainer for those who work in ALFs or long-term care settings; or
    - Previously employed as a core trainer for DOEA.[43]

<u>Long-Term Care Ombudsman Program</u>

The Long-Term Care Ombudsman program within DOEA, must "identify, investigate, and resolve complaints made by or on behalf of residents of long-term care facilities relating to actions or omissions by providers or representatives of providers of long-term care services, other public or private agencies,

[36] Rule 58A-5.0191, F.A.C.
[37] S. 429.52, F.S.
[38] Rule 58A-5.0191, F.A.C.
[39] S. 429.52, F.S.
[40] S. 429.52, F.S.
[41] Rule 58A-5.0191, F.A.C.
[42] Rule 58A-5.0191, F.A.C.
[43] S. 429.52, F.S.

guardians, or representative payees that may adversely affect."[44] The program consists of a state and local council, both of which serve under the ombudsman,[45] an individual appointed by Secretary of DOEA to head the ombudsman program.[46] The complaints, as well as the identities of the complainants made to the Ombudsman councils are confidential, with few exceptions.[47] Upon admission to an ALF, residents must be provided a brochure with contact information of the local ombudsman council,[48] to enable the residents to report mistreatments within the ALF.

Between 1/1/05 and 6/30/11 there have been 22,268 complaints made to through the ombudsman program. 988, approximately 38% of these complaints were regarding abuse, gross neglect, and exploitation.[49] Of the total 22,268 complaints, 7,443, approximately 33% were in reference to facilities holding LMH licenses.[50]

Assisted Living Workgroup

In 2011 the Miami Herald released a four-part newspaper series, addressing instances of improper treatment inside ALFs.[51] In July 2011, AHCA created the Assisted Living Workgroup (ALW), in response for the Governor's request "to examine the regulation and oversight of assisted living facilities in Florida."[52] The ALW consisted of three meetings throughout the state[53] and included 14 members including two members of legislature and 12 members involved in the ALF industry.[54] Staff of state agencies also attended the meeting, as nonvoting members of the ALW.[55]

At the conclusion of the final meeting, the ALW made a number of recommendations to the Legislature. The recommendations focus on changes in areas including administrator qualifications, training and staffing standards, surveys and inspections, licensure, resident discharge, information and reporting, enforcement of regulations, resident advocacy, mental health ALFs, multiple regulators of ALFs, and home and community based care.[56]

Hospital Safety

Hospitals are licensed pursuant to part I of chapter 395, F.S. The Agency for Health Care Administration (AHCA) has the authority to develop rules to implement the provisions of the chapter.[57] The rules must include fair and minimum standards to ensure that hospitals are maintaining adequate staffing levels,[58] have a comprehensive emergency management plan which is update annually,[59] and are operated in a manner consistent with applicable statutes and rules.[60]

In addition, the agency is required to establish rules for infection control and sanitary conditions that will protect patient care and safety.[61] Rules for infection control require the establishment of an Infection

---

[44] S. 400.0065, F.S.
[45] S. 400.0065, F.S.
[46] S. 400.0060, F.S.
[47] S. 400.0077, F.S.
[48] Rule 58A-5.0181, F.A.C.
[49] Ombudsman Complaints, *available at:* http://ahca.myflorida.com/SCHS/ALWG2011/alwg2011.shtml.
[50] Ombudsman Complaints, *available at:* http://ahca.myflorida.com/SCHS/ALWG2011/alwg2011.shtml.
[51] *Neglected to Death* Series, The Miami Herald, *available at:* http://www.miamiherald.com/neglected_to_death/.
[52] Assisted Living Workgroup, Final Report and Recommendations, *available at:* http://ahca.myflorida.com/SCHS/ALWG2011/alwg2011.shtml.
[53] Assisted Living Workgroup, Final Report and Recommendations, *available at:* http://ahca.myflorida.com/SCHS/ALWG2011/alwg2011.shtml.
[54] Assisted Living Workgroup Members, *available at* http://ahca.myflorida.com/SCHS/ALWG2011/wgmembers.shtml.
[55] Assited Living Workgroup Organizational Structure, *available at:* http://ahca.myflorida.com/SCHS/ALWG2011/alwg2011.shtml.
[56] Assisted Living Workgroup, Final Report and Recommendations, *available at:* http://ahca.myflorida.com/SCHS/ALWG2011/alwg2011.shtml.
[57] S. 395.1055(1), F.S.
[58] S. 395.1055(1)(a), F.S.
[59] S. 395.1055(1)(c), F.S.
[60] S. 395.1055(1)(d), F.S.
[61] S. 395.1055(1)(b), F.S.

