A bill to be entitled

An act relating to quality improvement initiatives for entities regulated by the Agency for Health Care Administration; amending s. 394.4574, F.S.; providing responsibilities of the Department of Children and Family Services and mental health service providers for mental health residents who reside in assisted living facilities; directing the agency to impose contract penalties on Medicaid prepaid health plans under specified circumstances; directing the department to impose contract penalties on mental health service providers under specified circumstances; directing the department and the agency to enter into an interagency agreement for the enforcement of their respective responsibilities and procedures related thereto; amending s. 395.002, F.S.; revising the definition of the term "accrediting organizations"; amending s. 395.1051, F.S.; requiring a hospital to provide notice to all obstetrical physicians with privileges at that hospital within a specified period of time before the hospital closes an obstetrics department or ceases to provide obstetrical services; amending s. 395.1055, F.S.; revising provisions relating to agency rules regarding standards for infection control, housekeeping, and sanitary conditions in a hospital; requiring housekeeping and sanitation staff to employ and document compliance with specified cleaning and

disinfecting procedures; authorizing imposition of administrative fines for noncompliance; amending s. 400.0078, F.S.; requiring specified information regarding the confidentiality of complaints to the State Long-Term Care Ombudsman Program to be provided to residents of a long-term care facility upon admission to the facility; amending s. 408.05, F.S.; directing the agency to collect, compile, analyze, and distribute specified health care information for specified uses; providing for the agency to release data necessary for the administration of the Medicaid program to quality improvement collaboratives for specified purposes; amending s. 408.802, F.S.; providing that the provisions of part II of ch. 408, F.S., the Health Care Licensing Procedures Act, apply to assisted living facility administrators; amending s. 408.820, F.S.; exempting assisted living facility administrators from specified provisions of part II of ch. 408, F.S., the Health Care Licensing Procedures Act; amending s. 409.212, F.S.; increasing a limitation on additional supplementation a person who receives optional supplementation may receive; creating s. 409.986, F.S.; providing definitions; directing the agency to establish and implement methodologies to adjust Medicaid rates for hospitals, nursing homes, and managed care plans; providing criteria for and limits on the amount of Medicaid payment rate adjustments; directing the agency to seek

federal approval to implement a performance payment system; providing for implementation of the system in fiscal year 2015-2016; authorizing the agency to appoint a technical advisory panel; providing applicability of the performance payment system to general hospitals, skilled nursing facilities, and managed care plans and providing criteria therefor; amending s. 415.1034, F.S.; providing that specified persons who have regulatory responsibilities over or provide services to persons residing in certain facilities must report suspected incidents of abuse to the central abuse hotline; amending s. 429.02, F.S.; revising definitions applicable to the Assisted Living Facilities Act; amending s. 429.07, F.S.; requiring that an assisted living facility be under the management of a licensed assisted living facility administrator; providing for a reduced number of monitoring visits for an assisted living facility that is licensed to provide extended congregate care services under specified circumstances; providing for a reduced number of monitoring visits for an assisted living facility that is licensed to provide limited nursing services under specified circumstances; amending s. 429.075, F.S.; providing additional requirements for a limited mental health license; removing specified assisted living facility requirements; authorizing a training provider to charge a fee for the training required of facility

administrators and staff; revising provisions for application for a limited mental health license; creating s. 429.0751, F.S.; providing requirements for an assisted living facility that has mental health residents; requiring the assisted living facility to enter into a cooperative agreement with a mental health care service provider; providing for the development of a community living support plan; specifying who may have access to the plan; requiring documentation of mental health resident assessments; amending s. 429.178, F.S.; conforming cross-references; amending s. 429.19, F.S.; providing fines and penalties for specified violations by an assisted living facility; amending s. 429.195, F.S.; revising applicability of prohibitions on rebates provided by an assisted living facility for certain referrals; amending s. 817.505, F.S.; providing an exception from prohibitions relating to patient brokering; creating s. 429.231, F.S.; directing the Department of Elderly Affairs to create an advisory council to review the facts and circumstances of unexpected deaths in assisted living facilities and of elopements that result in harm to a resident; providing duties; providing for appointment and terms of members; providing for meetings; requiring a report; providing for per diem and travel expenses; amending s. 429.34, F.S.; providing a schedule for the inspection of assisted living facilities; providing exceptions;

providing for fees for additional inspections after specified violations; creating s. 429.50, F.S.; prohibiting a person from performing the duties of an assisted living facility administrator without a license; providing qualifications for licensure; providing requirements for the issuance of assisted living facility administrator certifications; providing agency responsibilities; providing exceptions; providing license and license renewal fees; providing grounds for revocation or denial of licensure; providing rulemaking authority; authorizing the agency to issue a temporary license to an assisted living facility administrator under certain conditions and for a specified period of time; amending s. 429.52, F.S.; providing training, competency testing, and continuing education requirements for assisted living facility administrators and license applicants; specifying entities that may provide training; providing a definition; requiring assisted living facility trainers to keep certain training records and submit those records to the agency; providing rulemaking authority; amending s. 429.54, F.S.; requiring the Agency for Health Care Administration, the Department of Elderly Affairs, the Department of Children and Family Services, and the Agency for Persons with Disabilities to develop or modify electronic information systems and other systems to ensure efficient communication regarding regulation of

assisted living facilities, subject to the availability of funds; providing an appropriation and authorizing positions; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 394.4574, Florida Statutes, is amended to read:

394.4574 Department responsibilities for a mental health resident who resides in an assisted living facility ~~that holds a limited mental health license~~.—

(1) The term "mental health resident," for purposes of this section, means 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.

(2) The department must ensure that:

(a) A mental health resident has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or psychiatric nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be provided to the administrator of the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection

related to appropriateness for placement as a mental health resident if it was completed within 90 days prior to admission to the facility.

(b) A cooperative agreement, as required in s. 429.0751 ~~429.075~~, is developed between the mental health care services provider that serves a mental health resident and ~~the administrator of~~ the assisted living facility ~~with a limited mental health license~~ in which the mental health resident is living. ~~Any entity that provides Medicaid prepaid health plan services shall ensure the appropriate coordination of health care services with an assisted living facility in cases where a Medicaid recipient is both a member of the entity's prepaid health plan and a resident of the assisted living facility. If the entity is at risk for Medicaid targeted case management and behavioral health services, the entity shall inform the assisted living facility of the procedures to follow should an emergent condition arise.~~

(c) The community living support plan, as defined in s. 429.02, has been prepared by a mental health resident and a mental health case manager of that resident in consultation with the administrator of the facility or the administrator's designee. The plan must be provided to the administrator of the assisted living facility ~~with a limited mental health license~~ in which the mental health resident lives. The support plan and the agreement may be in one document.

(d) The assisted living facility ~~with a limited mental health license~~ is provided with documentation that the individual meets the definition of a mental health resident.

(e) The mental health services provider assigns a case manager to each mental health resident who lives in an assisted living facility with a limited mental health license. The case manager is responsible for coordinating the development of and implementation of the community living support plan defined in s. 429.02. The plan must be updated as needed, but at least annually, to ensure that the ongoing needs of the residents are addressed.

The department shall adopt rules to implement the community living support plans and cooperative agreements established under this section.