Control Program designed to protect patients and staff from communicable diseases and other infections found in an ambulatory surgical center environment.[62] Similar rules have been established for hospitals.[63]

Pay for Performance Programs

The Centers for Medicare and Medicaid Services defines "pay-for-performance" as "the use of payment methods and other incentives to encourage quality improvement and patient-focused high-value care".[64] Pay-for-performance programs are designed to offer financial incentives to physicians and other health care providers to meet defined quality, efficiency, or other targets.[65]

Beginning in 1991 with Wisconsin, states have been utilizing pay-for-performance in Medicaid as a way to incentivize the health plans with which they contract to improve their performance. More recently, models are emerging by which states are focusing the incentives directly on providers, both physician practices and hospitals. Some states are considering innovative models that would provide incentives for nursing homes and other institutional settings.[66] A review of states that have implemented pay-for-performance in Medicaid managed care found that the top five goals were to reward high-quality care, reduce variation in patterns of care, improve performance on specific measures, support broader quality strategies, including value-based purchasing, and improve access to care and support for the safety net.[67]

As costs escalate rapidly, large purchasers of health care services—employers, health plans, and government programs—are embracing pay-for-performance in an effort to link health care spending to quality and use limited financial resources more effectively.[68] The Medicaid program is a partnership between the federal government and the states, with each state having significant independence in program design and operation. As such, many states have taken the initiative to start pay-for-performance programs unique to their situations. Moreover, CMS has been promoting quality and value-based purchasing through its Medicaid/State Children's Health Insurance Program Quality Initiative.[69]

Florida Center for Health Information and Policy Analysis

The Florida Center for Health Information and Policy Analysis (Center) is responsible for collecting, compiling, coordinating, analyzing, and disseminating health related data and statistics for the purpose of developing public policy and promoting the transparency of consumer health care information through www.FloridaHealthFinder.gov.[70] These data provide accurate and timely health care information to consumers, policy analysts, administrators, and researchers in order to evaluate cost, quality, and access to care. The Florida Center is also responsible for collecting adverse incident reports from hospitals, ambulatory surgery centers, health maintenance organizations, nursing homes, and assisted living facilities.

---

[62] Rule 59A-5.011, F.A.C.
[63] Rule 59A-3.250, F.A.C.
[64] Center for Medicaid and State Operations, Centers for Medicaid and Medicare Services, *State Health Official Letter #06-003*, April 6, 2006.
[65] Agency for Healthcare Research and Quality, Rockville, MD, *Pay for Performance (P4P): AHRQ Resources*, March 2006; available at http://www.ahrq.gov/qual/pay4per.htm. (last viewed on February 22, 2012).
[66] The Commonwealth Fund, *States in Action- Medicaid Pay-for-Performance: Ongoing Challenges, New Opportunities*, Jan./Feb. 2007; available at http://www.commonwealthfund.org/Newsletters/States-in-Action/2007/Jan/January-February-2007/Profile--In-Depth-Look-at-an-Initiative-that-Is-Making-a-Difference/Medicaid-Pay-for-Performance--Ongoing-Challenges--New-Opportunities.aspx (last viewed on February 22, 2012).
[67] L. Duchon and V. Smith, *Quality Performance Measurement in Medicaid and SCHIP: Results of a 2006 National Survey of State Officials*, Health Management Associates for National Association of Children's Hospitals, September 2006.
[68] Kuhmerker, Kathyrn, and Hartman, Thomas, The Commonwealth Fund, IPRO, *Pay-for-Performance in State Medicaid Programs-A Survey of State Medicaid Directors and Programs*, page 1, April 2007.
[69] *Id.* at page 2; *see also* http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/.
[70] *See* Agency for Health Care Administration, Florida Center for Health Information and Policy Analysis, available at http://ahca.myflorida.com/SCHS/index.shtml (last viewed on February 22, 2012).

The Office of Data Collection & Quality Assurance DCQA within the Center currently collects patient discharge data from all licensed acute care hospitals, including psychiatric and comprehensive rehabilitation hospitals, ambulatory surgical centers and emergency departments. The data is the primary source of information for the evaluation of health care utilization and the assessment of community health for the improvement of public health planning initiatives.

Effect of Proposed Changes:

ALF Administrators

The bill creates a license for ALF administrators and requires that as of July 1, 2013, all ALF administrators be licensed. The ALF administrator licensure program will be implemented by AHCA.

To qualify for licensure as an ALF administrator an individual must:

- Be 21 years old,
- Complete 30 hours of core training and 10 hours of supplemental training,
- Pass a competency test with a score of 80, and
- Complete the required background screening.

Currently, ALF administrators are not licensed, but are required, through the ALF license, to be 21 years old[71], pass a competency test with a score of 75,[72] complete 26 hours of core training,[73] and complete the required background screening.[74] ALF administrators are also currently required to complete 12 hours of continuing education biennially;[75] the bill would increase this continuing education requirement to 18 hours every 2 years.

The bill sets a licensure fee of $150 for the initial ALF administrator license and for the renewal of that license. Administrator licenses must be renewed biennially.

An individual may be licensed as an ALF administrator without completing the training or taking the competency test if the individual:

- Has been employed as an administrator for 2 of the 5 years immediately preceding July 1, 2013, is in compliance with the continuing education requirements, and was not an administrator for a facility that was cited for a Class I or Class II violation within the past two years; <u>or</u>
- Is licensed in accordance with part II of Chapter 468 (nursing home administration) and is in compliance with the continuing education requirements of that chapter.

The bill requires AHCA to revoke or deny an administrator license if the applicant or licensee:

- Was the administrator of, or had a controlling interest in, an ALF or nursing home when that facility was cited for violations resulting in denial or revocation of a license;
- Has a final agency action for unlicensed activity pursuant to Chapter 429 or Part II of Chapter 408 or authorizing statutes; or
- Was the administrator of, or had a controlling interest in, an ALF or nursing home when that facility was cited for violations within the previous three years that resulted in the death of a resident.

An applicant or a licensee may challenge a denial, revocation, or any other action against the license by AHCA under the provisions of Chapter 120, F.S.[76]

[71] Rule 58A-5.0191(1)(a), F.A.C.
[72] Rule 58A-5.0191(1)(b), F.A.C.
[73] Rule 58A-5.0191(1)(a), F.A.C.
[74] S. 429.174, F.S.
[75] S. 429.52, F.S.
[76] S. 408.817, F.S.

The bill allows AHCA to issue ALF administrator licenses for a period less than 2 years in order to stagger license expiration dates. AHCA must charge a prorated licensure fee for any shortened period. The authority expires on December 31, 2013.

The bill gives AHCA rulemaking authority regarding administrator licenses.

Training and Competency Test

Training

The bill requires administrators to complete a core training course, to complete a supplemental course, and to pass a test on the content of those courses prior to licensure. The core training and competency test are currently required, but currently administrators have 3 months after employment as the administrator to complete these requirements.[77] The bill also modifies the required continuing education training.

The bill requires DOEA, in consultation with AHCA, DCF, and stakeholders, to approve a standardized 40 hour core training curriculum. This training must be offered in English and Spanish and must be updated timely to reflect changes in law, rules, and best practices. The core training must be completed by administrators to qualify for licensure. The core training curriculum must include the same topics as currently required, as well as:

- Elopement prevention;
- Aggression and behavior management, de-escalation techniques, and proper protocols and procedures of the Baker Act;
- Do not resuscitate orders;
- Infection control;
- Admission, continuing residency and industry best practices; and
- Phases of care.