(3) A Medicaid prepaid health plan shall ensure the appropriate coordination of health care services with an assisted living facility when a Medicaid recipient is both a member of the entity's prepaid health plan and a resident of the assisted living facility. If the Medicaid prepaid health plan is responsible for Medicaid-targeted case management and behavioral health services, the plan shall inform the assisted living facility of the procedures to follow when an emergent condition arises.

(4) The department shall include in contracts with mental health service providers provisions that require the service provider to assign a case manager for a mental health resident, prepare a community living support plan, enter into a cooperative agreement with the assisted living facility, and otherwise comply with the provisions of this section. The department shall establish and impose contract penalties for

mental health service providers under contract with the department that fail to comply with this section.

(5) The Agency for Health Care Administration shall include in contracts with Medicaid prepaid health plans provisions that require the mental health service provider to prepare a community living support plan, enter into a cooperative agreement with the assisted living facility, and otherwise comply with the provisions of this section. The agency shall also establish and impose contract penalties for Medicaid prepaid health plans that fail to comply with this section.

(6) The department shall enter into an interagency agreement with the Agency for Health Care Administration that delineates their respective responsibilities and procedures for enforcing the requirements of this section with respect to assisted living facilities and mental health service providers.

(7) ~~(3)~~ The Secretary of Children and Family Services, in consultation with the Agency for Health Care Administration, shall annually require each district administrator to develop, with community input, detailed plans that demonstrate how the district will ensure the provision of state-funded mental health and substance abuse treatment services to residents of assisted living facilities ~~that hold a limited mental health license~~. These plans must be consistent with the substance abuse and mental health district plan developed pursuant to s. 394.75 and must address case management services; access to consumer-operated drop-in centers; access to services during evenings, weekends, and holidays; supervision of the clinical needs of the residents; and access to emergency psychiatric care.

Section 2. Subsection (1) of section 395.002, Florida Statutes, is amended to read:

395.002 Definitions.—As used in this chapter:

(1) "Accrediting organizations" means national accreditation organizations that are approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state ~~the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, and the Accreditation Association for Ambulatory Health Care, Inc~~.

Section 3. Section 395.1051, Florida Statutes, is amended to read:

395.1051 Duty to notify ~~patients~~.—

(1) An appropriately trained person designated by each licensed facility shall inform each patient, or an individual identified pursuant to s. 765.401(1), in person about adverse incidents that result in serious harm to the patient. Notification of outcomes of care that result in harm to the patient under this section does ~~shall~~ not constitute an acknowledgment or admission of liability and may not~~, nor can it~~ be introduced as evidence.

(2) A hospital must provide notice to all obstetrical physicians with privileges at the hospital at least 120 days before the hospital closes an obstetrics department or ceases to provide obstetrical services.

Section 4. Paragraph (b) of subsection (1) of section 395.1055, Florida Statutes, is amended to read:

395.1055 Rules and enforcement.—

(1) The agency shall adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part, which shall include reasonable and fair minimum standards for ensuring that:

(b) Infection control, housekeeping, sanitary conditions, and medical record procedures that will adequately protect patient care and safety are established and implemented. These procedures shall require housekeeping and sanitation staff to wear masks and gloves when cleaning patient rooms, to disinfect environmental surfaces in patient rooms in accordance with the time instructions on the label of the disinfectant used by the hospital, and to document compliance with this paragraph. The agency may impose an administrative fine for each day that a violation of this paragraph occurs.

Section 5. Subsection (2) of section 400.0078, Florida Statutes, is amended to read:

400.0078 Citizen access to State Long-Term Care Ombudsman Program services.—

(2) ~~Every resident or representative of a resident shall receive,~~ Upon admission to a long-term care facility, each resident or representative of a resident must receive information regarding:

(a)1. The purpose of the State Long-Term Care Ombudsman Program;~~,~~

2. The statewide toll-free telephone number for receiving complaints;~~,~~

3. The residents rights under s. 429.28, including

information that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other of these rights; and

4. Other relevant information regarding how to contact the program.

(b) Residents or their representatives must be furnished additional copies of this information upon request.

Section 6. Subsection (3) of section 408.05, Florida Statutes, is amended to read:

408.05 Florida Center for Health Information and Policy Analysis.—

(3) COMPREHENSIVE HEALTH INFORMATION SYSTEM.—The agency shall collect, compile, analyze, and distribute ~~In order to produce comparable and uniform~~ health information and statistics. Such information shall be used for developing ~~the development of~~ policy recommendations, evaluating program and provider performance, and facilitating the independent and collaborative quality improvement activities of providers, payors, and others involved in the delivery of health services. The agency shall perform the following functions:

(a) Coordinate the activities of state agencies involved in the design and implementation of the comprehensive health information system.

(b) Undertake research, development, and evaluation respecting the comprehensive health information system.

(c) Review the statistical activities of state agencies to ensure that they are consistent with the comprehensive health information system.

(d) Develop written agreements with local, state, and federal agencies for the sharing of health-care-related data or using the facilities and services of such agencies. State agencies, local health councils, and other agencies under state contract shall assist the center in obtaining, compiling, and transferring health-care-related data maintained by state and local agencies. Written agreements must specify the types, methods, and periodicity of data exchanges and specify the types of data that will be transferred to the center.

(e) Establish by rule the types of data collected, compiled, processed, used, or shared. Decisions regarding center data sets should be made based on consultation with the State Consumer Health Information and Policy Advisory Council and other public and private users regarding the types of data which should be collected and their uses. The center shall establish standardized means for collecting health information and statistics under laws and rules administered by the agency.

(f) Establish minimum health-care-related data sets which are necessary on a continuing basis to fulfill the collection requirements of the center and which shall be used by state agencies in collecting and compiling health-care-related data. The agency shall periodically review ongoing health care data collections of the Department of Health and other state agencies to determine if the collections are being conducted in accordance with the established minimum sets of data.

(g) Establish advisory standards to ensure the quality of health statistical and epidemiological data collection, processing, and analysis by local, state, and private

organizations.

(h) Prescribe standards for the publication of health-care-related data reported pursuant to this section which ensure the reporting of accurate, valid, reliable, complete, and comparable data. Such standards should include advisory warnings to users of the data regarding the status and quality of any data reported by or available from the center.

(i) Prescribe standards for the maintenance and preservation of the center's data. This should include methods for archiving data, retrieval of archived data, and data editing and verification.

(j) Ensure that strict quality control measures are maintained for the dissemination of data through publications, studies, or user requests.