The bill requires administrators to complete a supplemental 10 hour course prior to licensure. The course must be developed by DOEA, in consultation with DCF and stakeholders, and must include the following topics:

- Extended congregate care;
- Limited mental health; and
- Business operations, including human resources, financial management, and supervision of staff.

The requirements for training for staff, other than the administrator, are currently set by rule by DOEA.[78] The bill maintains the current training requirements for staff, including that staff training may be in-service, and codifies the requirements in statute. The bill requires that staff training cover, at a minimum, the following topics:

- Reporting major incidents and reporting adverse incidents;
- Resident rights and identifying and reporting abuse, neglect, and exploitation;
- Emergency procedures, including firesafety and resident elopement response policies and procedure; and
- General information on interacting with individuals with Alzheimer's disease and related disorders.

The bill requires DOEA, in consultation with AHCA and stakeholders to approve curricula for continuing education requirements. The curricula must include topics similar to that of the core training. This must be offered through online courses and any fees associated with the continuing education must be paid by the licensee or the facility. The education must cover:

- Elopement prevention;

[77] Rule 58A-5.0191(1)(b), F.A.C.
[78] Rule 58A-5.0191, F.A.C.

- De-escalation techniques; and
- Phases of care and interacting with residents.

The bill requires that as of January 1, 2013, all staff and administrator training must be conducted by any:
- Florida College System institution;
- Non-public post-secondary institution licensed or exempt from licensure pursuant to Chapter 1005; or
- Statewide association which contracts with DOEA to provide training. "Statewide association" means any statewide entity which represents and provides technical assistance to ALFs. DOEA may specify in contract minimum trainer qualifications.

The bill requires ALF trainers to keep a record of individuals who complete training and submit the record AHCA within 30 days of completing the course.

The bill maintains DOEA's rulemaking authority regarding training.

Competency Test

Administrators are currently required to pass a competency examination.[79] The bill maintains this requirement, but alters DOEA's involvement in this test. Currently, DOEA establishes a competency test and a minimum score required to pass the core competency training.[80] The bill removes DOEA's authority to determine a passing score and requires a score of 80 to pass the competency test. DOEA currently requires a score of 75 to pass the competency test.[81] The bill also requires DOEA to approve, rather than to develop the test. The test must be reviewed and updated annually to reflect any changes in the laws, rules, and best practices. It must be offered in English and Spanish and may be offered through testing centers.

Inspections

The bill requires additional inspections for facilities which have been cited for a Class I violation or two or more Class II violations from separate surveys within a 60 day period. The bill requires those facilities to have two additional inspections conducted every six months for a year and requires AHCA to assess a fee of $69 per bed for each of the additional inspections. These additional fees may not exceed $12,000.

AHCA is required to verify that any violation is corrected which was identified during an inspection. This verification must take place through subsequent inspections. The bill provides that a Class III or Class IV violation unrelated to residents right or resident care can be verified through written documentation submitted by the facility rather than by reinspection.

The bill allows facilities accredited by the Joint Commission, the Council on Accreditation, or the Commission on Accreditation of Rehabilitation Facilities to be inspected less frequently than the required biennial inspection. The bill requires these facilities to be inspected at least once every five years.

Sanctions

The bill changes fines for facilities with a history of violations and facilities with violations resulting in serious consequences. The bill requires AHCA to impose a $10,000 fine for any violation resulting in the death of a resident. The bill requires AHCA to double the fine for a subsequent violation if the facility is cited for a violation in the same class as a prior violation cited in the past 24 months.

---

[79] S. 429.52(2), F.S.
[80] S. 429.52(2), F.S.
[81] Rule 58A-5.0191, F.A.C.

Mental Health Residents

Currently, DCF has a number of responsibilities for mental health residents who live in LMH facilities. "Mental health residents" are defined to include only those individuals who receive social security disability income due to a mental disorder as determined by the Social Security Administration or receives supplemental security income due to a mental disorder as determined by the Social Security Administration and receives optional state supplementation.[82] DCF's responsibilities include ensuring that such a mental health resident has been evaluated and determined appropriate to live in an ALF, ensuring that an ALF is provided documentation that the resident meets the definition of a mental health resident, ensuring that a mental health resident is assigned a case manager, and ensuring that mental health residents have the required plans and agreements with the ALFs in which they reside.[83] The bill makes these responsibilities applicable to mental health residents who live in any ALF, rather than just residents who live in an ALFs with a LMH license.

The bill requires DCF to include a provision in contracts with community mental health service providers to assign a case manager for a mental health resident, prepare a community living support plan, and enter into a cooperative agreement with the ALF. The bill also requires case managers to update the community living support plan as needed, to ensure that the ongoing needs of the residents are addressed.

The bill requires DCF to impose contract penalties on providers who fail to comply with requirements for mental health residents and requires AHCA to establish contract penalties to Medicaid prepaid plans which fail to comply with requirements for mental health residents. The bill requires DCF and AHCA to enter into an interagency agreement to establish responsibilities and procedures to enforce the abovementioned changes.

The bill prohibits a facility from obtaining a LMH license under certain scenarios. The bill denies facilities a LMH license if they have been subject to administrative sanctions during the last 2 years, or since initial licensure if they have not been licensed for 2 years, because of:

- One or more class I violation imposed by final agency action;
- Three or more class II violations imposed by final agency action;
- Ten or more uncorrected class II violations, in accordance with s. 408.811 (4);
- Denial, suspension, or revocation of a license for another facility in which the license applicant had at least 25% ownership; or
- Imposition of a moratorium or injunctive proceedings pursuant to ALF or nursing home laws and regulations.

The bill requires DCF to contract training of staff and administrators of an ALF with a LMH license. Currently DCF may either perform this in house or contract the training.[84] The bill also allows the training provider to charge a reasonable fee for training.

Abuse

Mandatory reporting requires that those listed report abuse, neglect, or exploitation of vulnerable adults to the central abuse hotline. The bill creates a mandatory reporting requirement for employees or agents of state or local agencies with regulatory responsibilities over, or who provides services to persons residing in ALFs.

Ombudsman Program

All residents and their representatives are required to receive information regarding the State Long-Term Care Ombudsman Program. The bill changes the required contents to include information on

---

[82] S. 394.4574, F.S. and s. 429.02(15), F.S.
[83] S. 394.4574, F.S.
[84] S. 429.075, F.S.

confidentiality of the complainant and the confidentiality of the complaint in cases where the complaint will result in the identification of the resident about whom the complaint is made.

Interagency Communication

The bill requires that AHCA, DOEA, DCF, and Agency for Persons with Disabilities develop or modify electronic systems of communication among state-supported automated systems, if funds are available. The goal is to ensure that relevant information pertaining to the regulation of ALFs and facility staff is timely and effective communicated among agencies to protect residents.

Advisory Council

The bill requires DOEA to establish an advisory council to review facts and circumstances of unexpected deaths and elopements which harmed residents in ALFs, to gain understanding of causes and contributing factors these issues and to identify gaps, deficiencies, or problems regarding delivery of services. The council must recommend industry best practices, training and education requirements, and changes in the law, rules, or policies in order to prevent unexpected deaths and elopements. The council must also prepare a statistical report annually, regarding the incidence and causes of unexpected deaths and elopements resulting in harm within ALFs during the previous year. This must be submitted by December 31 of each year to the Governor, Senate President, and Speaker of the House of Representatives.