(k) Develop, in conjunction with the State Consumer Health Information and Policy Advisory Council, and implement a long-range plan for making available health care quality measures and financial data that will allow consumers to compare health care services. The health care quality measures and financial data the agency must make available shall include, but is not limited to, pharmaceuticals, physicians, health care facilities, and health plans and managed care entities. The agency shall update the plan and report on the status of its implementation annually. The agency shall also make the plan and status report available to the public on its Internet website. As part of the plan, the agency shall identify the process and timeframes for implementation, any barriers to implementation, and recommendations of changes in the law that may be enacted by the

Legislature to eliminate the barriers. As preliminary elements of the plan, the agency shall:

1. Make available patient-safety indicators, inpatient quality indicators, and performance outcome and patient charge data collected from health care facilities pursuant to s. 408.061(1)(a) and (2). The terms "patient-safety indicators" and "inpatient quality indicators" shall be as defined by the Centers for Medicare and Medicaid Services, the National Quality Forum, the Joint Commission ~~on Accreditation of Healthcare Organizations~~, the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, or a similar national entity that establishes standards to measure the performance of health care providers, or by other states. The agency shall determine which conditions, procedures, health care quality measures, and patient charge data to disclose based upon input from the council. When determining which conditions and procedures are to be disclosed, the council and the agency shall consider variation in costs, variation in outcomes, and magnitude of variations and other relevant information. When determining which health care quality measures to disclose, the agency:

a. Shall consider such factors as volume of cases; average patient charges; average length of stay; complication rates; mortality rates; and infection rates, among others, which shall be adjusted for case mix and severity, if applicable.

b. May consider such additional measures that are adopted by the Centers for Medicare and Medicaid Studies, National Quality Forum, the Joint Commission ~~on Accreditation of~~

~~Healthcare Organizations~~, the Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention, or a similar national entity that establishes standards to measure the performance of health care providers, or by other states.

When determining which patient charge data to disclose, the agency shall include such measures as the average of undiscounted charges on frequently performed procedures and preventive diagnostic procedures, the range of procedure charges from highest to lowest, average net revenue per adjusted patient day, average cost per adjusted patient day, and average cost per admission, among others.

2. Make available performance measures, benefit design, and premium cost data from health plans licensed pursuant to chapter 627 or chapter 641. The agency shall determine which health care quality measures and member and subscriber cost data to disclose, based upon input from the council. When determining which data to disclose, the agency shall consider information that may be required by either individual or group purchasers to assess the value of the product, which may include membership satisfaction, quality of care, current enrollment or membership, coverage areas, accreditation status, premium costs, plan costs, premium increases, range of benefits, copayments and deductibles, accuracy and speed of claims payment, credentials of physicians, number of providers, names of network providers, and hospitals in the network. Health plans shall make available to the agency any such data or information that is not currently reported to the agency or the office.

3. Determine the method and format for public disclosure of data reported pursuant to this paragraph. The agency shall make its determination based upon input from the State Consumer Health Information and Policy Advisory Council. At a minimum, the data shall be made available on the agency's Internet website in a manner that allows consumers to conduct an interactive search that allows them to view and compare the information for specific providers. The website must include such additional information as is determined necessary to ensure that the website enhances informed decisionmaking among consumers and health care purchasers, which shall include, at a minimum, appropriate guidance on how to use the data and an explanation of why the data may vary from provider to provider.

4. Publish on its website undiscounted charges for no fewer than 150 of the most commonly performed adult and pediatric procedures, including outpatient, inpatient, diagnostic, and preventative procedures.

(l) Assist quality improvement collaboratives by releasing information to the providers, payors, or entities representing and working on behalf of providers and payors. The agency shall release such data, which is deemed necessary for the administration of the Medicaid program, to quality improvement collaboratives for evaluation of the incidence of potentially preventable events.

Section 7. Subsection (31) is added to section 408.802, Florida Statutes, to read:

408.802 Applicability.—The provisions of this part apply to the provision of services that require licensure as defined

in this part and to the following entities licensed, registered, or certified by the agency, as described in chapters 112, 383, 390, 394, 395, 400, 429, 440, 483, and 765:

(31) Assisted living facility administrators, as provided under part I of chapter 429.

Section 8. Subsection (29) is added to section 408.820, Florida Statutes, to read:

408.820 Exemptions.—Except as prescribed in authorizing statutes, the following exemptions shall apply to specified requirements of this part:

(29) Assisted living facility administrators, as provided under part I of chapter 429, are exempt from ss. 408.806(7), 408.810(4)-(10), and 408.811.

Section 9. Paragraph (c) of subsection (4) of section 409.212, Florida Statutes, is amended to read:

409.212 Optional supplementation.—

(4) In addition to the amount of optional supplementation provided by the state, a person may receive additional supplementation from third parties to contribute to his or her cost of care. Additional supplementation may be provided under the following conditions:

(c) The additional supplementation shall not exceed four ~~two~~ times the provider rate recognized under the optional state supplementation program.

Section 10. Section 409.986, Florida Statutes, is created to read:

409.986 Quality adjustments to Medicaid rates.—

(1) As used in this section, the term:

(a) "Expected rate" means the risk-adjusted rate for each provider that accounts for the severity of illness, diagnosis related groups, and the age of a patient.

(b) "Hospital-acquired infections" means infections not present and without evidence of incubation at the time of admission to a hospital.

(c) "Observed rate" means the actual number for each provider of potentially preventable events divided by the number of cases in which potentially preventable events may have occurred.

(d) "Potentially preventable admission" means an admission of a person to a hospital that might have reasonably been prevented with adequate access to ambulatory care or health care coordination.

(e) "Potentially preventable ancillary service" means a health care service provided or ordered by a physician or other health care provider to supplement or support the evaluation or treatment of a patient, including a diagnostic test, laboratory test, therapy service, or radiology service, that may not be reasonably necessary for the provision of quality health care or treatment.

(f) "Potentially preventable complication" means a harmful event or negative outcome with respect to a person, including an infection or surgical complication, that:

1. Occurs after the person's admission to a hospital; and

2. May have resulted from the care, lack of care, or treatment provided during the hospital stay rather than from a natural progression of an underlying disease.

(g) "Potentially preventable emergency department visit" means treatment of a person in a hospital emergency room or freestanding emergency medical care facility for a condition that does not require or should not have required emergency medical attention because the condition can or could have been treated or prevented by a physician or other health care provider in a nonemergency setting.

(h) "Potentially preventable event" means a potentially preventable admission, a potentially preventable ancillary service, a potentially preventable complication, a potentially preventable emergency department visit, a potentially preventable readmission, or a combination of those events.

(i) "Potentially preventable readmission" means a return hospitalization of a person within 15 days that may have resulted from deficiencies in the care or treatment provided to the person during a previous hospital stay or from deficiencies in posthospital discharge followup. The term does not include a hospital readmission necessitated by the occurrence of unrelated events after the discharge. The term includes the readmission of a person to a hospital for:

1. The same condition or procedure for which the person was previously admitted;

2. An infection or other complication resulting from care previously provided; or

3. A condition or procedure that indicates that a surgical intervention performed during a previous admission was unsuccessful in achieving the anticipated outcome.

(j) "Quality improvement collaboration" means a structured

process involving multiple providers and subject matter experts to focus on a specific aspect of quality care in order to analyze past performance and plan, implement, and evaluate specific improvement methods.

(2) The agency shall establish and implement methodologies to adjust Medicaid payment rates for hospitals, nursing homes, and managed care plans based on evidence of improved patient outcomes. Payment adjustments shall be dependent on consideration of specific outcome measures for each provider category, documented activities by providers to improve performance, and evidence of significant improvement over time. Measurement of outcomes shall include appropriate risk adjustments, exclude cases that cannot be determined to be preventable, and waive adjustments for providers with too few cases to calculate reliable rates.

(a) Performance-based payment adjustments may be made up to 1 percent of each qualified provider's rate for hospital inpatient services, hospital outpatient services, nursing home care, and the plan-specific capitation rate for prepaid health plans. Adjustments for activities to improve performance may be made up to 0.25 percent based on evidence of a provider's engagement in activities specified in this section.

(b) Outcome measures shall be established for a base year, which may be state fiscal year 2010-2011 or a more recent 12-month period.

(3) Methodologies established pursuant to this section shall use existing databases, including Medicaid claims, encounter data compiled pursuant to s. 409.9122(14), and

hospital discharge data compiled pursuant to s. 408.061(1)(a). To the extent possible, the agency shall use methods for determining outcome measures in use by other payors.

(4) The agency shall seek any necessary federal approval for the performance payment system and implement the system in state fiscal year 2015-2016.

(5) The agency may appoint a technical advisory panel for each provider category in order to solicit advice and recommendations during the development and implementation of the performance payment system.

(6) The performance payment system for hospitals shall apply to general hospitals as defined in s. 395.002. The outcome measures used to allocate positive payment adjustments shall consist of one or more potentially preventable events such as potentially preventable readmissions and potentially preventable complications.

(a) For each 12-month period after the base year, the agency shall determine the expected rate and the observed rate for specific outcome indicators for each hospital. The difference between the expected and observed rates shall be used to establish a performance rate for each hospital. Hospitals shall be ranked based on performance rates.

(b) For at least the first three rate-setting periods after the performance payment system is implemented, a positive payment adjustment shall be made to hospitals in the top 10 percentiles, based on their performance rates, and the 10 hospitals with the best year-to-year improvement among those hospitals that did not rank in the top 10 percentiles. After the

third period of performance payment, the agency may replace the criteria specified in this subsection with quantified benchmarks for determining which providers qualify for positive payment adjustments.

(c) Quality improvement activities that may earn positive payment adjustments include:

1. Complying with requirements that reduce hospital-acquired infections pursuant to s. 395.1055(1)(b); or

2. Actively engaging in a quality improvement collaboration that focuses on reducing potentially preventable admissions, potentially preventable readmissions, or hospital-acquired infections.

(7) The performance payment system for skilled nursing facilities shall apply to facilities licensed pursuant to part II of chapter 400 with current Medicaid provider service agreements. The agency, after consultation with the technical advisory panel established in subsection (5), shall select outcome measures to be used to allocate positive payment adjustments. The outcome measures shall be consistent with the federal Quality Assurance and Performance Improvement requirements and include one or more of the following clinical care areas: pressure sores, falls, or hospitalizations.

(a) For each 12-month period after the base year, the agency shall determine the expected rate and the observed rate for specific outcome indicators for each skilled nursing facility. The difference between the expected and observed rates shall be used to establish a performance rate for each skilled nursing facility. Facilities shall be ranked based on

performance rates.

(b) For at least the first three rate-setting periods after the performance payment system is implemented, a positive payment adjustment shall be made to facilities in the top three percentiles, based on their performance rates, and the 10 facilities with the best year-to-year improvement among facilities that did not rank in the top three percentiles. After the third period of performance payment, the agency may replace the criteria specified in this subsection with quantified benchmarks for determining which facilities qualify for positive payment adjustments.

(c) Quality improvement activities that may earn positive payment adjustments include:

1. Actively engaging in a comprehensive fall-prevention program.

2. Actively engaging in a quality improvement collaboration that focuses on reducing potentially preventable hospital admissions or reducing the percentage of residents with pressure ulcers that are new or worsened.

(8) A performance payment system shall apply to all managed care plans. The outcome measures used to allocate positive payment adjustments shall consist of one or more potentially preventable events, such as potentially preventable initial hospital admissions, potentially preventable emergency department visits, or potentially preventable ancillary services.

(a) For each 12-month period after the base year, the agency shall determine the expected rate and the observed rate

for specific outcome indicators for each managed care plan. The difference between the expected and observed rates shall be used to establish a performance rate for each plan. Managed care plans shall be ranked based on performance rates.

(b) For at least the first three rate-setting periods after the performance payment system is implemented, a positive payment adjustment shall be made to the top 10 managed care plans. After the third period during which the performance payment system is implemented, the agency may replace the criteria specified in this subsection with quantified benchmarks for determining which plans qualify for positive payment adjustments.

(9) Payment adjustments made pursuant to this section may not result in expenditures that exceed the amounts appropriated in the General Appropriations Act for hospitals, nursing homes, and managed care plans.

Section 11. Paragraph (a) of subsection (1) of section 415.1034, Florida Statutes, is amended to read:

415.1034 Mandatory reporting of abuse, neglect, or exploitation of vulnerable adults; mandatory reports of death.—

(1) MANDATORY REPORTING.—

(a) Any person, including, but not limited to~~, any~~:

1. A physician, osteopathic physician, medical examiner, chiropractic physician, nurse, paramedic, emergency medical technician, or hospital personnel engaged in the admission, examination, care, or treatment of vulnerable adults;

2. A health professional or mental health professional other than one listed in subparagraph 1.;

3. A practitioner who relies solely on spiritual means for healing;

4. Nursing home staff; assisted living facility staff; adult day care center staff; adult family-care home staff; social worker; or other professional adult care, residential, or institutional staff;

5. A state, county, or municipal criminal justice employee or law enforcement officer;

6. An employee of the Department of Business and Professional Regulation conducting inspections of public lodging establishments under s. 509.032;

7. A Florida advocacy council member or long-term care ombudsman council member; ~~or~~

8. A bank, savings and loan, or credit union officer, trustee, or employee; or

9. An employee or agent of a state or local agency who has regulatory responsibilities over or who provides services to persons residing in a state-licensed assisted living facility,

who knows, or has reasonable cause to suspect, that a vulnerable adult has been or is being abused, neglected, or exploited must ~~shall~~ immediately report such knowledge or suspicion to the central abuse hotline.

Section 12. Subsections (7) and (8) of section 429.02, Florida Statutes, are amended to read:

429.02 Definitions.—When used in this part, the term:

(7) "Community living support plan" means a written document prepared by a mental health resident and the resident's

mental health case manager in consultation with the administrator of an assisted living facility ~~with a limited mental health license~~ or the administrator's designee. A copy must be provided to the administrator. The plan must include 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.

(8) "Cooperative agreement" means a written statement of understanding between a mental health care provider and the administrator of the assisted living facility ~~with a limited mental health license~~ in which a mental health resident is living. The agreement must specify directions for accessing emergency and after-hours care for the mental health resident. A single cooperative agreement may service all mental health residents who are clients of the same mental health care provider.

Section 13. Subsection (1) and paragraphs (b) and (c) of subsection (3) of section 429.07, Florida Statutes, are amended to read:

429.07 License required; fee.—

(1) The requirements of part II of chapter 408 apply to the provision of services that require licensure pursuant to this part and part II of chapter 408 and to entities licensed by or applying for such licensure from the agency pursuant to this part. A license issued by the agency is required in order to operate an assisted living facility in this state. Effective

July 1, 2013, an assisted living facility may not operate in this state unless the facility is under the management of an assisted living facility administrator licensed pursuant to s. 429.50.

(3) In addition to the requirements of s. 408.806, each license granted by the agency must state the type of care for which the license is granted. Licenses shall be issued for one or more of the following categories of care: standard, extended congregate care, limited nursing services, or limited mental health.

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

1. In order for extended congregate care services to be provided, the agency must first determine that all requirements established in law and rule are met and must specifically designate, on the facility's license, that such services may be provided and whether the designation applies to all or part of the facility. Such designation may be made at the time of initial licensure or relicensure, or upon request in writing by a licensee under this part and part II of chapter 408. The notification of approval or the denial of the request shall be made in accordance with part II of chapter 408. Existing facilities qualifying to provide extended congregate care

services must have maintained a standard license and may not have been subject to administrative sanctions during the previous 2 years, or since initial licensure if the facility has been licensed for less than 2 years, for any of the following reasons:

a. A class I or class II violation;

b. Three or more repeat or recurring class III violations of identical or similar resident care standards from which a pattern of noncompliance is found by the agency;

c. Three or more class III violations that were not corrected in accordance with the corrective action plan approved by the agency;

d. Violation of resident care standards which results in requiring the facility to employ the services of a consultant pharmacist or consultant dietitian;

e. Denial, suspension, or revocation of a license for another facility licensed under this part in which the applicant for an extended congregate care license has at least 25 percent ownership interest; or

f. Imposition of a moratorium pursuant to this part or part II of chapter 408 or initiation of injunctive proceedings.

2. A facility that is licensed to provide extended congregate care services shall maintain a written progress report on each person who receives services which describes the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. A registered nurse, or appropriate designee, representing the agency shall visit the facility at least once a year ~~quarterly~~

to monitor residents who are receiving extended congregate care services and to determine if the facility is in compliance with this part, part II of chapter 408, and relevant rules. One of the visits may be in conjunction with the regular survey. The monitoring visits may be provided through contractual arrangements with appropriate community agencies. A registered nurse shall serve as part of the team that inspects the facility. The agency may waive a ~~one of the required yearly~~ monitoring visit ~~visits~~ for a facility that has been licensed for at least 24 months to provide extended congregate care services, if, during the inspection, the registered nurse determines that extended congregate care services are being provided appropriately, and if the facility has no:

a. Class I or class II violations and no uncorrected class III violations;

b. Citations for a licensure violation which resulted from referrals by the ombudsman to the agency; or

c. Citation for a licensure violation which resulted from complaints to the agency. ~~The agency must first consult with the long-term care ombudsman council for the area in which the facility is located to determine if any complaints have been made and substantiated about the quality of services or care. The agency may not waive one of the required yearly monitoring visits if complaints have been made and substantiated.~~

3. A facility that is licensed to provide extended congregate care services must:

a. Demonstrate the capability to meet unanticipated resident service needs.

b. Offer a physical environment that promotes a homelike setting, provides for resident privacy, promotes resident independence, and allows sufficient congregate space as defined by rule.

c. Have sufficient staff available, taking into account the physical plant and firesafety features of the building, to assist with the evacuation of residents in an emergency.

d. Adopt and follow policies and procedures that maximize resident independence, dignity, choice, and decisionmaking to permit residents to age in place, so that moves due to changes in functional status are minimized or avoided.

e. Allow residents or, if applicable, a resident's representative, designee, surrogate, guardian, or attorney in fact to make a variety of personal choices, participate in developing service plans, and share responsibility in decisionmaking.

f. Implement the concept of managed risk.

g. Provide, directly or through contract, the services of a person licensed under part I of chapter 464.

h. In addition to the training mandated in s. 429.52, provide specialized training as defined by rule for facility staff.

4. A facility that is licensed to provide extended congregate care services is exempt from the criteria for continued residency set forth in rules adopted under s. 429.41. 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 nursing

supervision. A licensed facility that provides extended congregate care services must also provide each resident with a written copy of facility policies governing admission and retention.

5. The primary purpose of extended congregate care services is to allow residents, as they become more impaired, the option of remaining in a familiar setting from which they would otherwise be disqualified for continued residency. A facility licensed to provide extended congregate care 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 extended congregate care facility.

6. Before the admission of an individual to a facility licensed to provide extended congregate care services, the individual must undergo a medical examination as provided in s. 429.26(4) and the facility must develop a preliminary service plan for the individual.

7. When a facility can no longer provide or arrange for services in accordance with the resident's service plan and needs and the facility's policy, the facility shall make arrangements for relocating the person in accordance with s. 429.28(1)(k).

8. Failure to provide extended congregate care services may result in denial of extended congregate care license renewal.

(c) A limited nursing services license shall be issued to a facility that provides services beyond those authorized in

paragraph (a) and as specified in this paragraph.

1. In order for limited nursing services to be provided in a facility licensed under this part, the agency must first determine that all requirements established in law and rule are met and must specifically designate, on the facility's license, that such services may be provided. Such designation may be made at the time of initial licensure or relicensure, or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with part II of chapter 408. Existing facilities qualifying to provide limited nursing services shall have maintained a standard license and may not have been subject to administrative sanctions that affect the health, safety, and welfare of residents for the previous 2 years or since initial licensure if the facility has been licensed for less than 2 years.

2. Facilities that are licensed to provide limited nursing services shall maintain a written progress report on each person who receives such nursing services, which report describes the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. A registered nurse representing the agency shall visit such facilities at least once ~~twice~~ a year to monitor residents who are receiving limited nursing services and to determine if the facility is in compliance with applicable provisions of this part, part II of chapter 408, and related rules. The monitoring visits may be provided through contractual arrangements with appropriate community agencies. A registered nurse shall also

serve as part of the team that inspects such facility. The agency may waive a monitoring visit for a facility that has been licensed for at least 24 months to provide limited nursing services and if the facility has no:

a. Class I or class II violations and no uncorrected class III violations;

b. Citations for a licensure violation which resulted from referrals by the ombudsman to the agency; or

c. Citation for a licensure violation which resulted from complaints to the agency.

3. A person who receives limited nursing services under this part must meet the admission criteria established by the agency for assisted living facilities. When a resident no longer meets the admission criteria for a facility licensed under this part, arrangements for relocating the person shall be made in accordance with s. 429.28(1)(k), unless the facility is licensed to provide extended congregate care services.

Section 14. Section 429.075, Florida Statutes, is amended to read:

429.075 Limited mental health license.—In order to serve three or more mental health residents, an assisted living facility ~~that serves three or more mental health residents~~ must obtain a limited mental health license.

(1) To obtain a limited mental health license, a facility:

(a) Must hold a standard license as an assisted living facility; and~~,~~

(b) Must not have been subject to administrative sanctions during the previous 2 years, or since initial licensure if the

assisted living facility has been licensed for less than 2 years, for any of the following reasons:

1. One or more class I violations imposed by final agency action;

2. Three or more class II violations imposed by final agency action;

3. Ten or more class III violations that were not corrected in accordance with s. 408.811(4);

4. Denial, suspension, or revocation of a license for another assisted living facility licensed under this part in which the license applicant had at least a 25-percent ownership interest; or

5. Imposition of a moratorium pursuant to this part or part II of chapter 408 or initiation of injunctive proceedings. ~~any current uncorrected deficiencies or violations, and must ensure that,~~

(2) Within 6 months after receiving a limited mental health license, the facility administrator and the staff of the facility who are in direct contact with mental health residents must complete training of no less than 6 hours related to their duties. This training shall be approved by the Department of Children and Family Services. A training provider may charge a reasonable fee for the training.

(3) Application for a limited mental health license ~~Such designation~~ may be made at the time of initial licensure or relicensure or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of the license ~~such request~~ shall be made in accordance

with this part, part II of chapter 408, and applicable rules. ~~This training will be provided by or approved by the Department of Children and Family Services.~~

(4) ~~(2)~~ Facilities licensed to provide services to mental health residents shall provide appropriate supervision and staffing to provide for the health, safety, and welfare of such residents.

~~(3) A facility that has a limited mental health license must:~~

~~(a) Have a copy of each mental health resident's community living support plan and the cooperative agreement with the mental health care services provider. The support plan and the agreement may be combined.~~

~~(b) Have documentation that is provided by the Department of Children and Family Services that each mental health resident has been assessed and determined to be able to live in the community in an assisted living facility with a limited mental health license.~~

~~(c) Make the community living support plan available for inspection by the resident, the resident's legal guardian, the resident's health care surrogate, and other individuals who have a lawful basis for reviewing this document.~~

~~(d) Assist the mental health resident in carrying out the activities identified in the individual's community living support plan.~~

~~(4) A facility with a limited mental health license may enter into a cooperative agreement with a private mental health provider. For purposes of the limited mental health license, the~~

~~private mental health provider may act as the case manager.~~

Section 15. Section 429.0751, Florida Statutes, is created to read:

429.0751 Mental health residents.—An assisted living facility that has one or more mental health residents must:

(1) Enter into a cooperative agreement with the mental health care service provider responsible for providing services to the mental health resident, including a mental health care service provider responsible for providing private pay services to the mental health resident, to ensure coordination of care.

(2) Consult with the mental health case manager and the mental health resident in the development of a community living support plan and maintain a copy of each mental health resident's community living support plan.

(3) Make the community living support plan available for inspection by the resident, the resident's legal guardian, the resident's health care surrogate, and other individuals who have a lawful basis for reviewing this document.

(4) Assist the mental health resident in carrying out the activities identified in the individual's community living support plan.

(5) Have documentation that is provided by the Department of Children and Family Services that each mental health resident has been assessed and determined to be able to live in the community in an assisted living facility.

Section 16. Paragraphs (a) and (b) of subsection (2) of section 429.178, Florida Statutes, are amended to read:

429.178 Special care for persons with Alzheimer's disease

or other related disorders.—

(2)(a) An individual who is employed by a facility that provides special care for residents with Alzheimer's disease or other related disorders, and who has regular contact with such residents, must complete up to 4 hours of initial dementia-specific training developed or approved by the department. The training shall be completed within 3 months after beginning employment and shall satisfy the core training requirements of s. 429.52(2)(d) ~~429.52(2)(g)~~.

(b) A direct caregiver who is employed by a facility that provides special care for residents with Alzheimer's disease or other related disorders, and who provides direct care to such residents, must complete the required initial training and 4 additional hours of training developed or approved by the department. The training shall be completed within 9 months after beginning employment and shall satisfy the core training requirements of s. 429.52(2)(d) ~~429.52(2)(g)~~.

Section 17. Subsection (2) of section 429.19, Florida Statutes, is amended to read:

429.19 Violations; imposition of administrative fines; grounds.—

(2) Each violation of this part and adopted rules shall be classified according to the nature of the violation and the gravity of its probable effect on facility residents.

(a) The agency shall indicate the classification on the written notice of the violation as follows:

1.~~(a)~~ Class "I" violations are defined in s. 408.813. The agency shall issue a citation regardless of correction. The

agency shall impose an administrative fine for a cited class I violation in an amount not less than $5,000 and not exceeding $10,000 for each violation.

2.~~(b)~~ Class "II" violations are defined in s. 408.813. The agency may issue a citation regardless of correction. The agency shall impose an administrative fine for a cited class II violation in an amount not less than $1,000 and not exceeding $5,000 for each violation.

3.~~(c)~~ Class "III" violations are defined in s. 408.813. The agency shall impose an administrative fine for a cited class III violation in an amount not less than $500 and not exceeding $1,000 for each violation.

4.~~(d)~~ Class "IV" violations are defined in s. 408.813. The agency shall impose an administrative fine for a cited class IV violation in an amount not less than $100 and not exceeding $200 for each violation.

(b) In lieu of the penalties provided in paragraph (a), the agency shall impose a $10,000 penalty for a violation that results in the death of a resident.

(c) Notwithstanding paragraph (a), if the assisted living facility is cited for a class I or class II violation and within 24 months the facility is cited for another class I or class II violation, the agency shall double the fine for the subsequent violation if the violation is in the same class as the previous violation.

Section 18. Section 429.195, Florida Statutes, is amended to read:

429.195 Rebates prohibited; penalties.—

(1) It is unlawful for any assisted living facility licensed under this part to contract or promise to pay or receive any commission, bonus, kickback, or rebate or engage in any split-fee arrangement in any form whatsoever with any person, health care provider, or health care facility as provided in s. 817.505 ~~physician, surgeon, organization, agency, or person, either directly or indirectly, for residents referred to an assisted living facility licensed under this part. A facility may employ or contract with persons to market the facility, provided the employee or contract provider clearly indicates that he or she represents the facility. A person or agency independent of the facility may provide placement or referral services for a fee to individuals seeking assistance in finding a suitable facility; however, any fee paid for placement or referral services must be paid by the individual looking for a facility, not by the facility.~~

(2) This section does not apply to:

(a) Any individual employed by the assisted living facility or with whom the facility contracts to market the facility if the individual clearly indicates that he or she works with or for the facility.

(b) Payments by an assisted living facility to a referral service that provides information, consultation, or referrals to consumers to assist them in finding appropriate care or housing options for seniors or disabled adults, if such referred consumers are not Medicaid recipients.

(c) A resident of an assisted living facility who refers to the assisted living facility a friend, family member, or

other individual with whom the resident has a personal relationship, in which case the assisted living facility may provide a monetary reward to the resident for making such referral.

(3) ~~(2)~~ A violation of this section shall be considered patient brokering and is punishable as provided in s. 817.505.

Section 19. Paragraph (j) is added to subsection (3) of section 817.505, Florida Statutes, to read:

817.505 Patient brokering prohibited; exceptions; penalties.—

(3) This section shall not apply to:

(j) Any payment permitted under s. 429.195(2).

Section 20. Section 429.231, Florida Statutes, is created to read:

429.231 Advisory council; membership; duties.—

(1) The department shall establish an advisory council to review the facts and circumstances of unexpected deaths in assisted living facilities and of elopements that result in harm to a resident. The purpose of this review is to:

(a) Achieve a greater understanding of the causes and contributing factors of the unexpected deaths and elopements.

(b) Identify any gaps, deficiencies, or problems in the delivery of services to the residents.

(2) Based on the review, the advisory council shall make recommendations for:

(a) Industry best practices that could be used to prevent unexpected deaths and elopements.

(b) Training and educational requirements for employees

and administrators of assisted living facilities.

(c) Changes in the law, rules, or other policies to prevent unexpected deaths and elopements.

(3) The advisory council shall prepare an annual statistical report on the incidence and causes of unexpected deaths in assisted living facilities and of elopements that result in harm to residents during the prior calendar year. The advisory council shall submit a copy of the report by December 31 of each year to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The report may make recommendations for state action, including specific policy, procedural, regulatory, or statutory changes, and any other recommended preventive action.

(4) The advisory council shall consist of the following members:

(a) The Secretary of Elderly Affairs, or a designee, who shall be the chair.

(b) The Secretary of Health Care Administration, or a designee.

(c) The Secretary of Children and Family Services, or a designee.

(d) The State Long-Term Care Ombudsman, or a designee.

(e) The following members, selected by the Governor:

1. An owner or administrator of an assisted living facility with fewer than 17 beds.

2. An owner or administrator of an assisted living facility with 17 or more beds.

3. An owner or administrator of an assisted living

facility with a limited mental health license.

4. A representative from each of three statewide associations that represent assisted living facilities.

5. A resident of an assisted living facility.

(5) The advisory council shall meet at the call of the chair, but at least twice each calendar year. The chair may appoint ad hoc committees as necessary to carry out the duties of the council.

(6) The members of the advisory council selected by the Governor shall be appointed to staggered terms of office which may not exceed 2 years. Members are eligible for reappointment.

(7) Members of the advisory council shall serve without compensation, but are entitled to reimbursement for per diem and travel expenses incurred in the performance of their duties as provided in s. 112.061 and to the extent that funds are available.

Section 21. Section 429.34, Florida Statutes, is amended to read:

429.34 Right of entry and inspection.—

(1) In addition to the requirements of s. 408.811, any duly designated officer or employee of the department, the Department of Children and Family Services, the Medicaid Fraud Control Unit of the Office of the Attorney General, the state or local fire marshal, or a member of the state or local long-term care ombudsman council may ~~shall have the right to~~ enter unannounced upon and into the premises of any facility licensed pursuant to this part in order to determine the state of compliance with ~~the provisions of~~ this part, part II of chapter

408, and applicable rules. Data collected by the state or local long-term care ombudsman councils or the state or local advocacy councils may be used by the agency in investigations involving violations of regulatory standards.

(2) In accordance with s. 408.811, every 24 months the agency shall conduct at least one unannounced inspection to determine compliance with this part, part II of chapter 408, and applicable rules. If the assisted living facility is accredited by the Joint Commission, the Council on Accreditation, or the Commission on Accreditation of Rehabilitation Facilities, the agency may conduct inspections less frequently, but in no event less than once every 5 years.

(a) Two additional inspections shall be conducted every 6 months for the next year if the assisted living facility has been cited for a class I violation or two or more class II violations arising from separate inspections within a 60-day period. In addition to any fines imposed on an assisted living facility under s. 429.19, the agency shall assess a fee of $69 per bed for each of the additional two inspections, not to exceed $12,000 per inspection.

(b) The agency shall verify through subsequent inspections that any violation identified during an inspection is corrected. However, the agency may verify the correction of a class III or class IV violation unrelated to resident rights or resident care without reinspection if the facility submits adequate written documentation that the violation has been corrected.

Section 22. Section 429.50, Florida Statutes, is created to read:

429.50 Assisted living facility administrator; qualifications; licensure; fees; continuing education.—

(1) The requirements of part II of chapter 408 apply to the provision of services that require licensure pursuant to this section. Effective July 1, 2013, an assisted living facility administrator must have a license issued by the agency.

(2) To be eligible to be licensed as an assisted living facility administrator, an applicant must provide proof of a current and valid assisted living facility administrator certification and complete background screening pursuant to s. 429.174.

(3) Notwithstanding subsection (2), the agency may grant an initial license to an applicant who:

(a)1. Has been employed as an assisted living facility administrator for 2 of the 5 years immediately preceding July 1, 2013, or who is employed as an assisted living facility administrator on June 1, 2013;

2. Is in compliance with the continuing education requirements in this part;

3. Within 2 years before the initial application for an assisted living facility administrator license, has not been the administrator of an assisted living facility when a Class I or Class II violation occurred for which the facility was cited by final agency action; and

4. Has completed background screening pursuant to s. 429.174; or

(b) Is licensed in accordance with part II of chapter 468, is in compliance with the continuing education requirements in

part II of chapter 468, and has completed background screening pursuant to s. 429.174.

(4) An assisted living facility administrator certification must be issued by a third-party credentialing entity under contract with the agency, and, for the initial certification, the entity must certify that the individual:

(a) Is at least 21 years old.

(b) Has completed 30 hours of core training and 10 hours of supplemental training as described in s. 429.52.

(c) Has passed the competency test described in s. 429.52 with a minimum score of 80.

(d) Has otherwise met the requirements of this part.

(5) The agency shall contract with one or more third-party credentialing entities for the purpose of certifying assisted living facility administrators. A third-party credentialing entity must be a nonprofit organization that has met nationally recognized standards for developing and administering professional certification programs. The contract must require that a third-party credentialing entity:

(a) Develop a competency test as described in s. 429.52(7).

(b) Maintain an Internet-based database, accessible to the public, of all persons holding an assisted living facility administrator certification.

(c) Require continuing education consistent with s. 429.52 and, at least, biennial certification renewal for persons holding an assisted living facility administrator certification.

(6) The license shall be renewed biennially.

(7) The fees for licensure shall be $150 for the initial licensure and $150 for each licensure renewal.

(8) A licensed assisted living facility administrator must complete continuing education described in s. 429.52 for a minimum of 18 hours every 2 years.

(9) The agency shall deny or revoke the license if the applicant or licensee:

(a) Was the assisted living facility administrator of record for an assisted living facility licensed by the agency under this chapter, part II of chapter 408, or applicable rules, when the facility was cited for violations that resulted in denial or revocation of a license; or

(b) Has a final agency action for unlicensed activity pursuant to this chapter, part II of chapter 408, or applicable rules.

(10) The agency may deny or revoke the license if the applicant or licensee was the assisted living facility administrator of record for an assisted living facility licensed by the agency under this chapter, part II of chapter 408, or applicable rules, when the facility was cited for violations within the previous 3 years that resulted in a resident's death.

(11) The agency may adopt rules as necessary to administer this section.

Section 23. For the purpose of staggering license expiration dates, the Agency for Health Care Administration may issue a license for less than a 2-year period for assisted living facility administrator licensure as authorized in this act. The agency shall charge a prorated licensure fee for this

shortened period. This section and the authority granted under this section expire December 31, 2013.

Section 24. Effective January 1, 2013, section 429.52, Florida Statutes, is amended to read:

429.52 Staff, administrator, and administrator license applicant training and educational programs; core educational requirement.—

(1) Administrators, applicants to become administrators, and other assisted living facility staff must meet minimum training and education requirements established by the Department of Elderly Affairs by rule. This training and education is intended to assist facilities to appropriately respond to the needs of residents, to maintain resident care and facility standards, and to meet licensure requirements.

(2) For assisted living facility staff other than administrators, ~~The department shall establish a competency test and a minimum required score to indicate successful completion of the training and educational requirements. The competency test must be developed by the department in conjunction with the agency and providers.~~ the required training and education, which may be provided as inservice training, must cover at least the following topics:

(a) Reporting major incidents and reporting adverse incidents ~~State law and rules relating to assisted living facilities~~.

(b) Resident rights and identifying and reporting abuse, neglect, and exploitation.

(c) Emergency procedures, including firesafety and

resident elopement response policies and procedures ~~Special needs of elderly persons, persons with mental illness, and persons with developmental disabilities and how to meet those needs~~.

(d) General information on interacting with individuals with Alzheimer's disease and related disorders ~~Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food~~.

~~(e) Medication management, recordkeeping, and proper techniques for assisting residents with self-administered medication.~~

~~(f) Firesafety requirements, including fire evacuation drill procedures and other emergency procedures.~~

~~(g) Care of persons with Alzheimer's disease and related disorders.~~

~~(3) Effective January 1, 2004, a new facility administrator must complete the required training and education, including the competency test, within a reasonable time after being employed as an administrator, as determined by the department. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the department by rule.~~

~~(4) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years.~~

(3)~~(5)~~ Staff involved with the management of medications and assisting with the self-administration of medications under s. 429.256 must complete a minimum of 4 additional hours of training provided by a registered nurse, licensed pharmacist, or department staff. The department shall establish by rule the minimum requirements of this additional training.

~~(6)~~ Other facility staff shall participate in training relevant to their job duties as specified by rule of the department.

(4)~~(7)~~ If the department or the agency determines that there are problems in a facility that could be reduced through specific staff training or education beyond that already required under this section, the department or the agency may require, and provide, or cause to be provided, the training or education of any personal care staff in the facility.

(5) The department, in consultation with the agency, the Department of Children and Family Services, and stakeholders, shall approve a standardized core training curriculum that must be completed by an applicant for licensure as an assisted living facility administrator. The curriculum must be offered in English and Spanish and timely updated to reflect changes in the law, rules, and best practices. The required training must cover, at a minimum, the following topics:

(a) State law and rules relating to assisted living facilities.

(b) Residents' rights and procedures for identifying and reporting abuse, neglect, and exploitation.

(c) Special needs of elderly persons, persons who have

mental illnesses, and persons who have developmental disabilities and how to meet those needs.

(d) Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food.

(e) Medication management, recordkeeping, and proper techniques for assisting residents who self-administer medication.

(f) Firesafety requirements, including procedures for fire evacuation drills and other emergency procedures.

(g) Care of persons who have Alzheimer's disease and related disorders.

(h) Elopement prevention.

(i) Aggression and behavior management, deescalation techniques, and proper protocols and procedures of the Baker Act as provided in part I of chapter 394.

(j) Do-not-resuscitate orders.

(k) Infection control.

(l) Admission, continuing residency, and best practices in the assisted living industry.

(m) Phases of care and interacting with residents.

(6) The department, in consultation with the agency, the Department of Children and Family Services, and stakeholders, shall approve a supplemental training curriculum consisting of topics related to extended congregate care, limited mental health, and business operations, including human resources, financial management, and supervision of staff, which must be completed by an applicant for licensure as an assisted living facility administrator.

(7) The department shall approve a competency test for applicants for licensure as an assisted living facility administrator which tests the individual's comprehension of the training required in subsections (5) and (6). The competency test must be reviewed annually and timely updated to reflect changes in the law, rules, and best practices. The competency test must be offered in English and Spanish and may be made available through testing centers.

(8) The department, in consultation with the agency and stakeholders, shall approve curricula for continuing education for administrators and staff members of an assisted living facility. Continuing education shall include topics similar to that of the core training required for staff members and applicants for licensure as assisted living facility administrators. Continuing education may be offered through online courses, and any fees associated with the online service shall be borne by the licensee or the assisted living facility. Required continuing education must, at a minimum, cover the following topics:

(a) Elopement prevention.

(b) Deescalation techniques.

(c) Phases of care and interacting with residents.

(9) The training required by this section shall be conducted by:

(a) Any Florida College System institution;

(b) Any nonpublic postsecondary educational institution licensed or exempted from licensure pursuant to chapter 1005; or

(c) Any statewide association that contracts with the

department to provide training. The department may specify minimum trainer qualifications in the contract. For the purposes of this section, the term "statewide association" means any statewide entity which represents and provides technical assistance to assisted living facilities.

(10) Assisted living facility trainers shall keep a record of individuals who complete training and shall, within 30 days after the individual completes the course, electronically submit the record to the agency and to all third-party credentialing entities under contract with the agency pursuant to s. 429.50(5).

(11) The department shall adopt rules as necessary to administer this section.

~~(8) The department shall adopt rules related to these training requirements, the competency test, necessary procedures, and competency test fees and shall adopt or contract with another entity to develop a curriculum, which shall be used as the minimum core training requirements. The department shall consult with representatives of stakeholder associations and agencies in the development of the curriculum.~~

~~(9) The training required by this section shall be conducted by persons registered with the department as having the requisite experience and credentials to conduct the training. A person seeking to register as a trainer must provide the department with proof of completion of the minimum core training education requirements, successful passage of the competency test established under this section, and proof of compliance with the continuing education requirement in~~

~~subsection (4).~~

~~(10) A person seeking to register as a trainer must also:~~

~~(a) Provide proof of completion of a 4-year degree from an accredited college or university and must have worked in a management position in an assisted living facility for 3 years after being core certified;~~

~~(b) Have worked in a management position in an assisted living facility for 5 years after being core certified and have 1 year of teaching experience as an educator or staff trainer for persons who work in assisted living facilities or other long-term care settings;~~

~~(c) Have been previously employed as a core trainer for the department; or~~

~~(d) Meet other qualification criteria as defined in rule, which the department is authorized to adopt.~~

~~(11) The department shall adopt rules to establish trainer registration requirements.~~

Section 25. Section 429.54, Florida Statutes, is amended to read:

429.54 Collection of information; local subsidy; interagency communication.—

(1) To enable the department to collect the information requested by the Legislature regarding the actual cost of providing room, board, and personal care in assisted living facilities, the department may ~~is authorized to~~ conduct field visits and audits of facilities as ~~may be~~ necessary. The owners of randomly sampled facilities shall submit such reports, audits, and accountings of cost as the department may require by

rule; however, ~~provided that~~ such reports, audits, and accountings may not be more than ~~shall be~~ the minimum necessary to implement the provisions of this subsection ~~section~~. Any facility selected to participate in the study shall cooperate with the department by providing cost of operation information to interviewers.

(2) Local governments or organizations may contribute to the cost of care of local facility residents by further subsidizing the rate of state-authorized payment to such facilities. Implementation of local subsidy shall require departmental approval and may ~~shall~~ not result in reductions in the state supplement.

(3) Subject to the availability of funds, the agency, the department, the Department of Children and Family Services, and the Agency for Persons with Disabilities shall develop or modify electronic systems of communication among state-supported automated systems to ensure that relevant information pertaining to the regulation of assisted living facilities and assisted living facility staff is timely and effectively communicated among agencies in order to facilitate the protection of residents.

Section 26. For fiscal year 2012-2013, 8 full-time equivalent positions, with associated salary rate of 324,962, are authorized and the sum of $554,399 in recurring funds from the Health Care Trust Fund of the Agency for Health Care Administration are appropriated to the Agency for Health Care Administration for the purpose of carrying out the regulatory activities provided in this act.

Section 27. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2012.