The advisory council must contain the following members:
- The Secretary of DOEA, or a designee, who will serve as the chair;
- The Secretary of AHCA, or a designee;
- The Secretary of DCF, or a designee;
- The State Long-Term Care Ombudsman, or a designee;
- An owner of administrator of an ALF with less than 17 bed, selected by the Governor;
- An owner of administrator of an ALF with more than 17 bed, selected by the Governor;
- An owner of administrator of an ALF with a LMH license, selected by the Governor; and
- A representative from each of three statewide associations that represents ALFs, selected by the Governor.
- A resident of an ALF, selected by the Governor.

The chair may appoint ad hoc committees as needed to carry out council duties. The members appointed by the Governor must be appointed to staggered terms of office, not exceeding 2 years. These members are also not eligible for reappointment. The council must meet at the call of the chair, at least twice per year. Members of the council are unpaid, but are entitled for reimbursement per diem and travel expenses incurred, to the extent that funds are available.

Quality Adjustments to Medicaid Rates

The PCB requires the AHCA, through the Florida Center for Health Information and Policy Analysis, to collect, analyze, and distribute health information and statistics for the purpose of evaluating the performance of programs and providers. Information and statistics are also to be made available to aid independent and collaborative quality improvement activities in the delivery of and payment for health services. The PCB requires the AHCA to release information and statistics to quality improvement collaboratives for evaluation of the incidence of potentially preventable events, defined in the bill, which is deemed necessary for administration of the Medicaid program. All state and federal privacy regulations with regard to information dispensed for the purpose of Medicaid program administration remain in effect.

The PCB creates a program that provides for positive adjustments in Medicaid payment rates for hospitals, nursing homes, and managed care plans that show measurable improvement in the quality of health care services provided to patients ("payment for performance" plan). Adjustments will be based on specific outcome measures and documented efforts to improve the delivery of health care services.

The program will include appropriate risk adjustments, will exclude measurable outcomes that cannot be deemed to have been preventable, and waive adjustments for providers with too few cases to establish reliable rates. The program will be implemented in state fiscal year 2015-16.

The program will use outcome measures to allocate positive payment adjustments; the measures will vary depending on the provider. The program will examine potentially preventable events in hospitals, such as potentially preventable admissions and potentially preventable complications. For skilled nursing facilities, the program will examine the rate of residents experiencing falls with major injuries, the rate of potentially preventable hospital admissions, and the percent of residents with new or worsened pressure ulcers. For managed care plans, the program will examine potentially preventable initial hospital admissions, potentially preventable emergency department visits, and potentially preventable ancillary services. The bill permits the agency, after the third period of performance payments using these criteria, to establish alternate benchmarks upon which future performance payments will be based.

The program will establish expected rates of potentially preventable events, defined within the section, for each facility or provider. The program will calculate the actual rate of potentially preventable events, which are defined within the section, for each facility by measuring those events that occurred during FY 2011-2012 or the most recent 12-month period. The program is directed to use Medicaid claims data, Medicaid encounter data, and hospital discharge data, as well as methods for measuring outcome measures used by other payers, to measure and establish these rates. A technical advisory panel for each category of provider will be established to assist the agency in development and implementing the program.

The program will establish expected rates of potentially preventable events for each subsequent fiscal year after the base year for each provider. The observed rate, which is the actual measured rate of potentially preventable events, will be compared with the expected rate. The difference in the two rates will result in a performance rate. Hospitals, skilled nursing facilities, and managed care plans will be ranked based on the improvement rate. Positive rate adjustments will be awarded to the highest ranking facilities and providers. Positive rate adjustments will also be awarded to a certain number of facilities and providers, not ranked in the top tier, which evidence the best year-to-year rate of improvement.

Performance-based payment adjustment may be made up to 1 percent of payment rates for hospital inpatient and outpatient services, nursing home care, and capitation rates for prepaid health plans. In addition, adjustments for documented activities to improve performance may be made up to .25 percent of applicable payment rates.

For at least the first three rate setting periods after the program is implemented, hospitals in the top ten percentiles will receive a payment adjustment up to 1 percent. The ten hospitals with the best year-to-year improvement, which are not ranked in the top ten percentiles, will receive a payment adjustment up to .25 percent. Skilled nursing facilities ranked in the top three percentiles will be eligible for the higher payment adjustment, and the ten facilities with the best year-to-year improvement, which are not ranked in the top three percentiles, will receive the smaller adjustment. The top ten managed care plans, also ranked by performance rate, will receive a positive payment adjustment up to 1 percent.

The bill provides examples of quality improvement activities which hospitals and skilled nursing facilities may engage in that may lead to positive payment adjustments. For hospitals, activities include complying with requirements to reduce hospital acquired infections and engaging in a quality improvement collaborative which focuses on reducing potentially preventable admissions or readmissions, or hospital acquired infections. For skilled nursing facilities, activities include engaging in a comprehensive fall prevention program and engaging in a quality improvement collaborative focusing on reducing potentially preventable hospital admissions, potentially preventable emergency department visits, and the percent of residents with new or worsened pressure ulcers.

The PCB defines several terms used in the payment for performance plan:

- Expected rate;
- Hospital acquired infections;
- Observed rate;
- Potentially preventable admission;
- Potentially preventable ancillary service;
- Potentially preventable complication;
- Potentially preventable emergency department visit;
- Potentially preventable event;
- Potentially preventable readmission; and
- Quality improvement collaborative.

The PCB amends Chapter 395, regulating hospitals, to add to current requirements for reasonable and fair minimum standards for infection control and sanitation activities to protect patient care and safety. The PCB requires AHCA to adopt rules that require hospital staff responsible for cleaning and disinfecting patient rooms use masks and gloves while cleaning, and to follow label directions with regard to the requisite time period that a disinfectant must remain on a surface to allow for proper disinfection. The facility must document compliance with the procedures established in the bill. Failure to comply with the procedures subjects the facility to possible administrative fines, assessed for each day the procedures are violated.

B. SECTION DIRECTORY:

Section 1: Amends s. 394.4574, relating to Department responsibilities for mental health residents in an assisted living facility.
Section 2: Amends s. 395.1055, relating to rules and enforcement.
Section 3: Amends s. 400.0078, relating to citizen access to State Long-Term Care Ombudsman Program services.
Section 4: Amends s. 408.05, relating to Florida Center for Health Information and Policy Analysis.
Section 5: Amends s. 408.802, relating to applicability.
Section 6: Amends s. 408.820, relating to exemptions.
Section 7: Amends s. 415.1034, relating to mandatory reporting of abuse, neglect, or exploitation of vulnerable adults.
Section 8: Amends s. 409.986, relating to quality adjustments to Medicaid Rates.
Section 9: Amends s. 429.07, relating to license required.
Section 10: Amends s. 429.075, relating to limited mental health license.
Section 11: Amends s. 429.0751, relating to mental health residents.
Section 12: Amends s. 429.19, relating to violations.
Section 13: Creates s. 429.231, relating to advisory council.
Section 14: Amends s. 429.34, relating to right of entry and inspections.
Section 15: Creates s. 429.50, relating to assisted living facility administrator.
Section 16: Creates an unnumbered section of law relating to staggering administrator license expiration dates.
Section 17: Amends s. 429.52, relating to staff, administrator, and administrator license applicant training and education programs.
Section 18: Amends s. 429.54, relating to interagency communication.
Section 19: Provides an effective date of July 1, 2012.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   See Fiscal Comments.

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Applicants will have to pay a $150 fee to obtain and renew an ALF administrator license. Additionally, applicants will have to pay for training and testing fees.

D. FISCAL COMMENTS:

The Agency for Health Care Administration will receive additional revenues from the $250 licensure fee for the assisted living facility administrator license. AHCA will also receive additional revenue from the increased fines for specified violations by ALFs. AHCA also will receive increased revenue from the reinspection fees.

AHCA will have an increased workload related to administering the ALF administrator license and the increased inspections of ALFs.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The Agency for Health Care Administration is given rulemaking authority to administer the ALF administrator license. The Department of Elder Affairs is given increased rulemaking authority to administer the ALF administrator testing and training program.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES