APPENDIX K

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Administration and Support

SERVICE: Administration and Support

ACTIVITY: Executive Direction

MEASURE: Percent of Agency administrative costs and positions compared to total Agency costs and positions

DATA SOURCES AND METHODOLOGY:
The Agency's financial data is maintained in the Florida Accounting Information Resource Subsystem (FLAIR). The Agency's administrative costs are first identified and then segregated from the Agency's total costs. The administrative costs are divided by the entire Agency's costs to arrive at the measurement.

The Agency's position data is maintained in the Cooperative Personnel Employee Subsystem (COPES). The Agency's administrative positions are first identified and then segregated from the Agency's total positions. The administrative positions are divided by the entire Agency's positions to arrive at the measurement.

VALIDITY:
The measure is a valid and appropriate tool to determine what percentage the Agency's administrative costs are of its total costs as established by an examination and analysis of the Agency's financial data.

The Agency's position data is a valid and appropriate tool to determine what percentage the Agency's positions are of its total positions as established by an examination and analysis of the Agency's COPES data.

RELIABILITY:
Only authorized personnel can access the FLAIR data and the COPES data. The data is reconciled on a regular basis, ensuring accuracy and reliability.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Children's Special Health Care (KidCare)

ACTIVITY: Purchase MediKids Program Services
Purchase Children's Medical Services Network Services
Purchase Florida Healthy Kids Corporation Services

MEASURE: Percent of hospitalizations for conditions preventable by good ambulatory care

DATA SOURCES AND METHODOLOGY:
The data source is the State Center for Health Statistics' hospital discharge data. All hospitalizations for beneficiaries in which a Medicaid HMO and Medicaid Non-HMO are reported as the payers are abstracted from the hospital discharge file. The beneficiaries who are under 21 years old are extracted for this measure. Hospitalizations for which the primary International Classification of Diseases (ICD)-9 code is maternity or mental health are first excluded. The remaining hospitalizations are classified as to whether the primary ICD-9 code is ambulatory sensitive. Those classified as ambulatory sensitive are counted and become the numerator. The denominator is the total number of hospitalizations for any condition excluding those for maternity or mental health.

VALIDITY:
Validity of the measure is fair. A condition is considered ambulatory sensitive if provision of quality care could reduce or eliminate the need for hospitalization. Some hospitalizations will always occur due to patient non-compliance. However, Medicaid providers are expected to work with patients to increase their likelihood of compliance in addition to providing direct treatment. The codes used to classify a hospital visit as ambulatory sensitive are a conservative number developed by Weissman as reported in "Rates of Avoidable Hospitalizations by Insurance Status in Massachusetts and Maryland", *Journal of the American Medical Association,* November 4, 1992. Some researchers have used additional conditions. In order to understand the data better, AHCA also obtains the measure using a broader list derived from other literature.

RELIABILITY:
The reliability of the measure is high. Hospitals provide the information to AHCA and must certify that it is accurate. The ICD-9 codes are used for billing, hospital report cards etc. so hospitals have incentives to be accurate in their use of these codes. Incentives for mistakes favor not classifying a condition as ambulatory sensitive. The payer source is less accurate. Payer source is coded when the patient enters the hospital and may not be known. There is no expectation that inaccuracies in payer classification would be related to the reason for hospitalization. Since the measure is based on the ratio of the two types of hospitalization and not absolute numbers the figure should be reliable for the purpose.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
_X_ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Children's Special Health Care (KidCare Program)

ACTIVITY: Purchase MediKids Program Services
Purchase Children's Medical Services Network Services
Purchase Florida Healthy Kids Corporation Services

MEASURE: Percentage of eligible uninsured children who receive health benefits coverage

DATA SOURCES AND METHODOLOGY:
When applications arrive at FHKC (Florida Healthy Kids Corporation), they are logged in and sent to Dental Health and Consulting Services (DHACS) and the Department of Children and Families (DCF) for further processing. Only children who become uninsured are included in the particular data set listed in the measure above. The number of enrolled children will be compared to the number of potentially eligible children.

Data comes from the Florida Healthy Kids Corporation Corporation (FHKC) and the Dental Health and Consulting Services (DHACS) in a monthly electronic data transfer and cross-tabulated to determine which children applied for services and which children were actually enrolled in KidCare. This information will be compared to results from the Florida Health Insurance Survey which will be adjusted in the future for population growth.

VALIDITY:
The intent of this data is to illustrate the number of insured children covered under KidCare. The Florida Health Insurance Survey was developed by a person skilled in survey design with input from several Florida State agencies. Questions on the instrument were designed and tested specifically for the purpose of determining insurance status and KidCare program eligibility. Results from this survey are compared to the data from DHACS and DCF, in order to compare the number of children who are insured under KidCare with those who are potentially eligible for enrollment. The measure does not address the Medicaid portion of KidCare.

The more time from the period of the study, the lower the validity of the measure. In addition, the effect of any crowd-out of beneficiaries failing to leave the program when they have access

to insurance as new individuals lose access to insurance will result in increased enrollment in KidCare and rates of uninsurance failing to decrease at the same level.

RELIABILITY:
The sampling plan and sample size were constructed to yield statistical estimates of the uninsured at a state and regional level. The Agency has included a request for budget authority to utilize a grant to update the Florida Health Insurance study. State workers and illegal alien status will be considered when the study is conducted.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Children's Special Health Care (KidCare Program)

ACTIVITY: Purchase MediKids Program Services
Purchase Children's Medical Services Network Services
Purchase Florida Healthy Kids Corporation Services

MEASURE: Percent of children enrolled with up-to-date immunizations

DATA SOURCES AND METHODOLOGY:
Data for this measure comes from a telephone survey of a random sample of caregivers of established enrollees from each component of KidCare who enter KidCare through a simplified eligibility form, and does not include those who receive Medicaid through the traditional welfare system. In that survey parents are asked to report on their child's immunization. Seventy percent reported using the child's actual immunization record. The remainder use recall. Data is compared to standards for those recommended by the American Academy of Pediatrics for the child's age. From that, the percent with up-to-date immunization is reported. The percent reported is for the lowest rate for any of the following shots, DPT, Polio, HIB, MMR, and Hepatitis B. Thus, the rate would be higher if based on the highest, which was 95.9% for MMR. The lowest was for Hepatitis B of 82.9%. The Child Health Policy Institute conducted the surveys on established enrollees. An established beneficiary had been enrolled in the program for six months. Approximately 1,464 caregivers of enrolled children were actually surveyed.

VALIDITY:
This is the most valid method until the Department of Health's Immunization Registry is fully operational. The surveys have undergone extensive field testing before use with the target populations. The immunization questions are taken from the National Immunization Survey. The surveys were combined and may not have been appropriately weighted given the difference in size of the populations and stratification of the original sample. Prior to the coming year, this issue will be addressed and, if necessary, the data revised. Measures were calculated separately for each program and these measures would not be affected. Those entering Medicaid through the traditional welfare application are not included. AHCA is working with Department of Health to get a measure for all Medicaid two-year olds as a separate indicator.

RELIABILITY:
Given the extensive testing of the measures, they are quite reliable within normal statistical limitations.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Children's Special Health Care (KidCare Program)

ACTIVITY: Purchase MediKids Program Services
Purchase Children's Medical Services Network Services
Purchase Florida Healthy Kids Corporation Services

MEASURE: Percent of compliance with the standards established in the Guidelines for Health Supervision of Children and Youth as developed by the American Academy of Pediatrics for children eligible under the program

DATA SOURCES AND METHODOLOGY:
Data for this measure comes from a telephone survey of caregiver of established beneficiaries in KidCare by the Child Health Policy Institute. Respondents are asked a series of questions about well-child care the target child has received. The caregiver information is compared with American Academy of Pediatrics (AAP) guidelines for well-child care. An established beneficiary had been enrolled in the program for six months. Approximately 2,800 children are included in this data, with interviews completed on about 2,000.

VALIDITY:
The Caregiver and New Enrollee surveys have undergone extensive field testing before use with the target populations. The Caregiver survey uses the CAHPS (Consumer Assessment of Health Plans Survey), a well-known and extremely reliable set of questions, that assesses not only consumer satisfaction but also several measures of well-child care. Those entering Medicaid through the traditional welfare application are not included. The surveys were combined and may not have been appropriately weighted given the difference in size of the populations and stratification of the original sample. Prior to the coming year, this issue will be addressed and if necessary the data revised. Measures were calculated separately for each program and these measures would not be affected.

RELIABILITY:
Given the extensive testing of the measures, they are quite reliable within normal statistical limitations.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Children's Special Health Care (KidCare Program)

ACTIVITY: Purchase MediKids Program Services
Purchase Children's Medical Services Network Services
Purchase Florida Healthy Kids Corporation Services

MEASURE: Percent of families satisfied with the care provided under the program

DATA SOURCES AND METHODOLOGY:
Data for this measure comes from a telephone survey of caregiver of established beneficiaries in KidCare by the Child Health Policy Institute. Percentage of caregivers giving a rating of eight or higher to the question "how would you rate your child's health plan now?" is used. The families are considered satisfied if they give a rating of 8 or higher, with 10 being "best health plan possible." An established beneficiary had been enrolled in the program for six months.

VALIDITY:
The Caregiver surveys have undergone extensive field testing before use with the target populations. The Caregiver survey uses the CAHPS (Consumer Assessment of Health Plans Survey), a well-known and extremely reliable set of questions, that assesses not only consumer satisfaction but also several measures of well-child care. Those entering Medicaid through the traditional welfare application are not included. The surveys were combined and may not have been appropriately weighted given the difference in size of the populations and stratification of the original sample. Prior to the coming year, this issue will be addressed and if necessary the data revised. Measures were calculated separately for each program and these measures would not be affected.

RELIABILITY:
Given the extensive testing of the measures, they are quite reliable within normal statistical limitations.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
_X_ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Children's Special Health Care (KidCare Program)

ACTIVITY: Purchase MediKids Program Services
Purchase Children's Medical Services Network Services
Purchase Florida Healthy Kids Corporation Services

MEASURE: Total number of uninsured children enrolled in KidCare

DATA SOURCES AND METHODOLOGY:
Chapter 409, Florida Statutes, establishes the "Florida Kidcare Act" and authorizes health insurance coverage for low-income, previously uninsured children through the Florida Kidcare Program. The Florida Kidcare Program uses the Title XXI (State Children's Health Insurance Program) programmatic and funding provisions created by the federal Balanced Budget Act of 1997 to provide health benefits coverage to children through: Medicaid, MediKids as created in s. 409.8132, Florida Statutes; the Florida Healthy Kids Cooperation as created in s. 624.91, Florida Statutes; and the Children's Medical Services network established in Chapter 391, Florida Statutes.

A component of Florida Kidcare is the expansion of Medicaid eligibility to infants to age one whose family income is above 133 percent but no more than 200 percent of the federal poverty level and to teenagers up to age 19 who were born before October 1, 1983, whose family income is at or below 100 percent of the federal poverty level.

MediKids provides the same benefits as Medicaid to children ages 1 through 4 who are not eligible for Medicaid and whose family income is no greater than 200 percent of the federal poverty level. The program is not an entitlement, and families pay a low monthly premium.

Florida Healthy Kids is a public/private partnership that provides comprehensive health insurance for school-age children (ages 5 through 18). Coverage for children who are not eligible for Medicaid and whose family income is no greater than 200 percent of the federal poverty level is paid in part by federal Title XXI funds. Families pay a low monthly premium and the state must provide matching funds for Title XXI. Florida Healthy Kids also provides

coverage to children who are not eligible for Medicaid or Title XXI through a combination of family premiums and local and state funding. Families with incomes above 200 percent of the federal poverty level may purchase coverage for their children at the full price of the coverage.

The Children's Medical Services Network provides health care coverage for children under age 19 with special, on-going health care needs, who are not eligible for Medicaid, and whose family income is at or below 200 percent of the federal poverty level. The Behavioral Health Specialty Care Network works in partnership with the Children's Medical Services Network to provide comprehensive behavioral health services to children with severe needs.

The data sources used are the Medicaid Recipient Subsystem (eligibility file) of the Florida Medicaid Management Information System (FMMIS), the data system maintained and operated by the Florida Healthy Kids Corporation's third party administrator, and the data system maintained by the Children's Medical Services Network.

Using the Recipient Subsystem (eligibility file) and data provided by the Florida Healthy Kids third party administrator's system and the CMS Network data system, the number of children enrolled in the Florida KidCare program is determined using the enrollment as of June of the fiscal year except for the Medicaid expansion and the Medicaid outreach. (See separate performance measure validity and reliability forms for how the Medicaid expansion and Medicaid outreach caseloads are determined.)

VALIDITY:
The purpose is to identify the number of children who depend on the Florida KidCare program as their source of health care coverage.

RELIABILITY:
This is a basic figure to help put into context the number of children who depend on the Florida KidCare program for health care coverage. The reliability of the measure is excellent as it comes directly from enrollment data, except that the reliability of the number of children enrolled due to Medicaid outreach is not very reliable.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Children's Special Health Care (KidCare Program)

ACTIVITY: Purchase Florida Healthy Kids Corporation Services

MEASURE: Number of uninsured children enrolled in Florida Healthy Kids

DATA SOURCES AND METHODOLOGY:
Chapter 409, Florida Statutes, establishes the "Florida Kidcare Act" and authorizes health insurance coverage for low-income, previously uninsured children through the Florida Kidcare Program. The Florida Kidcare Program uses the Title XXI (State Children's Health Insurance Program) programmatic and funding provisions created by the federal Balanced Budget Act of 1997 to provide health benefits coverage to children through: Medicaid, MediKids as created in s. 409.8132, Florida Statutes; the Florida Healthy Kids Cooperation as created in s. 624.91, Florida Statutes; and the Children's Medical Services network established in Chapter 391, Florida Statutes.

Florida Healthy Kids is a public/private partnership that provides comprehensive health insurance for school-age children (ages 5 through 18). Coverage for children who are not eligible for Medicaid and whose family income is no greater than 200 percent of the federal poverty level is paid in part by federal Title XXI funds. Families pay a low monthly premium and the state must provide matching funds for Title XXI. Florida Healthy Kids also provides coverage to children who are not eligible for Medicaid or Title XXI through a combination of family premiums and local and state funding. Families with incomes above 200 percent of the federal poverty level may purchase coverage for their children at the full price of the coverage.

The data source used is the data system maintained and operated by the Florida Healthy Kids Corporation's third party administrator.

Using the data provided by the Florida Healthy Kids third party administrator's system, the number of children enrolled in the Florida Healthy Kids program is determined using the enrollment as of June of the fiscal year.

VALIDITY:
The purpose is to identify the number of children who depend on the Florida Healthy Kids program as their source of health care coverage.

RELIABILITY:
This is a basic figure to help put into context the number of children who depend on the Florida Healthy Kids program for health care coverage. The reliability of the measure is excellent as it comes directly from enrollment data.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Children's Special Health Care (KidCare Program)

ACTIVITY: Purchase MediKids Program Services

MEASURE: Number of uninsured children enrolled in MediKids

DATA SOURCES AND METHODOLOGY:
Chapter 409, Florida Statutes, establishes the "Florida Kidcare Act" and authorizes health insurance coverage for low-income, previously uninsured children through the Florida Kidcare Program. The Florida Kidcare Program uses the Title XXI (State Children's Health Insurance Program) programmatic and funding provisions created by the federal Balanced Budget Act of 1997 to provide health benefits coverage to children through: Medicaid, MediKids as created in s. 409.8132, Florida Statutes; the Florida Healthy Kids Cooperation as created in s. 624.91, Florida Statutes; and the Children's Medical Services network established in Chapter 391, Florida Statutes.

MediKids provides the same benefits as Medicaid to children ages 1 through 4 who are not eligible for Medicaid and whose family income is no greater than 200 percent of the federal poverty level. The program is not an entitlement, and families pay a low monthly premium.

The data sources used are the Medicaid Recipient Subsystem (eligibility file) of the Florida Medicaid Management Information System (FMMIS) and the data system maintained and operated by the Florida Healthy Kids Corporation's third party administrator.

Using the Recipient Subsystem (eligibility file) and the data provided by the Florida Healthy Kids third party administrator's system, the number of children enrolled in the MediKids program is determined using the enrollment as of June of the fiscal year.

VALIDITY:
The purpose is to identify the number of children who depend on MediKids as their source of health care coverage.

RELIABILITY:
This is a basic figure to help put into context the number of children who depend on MediKids for health care coverage. The reliability of the measure is excellent as it comes directly from enrollment data.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Children's Special Health Care (KidCare Program)

ACTIVITY: Purchase Children's Medical Services Network Services

MEASURE: Number of uninsured children enrolled in Children's Medical Services Network

DATA SOURCES AND METHODOLOGY:
Chapter 409, Florida Statutes, establishes the "Florida Kidcare Act" and authorizes health insurance coverage for low-income, previously uninsured children through the Florida Kidcare Program. The Florida Kidcare Program uses the Title XXI (State Children's Health Insurance Program) programmatic and funding provisions created by the federal Balanced Budget Act of 1997 to provide health benefits coverage to children through: Medicaid, MediKids as created in s. 409.8132, Florida Statutes; the Florida Healthy Kids Cooperation as created in s. 624.91, Florida Statutes; and the Children's Medical Services network established in Chapter 391, Florida Statutes.

The Children's Medical Services Network provides health care coverage for children under age 19 with special, on-going health care needs, who are not eligible for Medicaid, and whose family income is at or below 200 percent of the federal poverty level. The Behavioral Health Specialty Care Network works in partnership with the Children's Medical Services Network to provide comprehensive behavioral health services to children with severe needs.

The data sources used are the data system maintained and operated by the Florida Healthy Kids Corporation's third party administrator and the data system maintained and operated by Children's Medical Services (CMS). These systems include enrollment data.

Using the data provided by the Florida Healthy Kids third party administrator's system and the CMS Network's system, the number of children enrolled in the CMS Network is determined using the enrollment as of June of the fiscal year.

VALIDITY:
The purpose is to identify the number of children who depend on the CMS Network as their source of health care coverage.

RELIABILITY:
This is a basic figure to help put into context the number of children who depend on the CMS Network for health care coverage. The reliability of the measure is excellent as it comes directly from enrollment data.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Children's Special Health Care

ACTIVITY: Purchase MediKids Program Services

MEASURE: Number of case months

DATA SOURCES AND METHODOLOGY:

The data sources used for the measurement of case months are the Medicaid Recipient Subsystem (beneficiary enrollment file) of the Florida Medicaid Management Information System (FMMIS) and the data system maintained and operated by the Florida Healthy Kids Corporation's third party administrator. The Recipient Subsystem is the source of all beneficiary data for FMMIS as generated by the Florida On-line Recipient Integrated Data Access (FLORIDA) system and the Social Security Administration (SSA) through State Data Exchange (SDX). The Recipient Subsystem contains all the activities related to the status of beneficiaries enrolled for Medicaid and the MediKids program. The activities include the maintenance of a file of current and historical records of individuals enrolled for Medicaid; managed care enrollment and disenrollment status; control of benefit limitations (caps) for each beneficiary; nursing home, institutional care for the developmentally disabled, and patient responsibility data; and production of Medicaid identification cards. The Department of Children and Families (DCF) and the Social Security Administration (SSA) determine beneficiary eligibility. The Healthy Kids Corporation or its third party administrator conducts Medicaid eligibility screening and referral and verifies lack of enrollment in Medicaid and access to state employee benefits. Applicants that are found to be eligible for the MediKids program are enrolled in that program and the information is sent electronically to the FMMIS Recipient Subsystem. Actual case months are determined through the Recipient Subsystem by determining the sum of the total number of months each person was enrolled for the year.

VALIDITY:

The number of case months is an appropriate, valid measurement because it allows for comparisons between various programs and activities and for measuring differences in costs from year to year.

RELIABILITY:

The reliability of the measure is excellent. The data comes directly from the Recipient Subsystem and the Florida Healthy Kids' third party administrator system, which contains information by beneficiary of periods of enrollment.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Children's Special Health Care

ACTIVITY: Purchase Children's Medical Services Network Services

MEASURE: Number of case months

DATA SOURCES AND METHODOLOGY:

The data sources used for the measurement of case months are the data system maintained and operated by the Florida Healthy Kids Corporation's third party administrator and the data system maintained and operated by Children's Medical Services. The Healthy Kids Corporation or its third party administrator conducts Medicaid eligibility screening and referral and verifies lack of enrollment in Medicaid and access to state employee benefits. Applicants that are found to be eligible for the Children's Medical Services program are enrolled in that program and the information is sent electronically to the Children Medical Services Network enrollment files. Actual case months are determined through the systems by determining the sum of the total number of months each person was enrolled for the year.

VALIDITY:

The number of case months is an appropriate, valid measurement because it allows for comparisons between various programs and activities and for measuring differences in costs from year to year.

RELIABILITY:

The reliability of the measure is excellent. The data comes directly from the Florida Healthy Kids' third party administrator system and the CMS Network system that contains information by beneficiary of periods of enrollment.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Children's Special Health Care

ACTIVITY: Purchase Florida Healthy Kids Corporation Services

MEASURE: Number of case months

DATA SOURCES AND METHODOLOGY:

The data source used for the measurement of case months is the data system maintained and operated by the Florida Healthy Kids Corporation's third party administrator. The Healthy Kids Corporation or its third party administrator conducts Medicaid eligibility screening and referral and verifies lack of enrollment in Medicaid and access to state employee benefits. Applicants that are found to be eligible for the Florida Healthy Kids Program are enrolled in that program and the information is maintained on the third party administrator's data base system. Actual case months are determined through the system by determining the sum of the total number of months each person was enrolled for the year.

VALIDITY:

The number of case months an appropriate, valid measurement because it allows for comparisons between various programs and activities and for measuring differences in costs from year to year.

RELIABILITY:

The reliability of the measure is excellent. The data comes directly from the Florida Healthy Kids' third party administrator system that contains information by beneficiary of periods of enrollment.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
_X_ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Executive Direction and Support Services

ACTIVITY: Executive Direction

MEASURE: Program administrative costs as a percent of total program costs

DATA SOURCES AND METHODOLOGY:
The Agency's financial data is maintained in the Florida Accounting Information Resource (FLAIR) system. The programs administrative costs are first identified and then segregated from the program's total costs. The administrative costs are divided by the entire program's costs to arrive at the measurement.

VALIDITY:
The measure is a valid tool to determine what percentage the program's administrative costs are of its total costs.

RELIABILITY:
The FLAIR data can only be accessed by authorized personnel. The data is reconciled on a regular basis, ensuring accuracy and reliability.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
_X_ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Executive Direction and Support Services

ACTIVITY: Fiscal Agent Contract

MEASURE: Average number of days between receipt of clean Medicaid claim and payment

DATA SOURCES AND METHODOLOGY:
The data source is the monthly and yearly statistical claims reports generated from the Medicaid Claims History File of the Florida Medicaid Management Information System (FMMIS).

This measure is calculated as the total number of days to pay all claims divided by the total number of clean claims for the fiscal year. A "clean claim" is defined to be a claim the system can adjudicate and process, then pay or deny payment and does not include claims that are suspended. The date of receipt for a claim is the date the claim form enters the mailroom or is electronically received. The date adjudicated is the date the system adjudicates the claim.

VALIDITY:
This calculation measures the efficiency of the state's fiscal agent in processing claims submitted by Medicaid providers. The Medicaid program relies on enrolled providers to meet the needs of Florida's Medicaid beneficiaries. Continued participation in the Medicaid program is influenced by the level of efficiency in processing claims.

RELIABILITY:
Claims are received and processed by the Medicaid fiscal agent in a highly controlled and monitored process. Processing is under the control of the Florida Medicaid Management Information System (FMMIS), subject to regular monitoring by State staff and annual Electronic Data Processing (EDP) auditing. Fields on the claim form indicate the date a claim was received by the fiscal agent, what its disposition was, and the date a check was issued in payment. From other fields on the claim, it can be determined whether the claim was "clean" and subject to payment without further review. The reports to make these calculations have not yet been developed and tested. When they are put in place, they will become a regular part of the FMMIS, subject to the system's monitoring and auditing requirements.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Executive Direction and Support Services

ACTIVITY: Fiscal Agent Contract

MEASURE: Number of Medicaid claims received

DATA SOURCES AND METHODOLOGY:
The data source is the monthly and yearly statistical claims reports generated from the Medicaid Claims History File of the Florida Medicaid Management Information System (FMMIS).

This measure calculated as the total number of line items on a claim form or electronic record submitted to the fiscal agent by the provider for Medicaid reimbursement for services rendered to a Medicaid beneficiary for the fiscal year. Each line item on a submission receives its own serial number and is counted as separate claim.

VALIDITY:
"Number of claims received" is used as the denominator in fractions which measure percentage of claims paid and denied and to assure that the universe of claims is considered in measuring the length of time to process claims. The Medicaid program relies on enrolled providers to meet the needs of Florida's Medicaid beneficiaries. Continued participation in the Medicaid program is influenced by the level of efficiency in processing claims submitted by Medicaid providers.

RELIABILITY:
Claims are received and processed by the Medicaid fiscal agent in a highly controlled and monitored process. Computer systems assign a serial number to each claim received. Balancing reports are produced daily and weekly under the control of the Florida Medicaid Management Information System (FMMIS), subject to regular monitoring by State staff and annual Electronic Data Processing (EDP) auditing.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Medicaid Services to Individuals

ACTIVITY: Elderly and Disabled/Fee for Service/MediPass—Hospital Inpatient
Women and Children/Fee for Service/MediPass—Hospital Inpatient
Medically Needy/Fee for Service/MediPass—Hospital Inpatient
Refugees/Fee for Service/MediPass—Hospital Inpatient

MEASURE: Percent of hospitalizations for conditions preventable by good ambulatory care

DATA SOURCES AND METHODOLOGY:
The data source is the State Center for Health Statistics' hospital discharge data. All hospitalizations for individuals in which a Medicaid HMO and Medicaid Non-HMO are reported as the payers are abstracted from the hospital discharge file. Hospitalizations for which the primary International Classification of Diseases (ICD)-9 code is maternity or mental health are first excluded. The remaining hospitalizations are classified as to whether the primary ICD-9 code is ambulatory sensitive. Those classified as ambulatory sensitive are counted and become the numerator. The denominator is the total number of hospitalizations for any condition excluding those for maternity or mental health.

VALIDITY:
Validity of the measure is fair. A condition is considered ambulatory sensitive if provision of quality care could reduce or eliminate the need for hospitalization. Some hospitalizations will always occur due to patient non-compliance. However, Medicaid providers are expected to work with patients to increase their likelihood of compliance in addition to providing direct treatment. The codes used to classify a hospital visit as ambulatory sensitive are a conservative number developed by Weissman as reported in "Rates of Avoidable Hospitalizations by Insurance Status in Massachusetts and Maryland", *Journal of the American Medical Association,* November 4, 1992. Some researchers have used additional conditions. In order to understand the data better, AHCA also obtains the measure using a broader list derived from other literature.

RELIABILITY:
The reliability of the measure is high. Hospitals provide the information to AHCA and must certify that it is accurate. The ICD-9 codes are used for billing, hospital report cards etc. so hospitals have incentives to be accurate in their use of these codes. Incentives for mistakes favor not classifying a condition as ambulatory sensitive. The payer source is less accurate. Payer source is coded when the patient enters the hospital and may not be known. There is no expectation that inaccuracies in payer classification would be related to the reason for hospitalization. Since the measure is based on the ratio of the two types of hospitalization and not absolute numbers the figure should be reliable for the purpose.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
_X_ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Medicaid Services to Individuals

ACTIVITY: Women and Children/Fee for Service/MediPass

MEASURE: Percent of women receiving adequate prenatal care

DATA SOURCES AND METHODOLOGY:
The data source is the Medicaid Maternal and Child Health Program Development Project Final Report, for the year for which data provided. Historical data is obtained for the report April through June 1998. This data is taken directly from the report prepared by the University of South Florida (USF). Adequate prenatal care is defined as prenatal care initiation begun earlier than the 5th month of pregnancy or more than 50% of prenatal visits were received (adjusted for gestational age). Data on the timing and number of prenatal visits is obtained from birth certificate data for women found to be Medicaid eligible by matching the birth certificate data with the Medicaid eligibility file. The percent is derived by dividing the number of Medicaid eligible women receiving adequate prenatal care by the total number of women delivering who were Medicaid eligible during their pregnancy.

VALIDITY:
Over 40 percent of women giving birth were Medicaid eligible during their pregnancy. Timely diagnosis and treatment of pre-pregnancy complications or reducing risk factors amenable to treatment improve birth outcomes. The measure (Kotelchuch APNCU index) takes into account when prenatal care was initiated and the expected number of prenatal visits based on prenatal care visitation standards. It does not measure the quality or content of the care provided. Medicaid providers are expected to meet quality standards and refer high-risk recipients to Healthy Start for additional services. MediPass physicians who serve as gatekeepers for Medicaid recipients electing this form of managed are to coordinate pregnancy benefits and ensure that enrollees access prenatal care early in their pregnancy. Recipients are not necessarily enrolled in Medicaid through out their pregnancy. Some only become eligible when pregnant. The longer the individual was enrolled in Medicaid during their pregnancy, the better Medicaid does on this measure. In 1996, the percent with adequate care was 88.7 percent for those in

Medicaid over 180 days during their pregnancy and 74.9 percent for those enrolled less than 180 days.

The data, definitions, and calculation procedures are reviewed annually by a data committee that includes representatives of the Agency for Health Care Administration, Department of Health, Center for Disease Control, and other experts.

RELIABILITY:
Reliability of the measure is high. The measure is only as accurate as the birth certificate and eligibility files. The Department of Health is responsible for maintaining the birth certificate file. Inaccuracies have been documented particularly in the prenatal care and gestational age data. Inaccuracies are not serious enough to jeopardize comparisons between programs or over time. Eligibility files are the responsibility of the Department of Children and Families. Early in the development of the eligibility system, some inaccuracies were found. The system is now considered accurate. It forms the basis on which claims for Medicaid services are paid.

Another source of potential error is the matching of the two files. Currently, a deterministic match between social security numbers is used. If a social security number is missing from a file, the file is omitted from the analysis. In 1996, 4.1 percent of the files were missing a social security number. Further, if a case was missing a value needed for the calculation the record was omitted from the analysis. Gestational age was computed based on the clinical estimate as listed on the birth certificate. If this was not present, the date of last menses as indicated on the birth certificate was used to estimate gestational age. If neither were present, the conception was computed as 270 days prior to delivery date. USF verified computer coding used in the analyses using a different analyst than originally created the code. Some problems were found. All programs are now considered accurate.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Medicaid Services to Individuals

ACTIVITY: Women and Children/Fee for Service/MediPass

MEASURE: Neonatal mortality rate per 1,000

DATA SOURCES AND METHODOLOGY:
The data source is the Medicaid Maternal and Child Health Program Development Project Final Report, for the year. Historical data is obtained from the April through June 1998 report. This data is taken directly from the report prepared by the University of South Florida (USF). The neonatal mortality rate is defined as the number of deaths of infants less than 28 days old per 1,000 deliveries. To obtain information about the Medicaid population, death certificate information is merged with Medicaid eligibility files. The number of deaths of infants to women who were Medicaid eligible during their pregnancy is then divided by the total number of women who were eligible for Medicaid during their pregnancy.

VALIDITY:
Neonatal mortality is a reflection of problems in the newborn that are linked to the pregnancy and delivery services. The Medicaid program wants to ensure that the quality of care provided to recipients is such as to minimize the incidence of adverse outcomes.

The data, definitions, and calculation procedures are reviewed annually by a data committee that includes representatives of the Agency for Health Care Administration, Department of Health, Center for Disease Control, and other experts.

RELIABILITY:
The measure is very reliable. The Department of Health is responsible for maintaining the death certificate file. Eligibility files are the responsibility of the Department of Children and Families. Early in the development of the eligibility system, some inaccuracies were found. The system is now considered accurate. It forms the basis on which claims for Medicaid services are paid.

Another source of potential error is the matching of the two files. Currently, a deterministic match between social security numbers is used. If a social security number is missing from a file, the file is omitted from the analysis. 1.21 percent of the death files were missing a social security number.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Medicaid Services to Individuals

ACTIVITY: Women and Children/Fee for Service/MediPass

MEASURE: Average number of months between pregnancies for those receiving family planning services

DATA SOURCES AND METHODOLOGY:
The data source is the Medicaid claims data from the Florida Medicaid Management Information System (FMMIS) that has been merged with a data set maintained by the University of Florida (USF) which contains Medicaid eligibility, birth certificate, death certificate, Healthy Start, and Women Infant and Children data related to women giving birth in Florida for each year since 1991.

Medicaid extracts claims for a year, which contains the social security number of the person. USF compares this information to the number of women giving birth in the following year and identifies those who had a birth. The inter-pregnancy interval for the women so identified is then calculated. The inter-pregnancy interval is calculated by subtracting the date of the last pregnancy for these women from the date of the last menstrual as reported on the birth certificate divided by the number of women identified as giving birth who had a pregnancy in the prior year.

VALIDITY:
This measure raises questions about how receipt of family planning services is determined. Thus, its validity is questionable.

RELIABILITY:
The reliability is considered high; although the measure is only as accurate as the birth certificate, FMMIS, system, and eligibility files. The Department of Health is responsible for maintaining the birth certificate file. Inaccuracies have been documented in date of last menses, which resulted in some deliveries having a negative value for the inter-pregnancy interval. Problems were most likely due to poor data collection or data entry. These cases were

eliminated from the analysis. Inaccuracies are not serious enough to jeopardize comparisons between programs or over time. Eligibility files are the responsibility of the Department of Children and Families. Early in the development of the eligibility system, some inaccuracies were found. The system is now considered accurate. It forms the basis on which claims for Medicaid services are paid. FMMIS data regarding services received is quite accurate, although some variation in number could occur as a result of the time that the extract from FMMIS is made. Providers have up to two years to submit claims and thus a few may be missed in order to present information in a more timely manner.

Another source of potential error is the matching of the three files. Currently, a deterministic match between social security numbers is used. If a social security number is missing from a file, the file is omitted from the analysis. In 1996, 4.1 percent of the birth certificate files were missing a social security number. Further if a case was missing a value needed for the calculation the record was omitted from the analysis. USF verified computer coding used in the analyses using a different analyst than originally created the code. Some problems were found. All programs are now considered accurate.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Medicaid Services to Individuals

ACTIVITY: Women and Children/Fee for Service/MediPass

MEASURE: Percent of eligible children who received all required components of EPSDT screen

DATA SOURCES AND METHODOLOGY:
The data source is the Medicaid Claims History File from the Florida Medicaid Management Information System (FMMIS), which is a complete year of claims processed and utilization data submitted by the Medicaid Health Maintenance Organizations (HMOs). This data is obtained from the FMMIS Annual EPSDT Participation Report Health Care Financing Administration (HCFA)-416 for the year reported. The report is extracted from FMMIS using specified procedure codes and the utilization reports required from the HMOs.

VALIDITY:
The measure is a required measure by the federal Centers for Medicare and Medicaid Services (CMS) and is considered a critical element of quality. ESPDT screening is designed to ensure that health problems are detected early so that future problems can be averted. For example, vision or hearing problems can be detected and corrected prior to a child experiencing poor academic performance. Screening requirements meet the American Academy of Pediatrics guidelines for quality.

RELIABILITY:
CMS issues detailed guidelines on how the measure is to be calculated. The General Accounting Office found that inaccuracies still existed. As of March 1998 CMS issued some new guidelines for completing the form. The instructions and forms were developed by a national work group composed of representatives from CMS central and regional offices, state Medicaid officials, state Maternal and Child Health administrators, the American Public Welfare Association and the American Academy or Pediatrics.

The numbers are only as good as the FFMIS system and HMO reporting. Some variation in number could occur as a result of the time that the extract from FFMIS is made. Providers have up to two years to submit claims and thus a few may be missed in order to present information in a more timely manner. Some oversight is provided to HMO utilization reporting, but full audits have not been conducted. However, numbers obtained from these sources are similar to those obtained from a review of a random sample of recipient files by the peer review organization.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Medicaid Services to Individuals

ACTIVITY: Women and Children/Fee for Service/MediPass

MEASURE: Number of children ages 1-20 enrolled in Medicaid

DATA SOURCES AND METHODOLOGY:
The data source is the Medicaid Claims History from the Florida Medicaid Management Information System (FMMIS) accessed through the Program Analysis Data Warehouse.

Using the data warehouse claim table, an unduplicated count is made for all beneficiaries who have at least one month of eligibility during the fiscal year and are between the ages of 1 and 20.

VALIDITY:
The purpose is to identify the number of children (age 1-20) who are enrolled in Medicaid during the fiscal year.

RELIABILITY:
The unduplicated population can be reliably calculated.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Medicaid Services to Individuals

ACTIVITY: Women and Children/Fee for Service/MediPass

MEASURE: Number of children receiving EPSDT services

DATA SOURCES AND METHODOLOGY:
The data source is the Medicaid Claims History from the Florida Medicaid Management Information System (FMMIS) accessed through the Program Analysis Data Warehouse.

Using the data warehouse claim table, an unduplicated count is made for all beneficiaries who have at least one claim for the EPSDT (Early Periodic Screening Diagnosis and Treatment) procedure code during the fiscal year and are between the ages of 1 and 20.

VALIDITY:
The purpose is to identify the number of children (age 1-20) who received child health screening service in the year.

RELIABILITY:
The unduplicated population can be reliably calculated. However this figure does not include the frequency of screening services for children or whether the appropriate referrals from the screenings occurred.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Medicaid Services to Individuals

ACTIVITY: Women and Children/Fee for Service/MediPass—Hospital Inpatient

MEASURE: Number of hospital inpatient services provided to children

DATA SOURCES AND METHODOLOGY:
The data source is the Medicaid Claims History from the Florida Medicaid Management Information System (FMMIS) accessed through the Program Analysis Data Warehouse.

Using the data warehouse claim table, a count is made of the number of paid claims for children (ages1-20) for hospital inpatient admits for the fiscal year.

VALIDITY:
This measure helps to identify the volume of hospital inpatient services the Medicaid children population receives in a year.

RELIABILITY:
The number of hospital inpatient services can be reliably calculated for fee-for-service settings. These figures do not include HMO (Health Maintenance Organization) services to children.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Medicaid Services to Individuals

ACTIVITY: Women and Children/Fee for Service/MediPass—Physician Services

MEASURE: Number of physician services provided to children

DATA SOURCES AND METHODOLOGY:
The data source is the Medicaid Claims History from the Florida Medicaid Management Information System (FMMIS) accessed through the Program Analysis Data Warehouse.

Using the data warehouse claim table, a count is made of the number of paid claims for children (ages 1-20) for physician services for the fiscal year.

VALIDITY:
This measure helps to identify the volume of physician services the Medicaid children population receives in a year.

RELIABILITY:
The number of physician services can be reliably calculated for fee-for-service settings. These figures do not include HMO (Health Maintenance Organization) services to children. For physician services, it consolidates a mixture of services to include visits, radiology, pathology, surgery and all other physician services.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
_X_ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Medicaid Services to Individuals

ACTIVITY: Women and Children/Fee for Service/MediPass—Prescribed Medicines

MEASURE: Number of prescribed drugs provided to children

DATA SOURCES AND METHODOLOGY:
The data source is the Medicaid Claims History from the Florida Medicaid Management Information System (FMMIS) accessed through the Program Analysis Data Warehouse.

Using the data warehouse claim table, a count is made of the number of paid claims for children (ages 1-20) for prescriptions for the fiscal year.

VALIDITY:
This measure helps to identify the volume of prescribed drug services the Medicaid children population receives in a year.

RELIABILITY:
The number of prescribed drug services can be reliably calculated for fee-for-service settings. These figures do not include HMO (Health Maintenance Organization) services to children. Prescriptions include all types of drugs, dosages and days supply.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Medicaid Services to Individuals

ACTIVITY: Elderly and Disabled/Fee for Service/MediPass—Hospital Inpatient

MEASURE: Number of hospital inpatient services provided to elders

DATA SOURCES AND METHODOLOGY:
The data source is the Medicaid Claims History from the Florida Medicaid Management Information System (FMMIS) accessed through the Program Analysis Data Warehouse.

Using the data warehouse claim table, a count is made of the number of paid claims for the elderly (age 65+) for hospital inpatient admits for the fiscal year.

VALIDITY:
This measure helps to identify the volume of hospital inpatient services the Medicaid elderly population receives in a year.

RELIABILITY:
The number of hospital inpatient services can be reliably calculated for fee-for-service settings. These figures do not include HMO (Health Maintenance Organization) services to the elderly.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Medicaid Services to Individuals

ACTIVITY: Elderly and Disabled/Fee for Service/MediPass—Physician Services

MEASURE: Number of physician services provided to elders

DATA SOURCES AND METHODOLOGY:
The data source is the Medicaid Claims History from the Florida Medicaid Management Information System (FMMIS) accessed through the Program Analysis Data Warehouse.

Using the data warehouse claim table, a count is made of the number of paid claims for the elderly (age 65+) for physician services for the fiscal year.

VALIDITY:
This measure helps to identify the volume of physician services the Medicaid elderly population receives in a year.

RELIABILITY:
The number of physician services can be reliably calculated for fee-for-service settings. These figures do not include HMO (Health Maintenance Organization) services to the elderly. For physician services, it consolidates a mixture of services to include visits, radiology, pathology, surgery and all other physician services.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Medicaid Services to Individuals

ACTIVITY: Elderly and Disabled/Fee for Service/MediPass—Prescribed Drugs

MEASURE: Number of prescribed drugs provided to elders

DATA SOURCES AND METHODOLOGY:
The data source is the Medicaid Claims History from the Florida Medicaid Management Information System (FMMIS) accessed through the Program Analysis Data Warehouse.

Using the data warehouse claim table, a count is made of the number of paid claims for the elderly (age 65+) for prescriptions for the fiscal year.

VALIDITY:
This measure helps to identify the volume of prescribed drug services that the Medicaid elderly population receives in a year.

RELIABILITY:
The number of prescribed drug services can be reliably calculated for fee-for-service settings. These figures do not include HMO (Health Maintenance Organization) services to the elderly. Prescriptions include all types of drugs, dosages and days supply.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Medicaid Services to Individuals

ACTIVITY: Women and Children/Fee for Service/MediPass

MEASURE: Number of uninsured children enrolled in the Medicaid expansion

DATA SOURCES AND METHODOLOGY:
Chapter 409, Florida Statutes, establishes the "Florida Kidcare Act" and authorizes health insurance coverage for low-income, previously uninsured children through the Florida Kidcare Program. The Florida Kidcare Program uses the Title XXI (State Children's Health Insurance Program) programmatic and funding provisions created by the federal Balanced Budget Act of 1997 to provide health benefits coverage to children through: Medicaid, MediKids as created in s. 409.8132, Florida Statutes; the Florida Healthy Kids Cooperation as created in s. 624.91, Florida Statutes; and the Children's Medical Services network established in Chapter 391, Florida Statutes.

A component of Florida Kidcare is the expansion of Medicaid eligibility to infants to age one whose family income is above 133 percent but no more than 200 percent of the federal poverty level and to teenagers up to age 19 who were born before October 1, 1983, whose family income is at or below 100 percent of the federal poverty level.

The data source used is the Medicaid Recipient Subsystem (eligibility file) of the Florida Medicaid Management Information System (FMMIS).

Using the Recipient Subsystem (eligibility file), the number of children enrolled in the Medicaid expansion is determined using the highest number enrolled during the month that had the highest enrollment for the fiscal year. (The caseload for this eligibility group is declining because the teens are aging out.)

VALIDITY:
The purpose is to identify the number of children who depend on the Medicaid expansion under the Kidcare Program as their source of health care coverage.

RELIABILITY:
This is a basic figure to help put into context the number of children who depend on the Medicaid expansion of eligibility under the Kidcare Program for health care coverage. The reliability of the measure is excellent as it comes directly from enrollment data.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Medicaid Services to Individuals

ACTIVITY: Women and Children/Fee for Service/MediPass

MEASURE: Number of uninsured children enrolled in Medicaid as a result of outreach efforts

DATA SOURCES AND METHODOLOGY:
The data source used is the Medicaid Recipient Subsystem (eligibility file) of the Florida Medicaid Management Information System (FMMIS).

Using the Recipient Subsystem (eligibility file) the number of children enrolled in the Medicaid program through outreach is estimated by calculating the total number of children enrolled as of the end of the year compared to the number of children enrolled as of the period when outreach efforts began. The enrollment number is capped at the number that the original funding anticipated (85,000).

VALIDITY:
The purpose is to identify the number of children who have become eligible for Medicaid primarily as the result of outreach activities.

RELIABILITY:
This is a basic figure to help put into context the number of children who depend on Medicaid for health care coverage and who were enrolled due to outreach activities. This measure is not very reliable because there is no definitive method of identifying children who are enrolled because of outreach.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Medicaid Services to Individuals

ACTIVITY: All

MEASURE: Number of case months Medicaid program services purchased

DATA SOURCES AND METHODOLOGY:

The data sources used for the measurement of case months are the Medicaid Recipient Subsystem (beneficiary enrollment file) of the Florida Medicaid Management Information System (FMMIS), and caseload projections adopted by the Social Services Estimating Conference for Medicaid caseload. The Recipient Subsystem is the source of all beneficiary data for FMMIS as generated by the Florida On-line Recipient Integrated Data Access (FLORIDA) system and the Social Security Administration (SSA) through State Data Exchange (SDX). The Recipient Subsystem contains all the activities related to the status of beneficiaries enrolled for Medicaid services. The activities include the maintenance of a file of current and historical records of individuals enrolled in Medicaid; managed care enrollment and disenrollment status; control of benefit limitations (caps) for each beneficiary; nursing home, institutional care for the developmentally disabled, and patient responsibility data; and production of Medicaid identification cards. The Department of Children and Families (DCF) and the Social Security Administration (SSA) determine beneficiary eligibility. Chapter 216, Florida Statutes, requires the Social Services Estimating Conference and that each state agency use the official information developed by the consensus estimating conferences in carrying out its duties under the state planning and budgeting system. The Social Services Estimating Conference adopts consensus projections of Medicaid caseload and expenditures at separate conferences. Using regression analyses of actual enrollment trends by major beneficiary groups and evaluation of the impact of eligibility policies, the conference adopts a consensus estimate of the Medicaid enrollment by month for the current fiscal year and for the subsequent fiscal year for which the funding needs are being developed. The caseloads are estimated for each major beneficiary group and within each beneficiary group by fee-for-service, MediPass, and HMO/prepaid health plan. Actual case months are determined through the Recipient Subsystem by determining the sum of the total number of months each person was enrolled for the year, by beneficiary group and by whether

the case month is a fee-for-service, MediPass or HMO/prepaid health plan case month. Estimated case months are determined by adding the total case months adopted by the Social Services Estimating Conference for each beneficiary group by fee-for-service, MediPass or HMO/prepaid health plan case month.

VALIDITY:

The number of case months the Medicaid program services purchased is an appropriate, valid measurement because it allows for comparisons between various programs and activities and for measuring differences in costs from year to year.

RELIABILITY:

The reliability of the measure is excellent. The data comes directly from the Recipient Subsystem that contains information by beneficiary of periods of Medicaid enrollment. The data also comes from the statutorily mandated Social Services Estimating Conference. The conference data is analyzed and a consensus beneficiary enrollment estimate is adopted by the principals of the conference including staff from the Executive Office of the Governor, the Office of Economic and Demographic Research, the Senate, the House of Representatives, the Agency for Health Care Administration, and the Department of Children and Families.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Medicaid Long-Term Care

ACTIVITY: Nursing Home Care
Home and Community-Based Services
Mental Health Disproportionate Share Program
Capitated Nursing Home Diversion Waiver

MEASURE: Percent of hospitalizations for conditions preventable with good ambulatory care

DATA SOURCES AND METHODOLOGY:
The data source is all Medicaid paid claims data for those months in which AHCA made a payment for long term care services on behalf of someone who is developmentally disabled. (Home and Community based waiver services, Supported Living waiver services or Intermediate Care Facility Care Facility for the Developmentally Disabled).

Claims data are examined to determine for whom a payment was made for long-term care services. All claims for the month a payment was made are obtained. Claims are sorted by age of recipient. A recipient is only included once even in months when payments may be for more than one of the programs.

For persons 65 or over, hospitalizations with a primary International Classification of Diseases (ICD)-9 code for maternity or mental health conditions is excluded. All remaining hospitalizations are counted for the denominator. The remaining hospitalizations are then classified as to whether the primary ICD-9 code is ambulatory sensitive. Those classified as ambulatory sensitive are counted and become the numerator.

VALIDITY:
Validity of the measure is fairly high. Some recipients may be eligible for Medicare. If eligible for Medicare, hospital claims are paid for by Medicare. This should not affect the relative ratio of hospitalizations. A condition is considered ambulatory sensitive if provision of quality care could reduce or eliminate the need for hospitalization. Some hospitalizations will always occur due to patient non-compliance. However, Medicaid providers are expected to work with patients

to increase their likelihood of compliance in addition to providing direct treatment. The hospital file does not designate whether someone is disabled or not, so this measure may include non-disabled people. The codes used to classify a hospital visit as ambulatory sensitive are a conservative number developed by Weissman as reported in "Rates of Avoidable Hospitalizations by Insurance Status in Massachusetts and Maryland" *Journal of the American Medical Association,* November 4, 1992. Some researchers have used additional conditions. The denominator used is other hospitalizations. Some researchers have used this to control for risk. Others have used the population enrolled as the denominator. This would be problematic for this population because Medicare pays for many claims.

RELIABILITY:

The reliability of the measure is fairly high. Although the ICD-9 codes are used for Medicare billing and reporting for the hospital discharge file, Medicaid reimbursement is not tied to ICD-9 codes. The accuracy of the ICD-9 information is only checked on a sample basis, as part of peer review of hospital care, so there is potential for error in the recorded diagnostic code. Projections are less reliable as the size of the relationship between programs, expenditures, and incidence in the population are not known with precision.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Medicaid Long Term Care

ACTIVITY: Home and Community-Based Services

MEASURE: Number of case months (home and community-based services)

DATA SOURCES AND METHODOLOGY:
The data source is the Medicaid Claims History from the Florida Medicaid Management Information System (FMMIS) accessed through the Program Analysis Data Warehouse.

Using the data warehouse claim table, an unduplicated count is made by month of all beneficiaries who had a least one claim during the month for a home and community-based service. The unduplicated count for each month is totaled to determine the number of case months provided for home and community-based services a year.

VALIDITY:
This measure helps to identify the volume of case months provided to Medicaid beneficiaries for home and community-based services during a year.

RELIABILITY:
The reliability of the measure is excellent as it comes directly from paid claims history data.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
_X_ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Medicaid Long Term Care

ACTIVITY: Nursing Home Care

MEASURE: Number of case months services purchased (Nursing Home)

DATA SOURCES AND METHODOLOGY:
The data source is the Medicaid Claims History from the Florida Medicaid Management Information System (FMMIS) accessed through the Program Analysis Data Warehouse.

Using the data warehouse claim table, an unduplicated count is made by month of all beneficiaries who had a least one claim during the month for nursing home services. The unduplicated count for each month is totaled to determine the number of case months provided for nursing home services for the fiscal year.

VALIDITY:
This measure helps to identify the volume of case months provided to Medicaid beneficiaries for nursing home services during a year.

RELIABILITY:
The reliability of the measure is excellent as it comes directly from paid claims history data.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
_X_ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Medicaid Long Term Care

ACTIVITY: All

MEASURE: Number of case months Medicaid program services purchased

DATA SOURCES AND METHODOLOGY:

The data sources used for the measurement of case months are the Medicaid Recipient Subsystem (beneficiary enrollment file) of the Florida Medicaid Management Information System (FMMIS), and caseload projections adopted by the Social Services Estimating Conference for Medicaid caseload. The Recipient Subsystem is the source of all beneficiary data for FMMIS as generated by the Florida On-line Recipient Integrated Data Access (FLORIDA) system and the Social Security Administration (SSA) through State Data Exchange (SDX). The Recipient Subsystem contains all the activities related to the status of beneficiaries enrolled for Medicaid services. The activities include the maintenance of a file of current and historical records of individuals enrolled in Medicaid; managed care enrollment and disenrollment status; control of benefit limitations (caps) for each beneficiary; nursing home, institutional care for the developmentally disabled, and patient responsibility data; and production of Medicaid identification cards. The Department of Children and Families (DCF) and the Social Security Administration (SSA) determine beneficiary eligibility. Chapter 216, Florida Statutes, requires the Social Services Estimating Conference and that each state agency use the official information developed by the consensus estimating conferences in carrying out its duties under the state planning and budgeting system. The Social Services Estimating Conference adopts consensus projections of Medicaid caseload and expenditures at separate conferences. Using regression analyses of actual enrollment trends by major beneficiary groups and evaluation of the impact of eligibility policies, the conference adopts a consensus estimate of the Medicaid enrollment by month for the current fiscal year and for the subsequent fiscal year for which the funding needs are being developed. The caseloads are estimated for each major beneficiary group and within each beneficiary group by fee-for-service, MediPass, and HMO/prepaid health plan. Actual case months are determined through the Recipient Subsystem by determining the sum of the total number of months each person was enrolled for the year, by beneficiary group and by whether the case month is a fee-for-service, MediPass or HMO/prepaid

health plan case month. Estimated case months are determined by adding the total case months adopted by the Social Services Estimating Conference for each beneficiary group by fee-for-service, MediPass or HMO/prepaid health plan case month.

VALIDITY:

The number of case months the Medicaid program services purchased is an appropriate, valid measurement because it allows for comparisons between various programs and activities and for measuring differences in costs from year to year.

RELIABILITY:

The reliability of the measure is excellent. The data comes directly from the Recipient Subsystem that contains information by beneficiary of periods of Medicaid enrollment. The data also comes from the statutorily mandated Social Services Estimating Conference. The conference data is analyzed and a consensus beneficiary enrollment estimate is adopted by the principals of the conference including staff from the Executive Office of the Governor, the Office of Economic and Demographic Research, the Senate, the House of Representatives, the Agency for Health Care Administration, and the Department of Children and Families.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Medicaid Prepaid Health Plans

ACTIVITY: Prepaid Health Plans—Elderly and Disabled

MEASURE: Percent of hospitalizations for conditions preventable by good ambulatory care

DATA SOURCES AND METHODOLOGY:
The data source is the State Center for Health Statistics hospital discharge data. All hospitalizations for individuals in which a Medicaid HMO is reported as the payer are abstracted from the hospital discharge file. The non-elderly women and children are extracted for another measure. The remaining hospitalizations are counted for this measure. Hospitalizations for which the primary International Classification of Diseases (ICD)-9 code is maternity or mental health are first excluded. The remaining hospitalizations are classified as to whether the primary ICD-9 code is ambulatory sensitive. Those classified as ambulatory sensitive are counted and become the numerator. The denominator is the total number of hospitalizations for any condition excluding those for maternity or mental health.

VALIDITY:
Validity of the measure is fair. A condition is considered ambulatory sensitive if provision of quality care could reduce or eliminate the need for hospitalization. Some hospitalizations will always occur due to patient non-compliance. However, Medicaid providers are expected to work with patients to increase their likelihood of compliance in addition to providing direct treatment. The hospital discharge file does not denote whether someone is disabled, and since this file is created with the remainder of hospitalizations after non-elderly women and children are excluded, there may be non-disabled individuals counted for this measure. The codes used to classify a hospital visit as ambulatory sensitive are a conservative number developed by Weissman as reported in "Rates of Avoidable Hospitalizations by Insurance Status in Massachusetts and Maryland" *Journal of the American Medical Association,* November 4, 1992. Some researchers have used additional conditions. In order to understand the data better, AHCA also obtains the measure using a broader list derived from other literature.

RELIABILITY:
The reliability of the measure is high. Hospitals provide the information to AHCA and must certify that it is accurate. The ICD-9 codes are used for billing, hospital report cards etc. so hospitals have incentives to be accurate in their use of these codes. Incentives for mistakes favor not classifying a condition as ambulatory sensitive. The payer source is less accurate. Payer source is coded when the patient enters the hospital and may not be known. There is no expectation that inaccuracies in payer classification would be related to the reason for hospitalization. Since the measure is based on the ratio of the two types of hospitalization and not absolute numbers the figure should be reliable for the purpose.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form when submitting the long-range program plan for all existing approved measures, when requesting revisions to approved measures, and when requesting new measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Medicaid Prepaid Health Plans

ACTIVITY: Prepaid Health Plans—Families

MEASURE: Percent of women and child hospitalizations for conditions preventable with good ambulatory care

DATA SOURCES AND METHODOLOGY:
The data source is the State Center for Health Statistics hospital discharge data. All hospitalizations for individuals in which a Medicaid HMO is reported as the payer are abstracted from the hospital discharge file. The non-elderly women and children are extracted for this measure. Hospitalizations for which the primary International Classification of Diseases (ICD)-9 code is maternity or mental health are first excluded. The remaining hospitalizations are classified as to whether the primary ICD-9 code is ambulatory sensitive. Those classified as ambulatory sensitive are counted and become the numerator. The denominator is the total number of hospitalizations for any condition excluding those for maternity or mental health.

VALIDITY:
Validity of the measure is (fairly) high. A condition is considered ambulatory sensitive if provision of quality care could reduce or eliminate the need for hospitalization. Some hospitalizations will always occur due to patient non-compliance. However, Medicaid providers are expected to work with patients to increase their likelihood of compliance in addition to providing direct treatment. The codes used to classify a hospital visit as ambulatory sensitive are a conservative number developed by Weissman as reported in "Rates of Avoidable Hospitalizations by Insurance Status in Massachusetts and Maryland" *Journal of the American Medical Association,* November 4, 1992. Some researchers have used additional conditions. In order to understand the data better, AHCA also obtains the measure using a broader list derived from other literature.

RELIABILITY:
The reliability of the measure is high. Hospitals provide the information to AHCA and must certify that it is accurate. The ICD-9 codes are used for billing, hospital report cards etc. so hospitals have incentives to be accurate in their use of these codes. Incentives for mistakes favor not classifying a condition as ambulatory sensitive. The payer source is less accurate. Payer source is coded when the patient enters the hospital and may not be known. There is no

expectation that inaccuracies in payer classification would be related to the reason for hospitalization. Since the measure is based on the ratio of the two types of hospitalization and not absolute numbers the figure should be reliable for the purpose.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Medicaid Prepaid Health Plans

ACTIVITY: Prepaid Health Plans—Elderly and Disabled

MEASURE: Number of case months services purchased (elderly and disabled)

DATA SOURCES AND METHODOLOGY:
The data sources are the Medicaid Claims History and the Medicaid Recipient Subsystem (eligibility file) from the Florida Medicaid Management Information System (FMMIS) accessed through the Program Analysis Data Warehouse.

Using the data warehouse claim table, an unduplicated count is made by month of all elderly or disabled beneficiaries who are enrolled at any time during the month for HMO home services. The unduplicated count for each month is totaled to determine the number of case months provided for HMO services for the fiscal year.

VALIDITY:
This measure helps to identify the volume of case months provided through Prepaid Health Plans/HMOs to elderly and disabled Medicaid beneficiaries during a year.

RELIABILITY:
The reliability of the measure is excellent as it comes directly from paid claims and enrollment history data.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
_X_ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Medicaid Prepaid Health Plans

ACTIVITY: Prepaid Health Plans—Families

MEASURE: Number of case months services purchased (families)

DATA SOURCES AND METHODOLOGY:
The data sources are the Medicaid Claims History and the Medicaid Recipient Subsystem (eligibility file) from the Florida Medicaid Management Information System (FMMIS) accessed through the Program Analysis Data Warehouse.

Using the data warehouse claim table, an unduplicated count is made by month of all family or family-related (non-elderly or non-disabled) beneficiaries who are enrolled at any time during the month for HMO home services. The unduplicated count for each month is totaled to determine the number of case months provided for HMO services for the fiscal year.

VALIDITY:
This measure helps to identify the volume of case months provided through Prepaid Health Plans/HMOs to all family and family-related Medicaid beneficiaries during a year.

RELIABILITY:
The reliability of the measure is excellent as it comes directly from paid claims and enrollment history data.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Services

SERVICE: Medicaid Prepaid Health Plans

ACTIVITY: All

MEASURE: Number of case months Medicaid program services purchased

DATA SOURCES AND METHODOLOGY:

The data sources used for the measurement of case months are the Medicaid Recipient Subsystem (beneficiary enrollment file) of the Florida Medicaid Management Information System (FMMIS), and caseload projections adopted by the Social Services Estimating Conference for Medicaid caseload. The Recipient Subsystem is the source of all beneficiary data for FMMIS as generated by the Florida On-line Recipient Integrated Data Access (FLORIDA) system and the Social Security Administration (SSA) through State Data Exchange (SDX). The Recipient Subsystem contains all the activities related to the status of beneficiaries enrolled for Medicaid services. The activities include the maintenance of a file of current and historical records of individuals enrolled in Medicaid; managed care enrollment and disenrollment status; control of benefit limitations (caps) for each beneficiary; nursing home, institutional care for the developmentally disabled, and patient responsibility data; and production of Medicaid identification cards. The Department of Children and Families (DCF) and the Social Security Administration (SSA) determine beneficiary eligibility. Chapter 216, Florida Statutes, requires the Social Services Estimating Conference and that each state agency use the official information developed by the consensus estimating conferences in carrying out its duties under the state planning and budgeting system. The Social Services Estimating Conference adopts consensus projections of Medicaid caseload and expenditures at separate conferences. Using regression analyses of actual enrollment trends by major beneficiary groups and evaluation of the impact of eligibility policies, the conference adopts a consensus estimate of the Medicaid enrollment by month for the current fiscal year and for the subsequent fiscal year for which the funding needs are being developed. The caseloads are estimated for each major beneficiary group and within each beneficiary group by fee-for-service, MediPass, and HMO/prepaid health plan. Actual case months are determined through the Recipient Subsystem by determining the sum of the total number of months each person was enrolled for the year, by beneficiary group and by whether

the case month is a fee-for-service, MediPass or HMO/prepaid health plan case month. Estimated case months are determined by adding the total case months adopted by the Social Services Estimating Conference for each beneficiary group by fee-for-service, MediPass or HMO/prepaid health plan case month.

VALIDITY:
The number of case months the Medicaid program services purchased is an appropriate, valid measurement because it allows for comparisons between various programs and activities and for measuring differences in costs from year to year.

RELIABILITY:
The reliability of the measure is excellent. The data comes directly from the Recipient Subsystem that contains information by beneficiary of periods of Medicaid enrollment. The data also comes from the statutorily mandated Social Services Estimating Conference. The conference data is analyzed and a consensus beneficiary enrollment estimate is adopted by the principals of the conference including staff from the Executive Office of the Governor, the Office of Economic and Demographic Research, the Senate, the House of Representatives, the Agency for Health Care Administration, and the Department of Children and Families.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Facility Field Operations

MEASURE: Percent of nursing home facilities with deficiencies that pose a serious threat to the health, safety or welfare of the public

DATA SOURCES AND METHODOLOGY:
This measure is defined as the number of nursing homes in which deficiencies are found during the period that pose a serious threat to the health, safety, or welfare of the public divided by the total number of nursing home facilities during the period. Deficiencies that pose a serious threat to the health, safety, or welfare of the public can arise from any type of survey (initial, renewal, complaint investigation, etc.).

Survey data are maintained in the Florida Regulatory and Enforcement System (FRAES) and centrally collected. In addition, data is collected in a stand-alone Access database called AdminActs. The number of facilities is obtained from FRAES.

VALIDITY:
The Agency is committed to acting decisively and pursuing more aggressive penalties for poorly performing facilities. Data collected for this outcome enables the Agency to determine how well it is meeting its goal of reducing the percentage of facilities in which deficiencies are found that pose a serious threat to the health, safety, or welfare of the public.

RELIABILITY:
Data maintained in FRAES and AdminActs are centrally collected. Centralized collection of data and management review of supporting data should ensure accurate and consistent reporting.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Facility Field Operations

MEASURE: Percent of investigations of alleged unlicensed facilities and programs that have been previously issued a cease and desist order, that are confirmed as repeated unlicensed activity

DATA SOURCES AND METHODOLOGY:
This measure is defined as the number of closed investigations of unlicensed activity resulting in a cease and desist order subsequent to a previous investigation of the same facility for unlicensed activity also resulting in the issuance of a cease and desist order, divided by the total number of investigations of confirmed unlicensed activity during the period.

Each confirmed complaint of unlicensed activity, which would result in a cease and desist order is maintained in the Florida Regulatory and Enforcement System (FRAES). In addition, the individual units maintain and annually report manual counts of the number of investigations and cease and desist orders issued for each program.

VALIDITY:
The Agency's goal relative to this measure is to increase the percentage of investigations of alleged unlicensed facilities and programs that have been previously issued a cease and desist order, that are confirmed as repeated unlicensed activity. Collection of this data permits an ongoing measurement of the Agency's ability to meet its objectives.

RELIABILITY:
Each confirmed complaint of unlicensed activity that would result in a cease and desist order is maintained in FRAES. Centralized collection of data combined with management review of supporting data should ensure accurate and consistent reporting, resulting in reliability for the measure.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Health Facility Regulation

MEASURE: Percent of Priority 1 consumer complaints about licensed facilities and programs that are investigated within 48 hours

DATA SOURCES AND METHODOLOGY:
This measure is defined as the number of Priority 1 consumer complaints about licensed facilities and programs that are investigated within 48 hours during the period divided by the total number of Priority 1 consumer complaints about licensed facilities and programs that are investigated during the period. This classification indicates that there is potential serious and immediate harm to the patient. The area office supervisor determines if the complaint is considered a Priority 1. If yes, then it must be investigated by the area office within 48 hours (2 working days) of receipt by the area office.

All complaint data are maintained in the Florida Regulatory and Enforcement System (FRAES) and centrally collected.

VALIDITY:
Two of the many values embraced by the Agency for Health Care Administration are acting decisively and providing a timely response to our consumers. This measure allows the Agency to determine if it is meeting the goal of investigating Priority 1 consumer complaints about licensed facilities and programs within 48 hours.

RELIABILITY:
Centralized collection of this data combined with management review of supporting data should ensure accurate and consistent reporting, resulting in reliability of the measure.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form when submitting the long-range program plan for all existing approved measures, when requesting revisions to approved measures, and when requesting new measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Facility Field Operations

MEASURE: Percent of accredited hospitals and ambulatory surgical centers cited for not complying with life safety, licensure, or emergency access standards

DATA SOURCES AND METHODOLOGY:
This measure is defined as the number of accredited hospitals and ambulatory surgical centers (ASCs) that have been cited for deficiencies during the period, divided by the total number of accredited hospitals and ASCs. Deficiencies that are cited are not tabulated individually (i.e. if five deficiencies are cited during a survey, it is reported as one deficiency in the numerator). In addition, deficiencies that are noted include any and all deficiencies from minor to severe. A national accrediting body confers accreditation. If a facility is accredited, a full licensure survey is not required to be performed biennially. A validation survey (same as a full licensure survey) is performed on a sample of facilities. Deficiencies may also be found during complaint investigations of accredited facilities. A life safety inspection is required annually for hospitals and ASCs. Life safety inspections evaluate the control and prevention of fire and other life-threatening conditions on the premises for the purpose of preserving human life. Emergency access standards require every hospital to treat and/or stabilize any patient admitted for an emergency medical condition.

Emergency access, complaint, and survey data are maintained in the Florida Regulatory and Enforcement System (FRAES) and centrally collected.

VALIDITY:
The Agency is committed to ensuring health care services compliance with standards of safety, quality and accessibility established by state and federal regulations. This outcome measure will enable the Agency to monitor its goal of decreasing the percentage of accredited hospitals and ambulatory surgical centers that have been cited for not complying with life safety, licensure or emergency access standards.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
_X_ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Facility Field Operations

MEASURE: Percent of validation surveys that are consistent with findings noted during the accreditation survey

DATA SOURCES AND METHODOLOGY:
This measure is defined as the number of state accreditation validation surveys conducted for hospitals and ambulatory surgical centers that are consistent with findings noted during the accreditation survey divided by the total number of validation surveys performed during the period. A state validation survey is performed, at minimum, on a 5% sample of accredited hospitals and ambulatory surgical centers that have received their accreditation survey. This measure does not include federal accreditation validation surveys.

JCAHO provides to the Agency a monthly report that lists accreditation surveys scheduled for the next six weeks. This report is provided to the Manager of the Hospital Unit and the Chief of Field Operations on the last day of each month. Hospital Unit staff review the JCAHO list within five days of receipt and pull a sample of 5-10% of facilities (or a minimum of one) to be surveyed for state licensure validation inspection to be completed within 60 days of the survey end date noted on the report. To insure statewide distribution of facilities selected for validation surveys, the facilities that have a significant volume of complaint allegations and Risk Management deviations during the previous or current year will be identified for validation survey. Additional validation inspections in excess of the mandatory 5% random sampling will be selected by the Hospital Unit under consultation with the Chief of Field Operations and Field Office Management.

VALIDITY:

A validation survey assesses whether the review by the accrediting organization has adequately evaluated the facility according to minimum state standards (same as a full licensure survey).

RELIABILITY:

Hospital Unit staff compare AHCA validation survey results with the JCAHO survey utilizing a decision matrix developed by Health Standards and Quality/Field Operations staff and make the following notation in the FRAES validation inspection comment field: "consistent with accreditation findings" or "not consistent with accreditation findings". The review is completed within 30 days of receipt of both the state and JCAHO reports. The data entry is completed within 10 days of the review.

Survey data are maintained in FRAES and centrally collected. Centralized collection of FRAES data, and management review of supporting data should ensure accurate and consistent reporting.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
_X_ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Services Quality Assurance

SERVICE: Health Care Services & Facilities Regulation

ACTIVITY: Facility Field Operations

MEASURE: Percent of assisted living facilities with deficiencies that pose a serious threat to the health, safety or welfare of the public

DATA SOURCES AND METHODOLOGY:
This measure is defined as the number of assisted living facilities in which deficiencies are found during the period that pose a serious threat to the health, safety, or welfare of the public, divided by the total number of assisted living facilities during the period. Deficiencies that pose a serious threat to the health, safety, or welfare of the public are classified as Class I deficiencies (statutorily defined). These deficiencies can arise from any type of survey (initial, renewal, complaint investigation, etc.).

Survey data are maintained in the Florida Regulatory and Enforcement System (FRAES) and centrally collected. The data are pulled from FRAES and reviewed by the Facility Data Analysis staff for quality control purposes. The number of facilities is obtained from FRAES.

VALIDITY:
The Agency is committed to acting decisively and pursuing more aggressive penalties for poorly performing facilities. Data collected for this outcome enables the Agency to determine how well it is meeting its goal of reducing the percentage of facilities in which deficiencies are found that pose a serious threat to the health, safety, or welfare of the public.

RELIABILITY:
Survey data are maintained in FRAES and centrally collected. Centralized collection of FRAES data and management review of supporting data should ensure accurate and consistent reporting, resulting in a reliable measure.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Facility Field Operations

MEASURE: Percent of home health facilities with deficiencies that pose a serious threat to the health, safety or welfare of the public

DATA SOURCES AND METHODOLOGY:
This measure is defined as the number of home health facilities in which deficiencies are found during the period that pose a serious threat to the health, safety, or welfare of the public, divided by the total number of home health facilities during the period. Deficiencies that pose a serious threat to the health, safety or welfare of the public can arise from any type of survey (initial, renewal, complaint investigation, etc.). The deficiencies are classified as Class I deficiencies (statutorily defined).

Survey data are maintained in the Florida Regulatory and Enforcement System (FRAES) and centrally collected. FRAES has the capability to capture serious deficiencies for home health agencies. The data are pulled from FRAES and reviewed by the Facility Data Analysis staff for quality control purposes. The number of facilities is obtained from FRAES.

VALIDITY:
The Agency is committed to acting decisively and pursuing more aggressive penalties for poorly performing facilities. Data collected for this outcome enables the Agency to determine how well it is meeting its goal of reducing the percentage of facilities in which deficiencies are found that pose a serious threat to the health, safety, or welfare of the public.

RELIABILITY:
Survey data are maintained in FRAES and centrally collected. Centralized collection of FRAES data and management review of supporting data should ensure accurate and consistent reporting, resulting in a reliable measure.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
_X_ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Facility Field Operations

MEASURE: Percent of clinical laboratories with deficiencies that pose a serious threat for not complying with life safety, licensure or emergency access standards

DATA SOURCES AND METHODOLOGY:
This measure is defined as the number of clinical laboratories in which deficiencies are found during the period that pose a serious threat to the health, safety, or welfare of the public, divided by the total number of clinical laboratories during the period. Deficiencies that pose a serious threat to the health, safety, or welfare of the public can arise from any type of survey (initial, renewal, complaint investigation, etc.).

Survey data are maintained in the Florida Regulatory and Enforcement System (FRAES) and centrally collected. The data are pulled from FRAES and reviewed by the Facility Data Analysis staff for quality control purposes. The number of facilities is obtained from FRAES.

VALIDITY:
The Agency is committed to acting decisively and pursuing more aggressive penalties for poorly performing facilities. Data collected for this outcome enables the Agency to determine how well it is meeting its goal of reducing the percentage of facilities in which deficiencies are found that pose a serious threat to the health, safety, or welfare of the public.

RELIABILITY:
Survey data are maintained in FRAES and centrally collected. Centralized collection of FRAES data and management review of supporting data should ensure accurate and consistent reporting, resulting in a reliable measure.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Facility Field Operations

MEASURE: Percent of ambulatory surgical centers with deficiencies that pose a serious threat to the health, safety or welfare of the public

DATA SOURCES AND METHODOLOGY:
This measure is defined as the number of ambulatory surgical centers in which deficiencies are found during the period that pose a serious threat to the health, safety, or welfare of the public, divided by the total number of ambulatory surgical centers during the period. Deficiencies that pose a serious threat to the health, safety or welfare of the public can arise from any type of survey (initial, renewal, complaint investigation, etc.).

Survey data are maintained in the Florida Regulatory and Enforcement System (FRAES) and centrally collected. The data are pulled from FRAES and reviewed by the Facility Data Analysis staff for quality control purposes. The number of facilities is obtained from FRAES.

VALIDITY:
The Agency is committed to acting decisively and pursuing more aggressive penalties for poorly performing facilities. Data collected for this outcome enables the Agency to determine how well it is meeting its goal of reducing the percentage of facilities in which deficiencies are found that pose a serious threat to the health, safety, or welfare of the public.

RELIABILITY:
Survey data are maintained in FRAES and centrally collected. Centralized collection of FRAES data, data that is collected manually by the applicable unit, and management review of supporting data should ensure accurate and consistent reporting, resulting in reliability of the measure.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
_X_ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Facility Field Operations

MEASURE: Percent of hospitals with deficiencies that pose a serious threat to the health, safety or welfare of the public

DATA SOURCES AND METHODOLOGY:
This measure is defined as the number of hospitals in which deficiencies are found during the period that pose a serious threat to the health, safety, or welfare of the public by program divided by the total number of hospitals during the period. Deficiencies that pose a serious threat to the health, safety or welfare of the public can arise from any type of survey (initial, renewal, complaint investigation, etc.).

Survey data are maintained in the Florida Regulatory and Enforcement System (FRAES) and centrally collected. The data are pulled from FRAES and reviewed by the Facility Data Analysis staff for quality control purposes. The number of facilities is obtained from FRAES.

VALIDITY:
The Agency is committed to acting decisively and pursuing more aggressive penalties for poorly performing facilities. Data collected for this outcome enables the Agency to determine how well it is meeting its goal of reducing the percentage of facilities in which deficiencies are found that pose a serious threat to the health, safety, or welfare of the public.

RELIABILITY:
Survey data are maintained in FRAES and centrally collected. Centralized collection of FRAES data, data that is collected manually by the applicable unit, and management review of supporting data should ensure accurate and consistent reporting, resulting in reliability of the measure.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
_X_ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Facility Field Operations

MEASURE: Percent of hospitals that fail to report serious incidents (Agency identified)

DATA SOURCES AND METHODOLOGY:
The data source is the field surveys of hospitals and ambulatory surgical centers. Risk Management surveys are tracked in the Risk Management Monitoring System (RMMS) with a specific indicator for failure to report. Reports are run periodically regarding facilities that fail to report incidents to AHCA. A comparison is made of facilities that failed to report relative to facilities surveyed to produce a percentage of hospitals that fail to report.

VALIDITY:
This measure provides some indication of activity, but does not indicate level of performance. While the measure reflects the Agency's detection efforts, it is not a completely accurate reflection of the percentage of hospitals that are non-reporting because the measure is dependent upon records not always available to Agency staff. Also, there is no objective determination of whether a decrease in percentage indicates lack of regulatory activity on the part of the Agency, or better reporting by facilities due to better regulatory efforts by AHCA.

RELIABILITY:
The measure is only as reliable as the Agency's ability to review, at least on a statistically valid sampling basis, all medical records in every hospital and ambulatory surgical center for serious incidents and determine that these incidents have been reported. Since AHCA staff are precluded from routine review and reporting on peer review records, the measure is only reliable to the extent that the opportunity exists to "catch" a failure to report during a routine or risk management survey.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
_X_ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Medicaid Choice Counseling

MEASURE: Percent of new Medicaid recipients voluntarily selecting a managed care plan.

DATA SOURCES AND METHODOLOGY:
The source of the data is the Florida Medicaid Management Information System. Florida law mandates that Medicaid recipients eligible for managed care must be enrolled either with the MediPass program or with a Medicaid managed care organization. Eligible recipients are given 90 days from the date that the Medicaid eligibility begins to select a plan. If recipients do not voluntarily select either MediPass or a managed care plan, they are mandatorily assigned to MediPass or a managed care plan. The voluntary enrollment rate is calculated each month by dividing the number of recipients voluntarily selecting a managed care plan or enroll in MediPass divided by the total number of newly eligible Medicaid enrollees. A "newly eligible" is defined as a person who has not participated in a managed care plan within the previous 90 days prior to enrollment. The total number of "newly eligibles" excludes Medicaid recipients that are exempted from mandatory assignment.

VALIDITY:
The purpose of this measure is to determine the effectiveness of the Medicaid Options Enrollment Program in voluntarily enrolling "newly eligible recipients." The Medicaid Options Enrollment Program provides Medicaid recipients with written information about their plan choices and operates a toll-free call center, staffed with enrollment specialists, to enroll recipients. This program was established because the Agency believes that it is important that Medicaid recipients be provided with sufficient information to make informed choices about their health plan. The effectiveness of the Medicaid Options - Managed Care Enrollment Program is measured by the percent of newly eligible Medicaid recipients voluntarily enrolling MediPass or a managed care plan. The measure is most appropriate to assess the effectiveness of the program.

RELIABILITY:

The methodology relies on an objective data source, the Florida Medicaid Management Information System that is regularly updated. The data can be independently verified against Medicaid enrollment figures. The measure is reliable.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Managed Health Care

MEASURE: Percent of complaints of HMO patient dumping received that are investigated

DATA SOURCES AND METHODOLOGY:
The Bureau of Managed Care established a tracking system for complaints received by managed care enrollees about "patient dumping". "Patient dumping" generally refers to an action by the managed care plan to disenroll a patient involuntarily because of economic reasons benefiting the HMO. This is not to be confused with "facility l patient dumping".

The agency received 15 patient complaints related to health plan "dumping" in FY 2000-2001, and five (5) complaints in FY 2001- 2002. The measure is calculated by dividing the number of complaints investigated by the number received. To verify these allegations of patient dumping, the agency conducts HMO site visits, evaluates the HMOs grievance procedures, and reviews the member services file. For Medicaid patients, the agency reviews the patient's claims files after he/she was disenrolled to determine if large medical claims were filed under the fee-for-service program.

VALIDITY:
The purpose of the agency's activities is to determine if the patient allegation of "patient dumping" is justified. Site visits and the evaluation of individual patient records are the only valid measure to confirm these allegations.

RELIABILITY:
The methodology relies on objective, verifiable data sources, the patient's record and HMO procedures and policies. The source of the data can be independently verified and the review can be replicated by other observers; the measure is therefore reliable.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Facility Field Operations

MEASURE: Percent of facility patient dumping complaints confirmed

DATA SOURCES AND METHODOLOGY: The Florida Regulatory and Enforcement System (FRAES) database is used to obtain this information, which comes from a count of all complaints in the system with allegation codes 48 and 49. These are Medicaid and Medicare Patient Dumping, respectively. FRAES also identifies which complaints have been investigated and which have not as well as whether or not a complaint was confirmed or not confirmed. The percent of facility patient dumping complaints confirmed comes from dividing the total number of such complaints investigated and confirmed by the total number of complaints of facility patient dumping.

VALIDITY: The measure is based upon complaints entered into the FRAES computer system and investigated by field operations survey staff. A complaint is a valid transaction that begins either with a call to the call center or piece of correspondence to one of the facility units in the agency. All such complaints are entered into FRAES to be investigated. Complaints received by the call center are entered into FRAES by call center staff at the time of the call. Written complaints are tracked through the Agency Correspondence Tracking System (ACTS). They are entered into the FRAES computer system by facility unit staff before being sent to the survey staff for investigation.

RELIABILITY: The measure is as reliable as the input of data into the FRAES database. To the extent that any complaint is "missed" for inputting, it will also be missed for tracking purposes. All reports on this data are pulled directly from the FRAES database.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
_X_ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Facility Field Operations

MEASURE: Number of complaints of facility patient dumping received that are investigated

DATA SOURCES AND METHODOLOGY:
The Florida Regulatory and Enforcement System (FRAES) database is used to obtain this information, which comes from a count of all complaints in the system with allegation codes 48 and 49. These are Medicaid and Medicare Patient Dumping, respectively. FRAES also identifies which complaints have been investigated and which have not as well as whether or not a complaint was confirmed or not confirmed. All facility patient dumping complaints are investigated.

VALIDITY:
The measure is based upon actual complaints entered into the system and investigated by field operations survey staff. A complaint is a valid transaction that begins either with a call to the call center or a piece of correspondence to one of the facility units in the agency. All such complaints are entered into FRAES to be investigated.

RELIABILITY:
The measure is as reliable as the input of data into the FRAES database.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Executive Direction

MEASURE: Number of inquiries to the call center regarding practitioner licensure and disciplinary information

DATA SOURCES AND METHODOLOGY:
Call center staff members input data by call as they respond to phone calls. Calls are tracked in the computer as Customer Services Representatives input their transactions. Tallies from all call center staff are compiled daily and weekly by the call center manager. The monthly statistics are compiled in the same fashion using programming and software available to the call center. Year to date reports are also provided monthly.

VALIDITY:
Calls are counted after the call is answered. This does not include the calls attempted but not answered due to holding periods or inadvertent cutoffs. One call is counted from the time it is answered by the call center staff until the time the call is terminated. The system does not weight calls based on number of questions answered, complexity of matter, or time of call.

RELIABILITY:
The numbers are gathered daily, weekly and monthly by the call center manager and stored in the computer system. The call center manager reviews the statistics for obvious inconsistencies. The call center contract manager monitors calls and reviews data to ensure that calls are appropriately allocated to the correct categories of facility calls, professional calls and HMO calls. Only the inquiries associated with professional calls are allocated to the practitioner regulation function, which is not managed by the Department of Health.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Facility Field Operations

MEASURE: Number of facility emergency actions taken

DATA SOURCES AND METHODOLOGY:
This measure includes all facilities, both licensed and unlicensed, for which an emergency action is initiated during the period. An emergency action is taken when there is a threat to the health, safety, or welfare of the patient. Emergency actions include moratoria on admissions, emergency revocations, and court injunctions. Emergency revocations are initiated when the Agency has the authority, by statute, to revoke the license and close down the facility. A court injunction is obtained when it is necessary to close an unlicensed facility, or it is necessary to enforce the Agency's authority.

Historically, individual units submitted a summary count of facility emergency actions taken. This was a manual count of the number of emergency action letters issued to facilities.

VALIDITY:
One of the Agency's goals is to reduce the percentage of facilities that pose a serious threat to the health, safety, or welfare of the public. Some types of facilities, such as nursing homes and assisted living facilities have classes of deficiencies by which the Agency can determine the seriousness of a facility's lack of compliance with requirements. Other types of facilities, including hospitals, do not have such measures of severity. The only way that the Agency can assess the seriousness of a violation in those facilities that do not measure severity is to review the numbers of emergency actions taken as a proxy for a serious deficiency. For that reason, the measure is appropriate.

The objectives of the Agency relating to this output measure are two-fold. Through collection of this and related data, the Agency will be able to:

1) Determine the ratio of emergency actions that result in license revocations, license suspension, and administrative fines to total emergency actions.
2) Determine the percentage of healthcare facilities (including all types) found to pose a serious threat to the health, safety, or welfare of the public.

RELIABILITY:
Emergency actions are centrally collected and maintained in FRAES. An individual has assumed lead responsibility for entry and aggregation of this data and works with the units and area offices to improve and centralize the collection and reporting process. Centralized collection of data combined with management review of supporting data should ensure accurate and consistent reporting.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Facility Field Operations

MEASURE: Total number of full facility quality-of-care surveys conducted

DATA SOURCES AND METHODOLOGY:
A full facility survey is defined as initial, validation, and renewal licensure and certification surveys. Plans and Construction surveys are not included. Licensure and certification surveys performed together, for the same facility, count as one survey. Full surveys do not include separate life safety surveys, risk management surveys, or complaint investigations. All state and certification full facility surveys are entered into the Florida Regulatory and Enforcement System (FRAES). This allows a count of the actual number of surveys conducted during any given period. FRAES training is offered on an on-going basis to both area office and central office personnel to ensure that the information is being accurately captured and reported in the system. Centralized aggregation of this data will ensure consistency among several facility types.

VALIDITY:
Florida's citizens want and expect government agencies to ensure that the health care they receive is of good quality. Data collected in this measure allows the Department to calculate the percentages of various outcomes related to facility compliance with standards of safety and quality established by state and federal regulations.

RELIABILITY:
Survey data are maintained in FRAES and centrally collected; consequently, the measure is reliable to the extent that data collected is correctly entered into the system.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Subscriber Assistance Panel

MEASURE: Average processing time (in days) for Statewide Provider and Subscriber Assistance Panel cases

DATA SOURCES AND METHODOLOGY:
An Access database and an Excel spreadsheet are maintained to track all processing steps from the opening of the case file to closure. Each case file's opening date is recorded on the database. All statutory time frames are measured based upon that date. The Excel spreadsheet is updated and reviewed on a weekly basis to insure each case is processed within the statutory requirements. The procedure used to measure the indicator is counting the number of days from the date the case is opened until it is closed for all closed cases and dividing by the total number of cases closed.

VALIDITY:
Sections 408.7056 (3), (8), (9) Florida Statutes require that cases be processed and closed within specific number of days. Thus the measurement of the number of days to close a case is appropriate.

RELIABILITY:
The methodology used results in reports on a case-by- case basis of the intake date and closure date for each case. Documentation of each is maintained in the case files as well as on computerized reports. Data contained in the system is verified and reported monthly on the Critical Business Processes Report. The measure is deemed reliable.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Plans and Construction

MEASURE: Number of construction reviews performed (plans and construction)

DATA SOURCES AND METHODOLOGY:
All plans and construction projects are tracked on the Office of Plans and Construction Review Tracking System (OPCRTS). This is an electronic database that contains an accounting of all projects, facilities, submissions and time invoiced by all reviewers. Data in this system can be accessed for any timeframe for various facility types or reviews. AHCA produces monthly reports using this data source. A query is made in the system to generate the number of submissions (or reviews) to which time was billed during the period. A submission occurs when a project is logged into the system and each time a review of plans and construction sites occurs.

VALIDITY:
Two administrative secretaries input the submissions. The total number of projects is logged into the system by facility number, project number, and submission number. There can be multiple projects and submissions per facility. This is the best available measure of the number of plans and construction reviews performed. The measuring instrument was specifically developed to measure this indicator.

RELIABILITY:
Project time sheets are reviewed and approved by the supervisors. One person enters the data from these sheets into the data system. There are various electronic flags in the system that will signal false data entry, i.e., incorrect date, incorrect log number, projects already closed, etc. The Office of Program Policy Analysis and Government Accountability (OPPAGA) reviewed the reliability of this measure. The reliability of data entry was improved according to OPPAGA's recommendations. External factors relating to available funding for health care construction have a direct impact on the number of projects submitted for review each year. Electronic data has been randomly checked against manual source material and been found to be substantially error free.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Medicaid Choice Counseling

MEASURE: Number of new enrollees provided choice counseling

DATA SOURCES AND METHODOLOGY:
The data sources are the Concera/ACS contractor and the Florida Medicaid Management Information System (FMMIS). The contractor is required by contract to collect the data and report the data monthly. The contractor keeps daily logs of all activities, including the number of enrollment packages mailed, and the number of telephone calls received. The Medicaid information system contains information on each Medicaid enrollee.

VALIDITY:
The purpose of this measure is to determine the productivity level of the Medicaid Options Enrollment Program under contract with the Agency.

The purpose of the Medicaid Options Enrollment Program is to assist eligible Medicaid recipients in choosing and enrolling in a health plan. The number of new Medicaid enrollees provided with MediPass and Managed Care Plan information is the most appropriate measure to assess productivity. The contractor is also responsible for enrolling Medicaid recipients who voluntarily choose a plan. This measure accurately reflects the productivity level of the program.

RELIABILITY:
AHCA reviews weekly and monthly reports from the data sources. The data are reviewed for internal consistency on a regular basis. The measure has been proven to be highly reliable during the four-year contract period.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Certificate of Need/Financial Analysis

MEASURE: Number of Certificate of Need Requests/Financial Reviews Conducted

DATA SOURCES AND METHODOLOGY:
Data are obtained from the internal CON database, the internal hospital financial review database, and the internal nursing home financial review database. These databases contain all information pertinent to the three activities. While the data contained in each of the records is complex, the number of records in each of these databases is relatively small, enabling staff to verify the numbers for accuracy based on their working knowledge of program operations. Staff members execute ad hoc queries to obtain the required measurement.

VALIDITY:
This measure accurately reflects a component of the productivity of the Health Facility Regulation staff. CON and financial analysis reviews are a major responsibility of the Bureau of Health Facility Regulation. They are complex, detailed tasks that require input from many sources. The coordination of these efforts and the actual processing of the CON applications and financial data consume a large amount of staff time.

RELIABILITY:

While the data contained in each of the records are complex, the number of records in each of these databases is relatively small, enabling staff to verify the numbers for accuracy based on their working knowledge of program operations. The measure is reliable.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Health Facility Regulation

MEASURE: Number of Licensure Applications

DATA SOURCES AND METHODOLOGY:
Data are obtained from the Florida Regulatory and Enforcement System (FRAES)/LicenseEase datamart. The datamart contains license application, inspection, and complaint information. The datamart is updated nightly to reflect the data input daily by Central Office and Field Office staff in the Bureau of Health Facility Regulation into the larger FRAES/LicenseEase transactional database. Ad hoc queries were written by staff in the Division of Managed Care and Health Quality and by AHCA information technology staff to run against the FRAES/LicenseEase datamart. Using the Impromptu ad hoc query tool, data are pulled to report the measure based on the time period to be measured and the definition of an application transaction. Application transaction data, including receipt date and completion date, are stored in the licensure module in FRAES/LicenseEase and specific codes are used to designate various transaction types. Unique codes designate initial applications, renewal applications, change of ownership applications, bed increases or decreases, service upgrades or downgrades, rating changes, expanded/reduced service areas, branch additions/deletions, and facility closures.

VALIDITY:
This measure accurately reflects one major component of the productivity of the Health Facility Regulation staff. License application processing is a major responsibility of the Bureau of Health Facility Regulation. It is a complex, detailed task that requires input from many sources. The coordination of these efforts and the actual processing of the application paperwork consume significant amounts of staff time.

RELIABILITY:
Since November 1996, all license application transactions have been recorded in FRAES/LicenseEase. The datamart is updated nightly from the FRAES/LicenseEase transactional database. Consequently, it is an extremely reliable source of accurate data. The ad

hoc query used to pull the number of processed license applications for a specified year period filters on a specific application status, specific application transaction codes, and the date the completion action was taken on an application. Once the application completion action is taken, the date of that action cannot change in FRAES/LicenseEase. Consequently, this same query run on different days should produce the same results.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Facility Field Operations

MEASURE: Number of Survey and Complaint Investigations

DATA SOURCES AND METHODOLOGY:
This measure is composed of two types of surveys, both of which are performed in order to ensure compliance with minimum standards in regulated health care facilities. They are defined as follows:

1. The total number of facility complaint investigations closed during the period. This includes quality-of-care complaints, complaints of unlicensed facilities, and emergency access complaints.

2. The total number of on-site visits made to licensed/certified facilities to ensure compliance with applicable state and federal regulations. Licensure and certification surveys performed during the same on-site visit are considered as one survey.

All complaint investigations and facility surveys are entered into the Florida Regulatory and Enforcement System (FRAES/LicenseEase). This allows a count of the actual number of investigations conducted and surveys performed during any given period. FRAES/LicenseEase training is offered on an on-going basis to both area office and central office personnel to ensure that the information is being accurately captured and reported in the system. Centralized aggregation of this data ensures consistency among facility types.

VALIDITY
Florida's citizens want and expect government agencies to ensure that the health care they receive is of good quality. Data collected in this measure allows the Agency to calculate the percentages of various outcomes related to facility compliance with standards of safety and quality established by state and federal regulations.

RELIABILITY

Complaint investigations and survey data are maintained in FRAES/LicenseEase and centrally collected. The measure is reliable.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Health Standards and Quality

MEASURE: Number of Transactions

DATA SOURCES AND METHODOLOGY:
There are three types of transactions included in this measure:

A. The number of Minimum Data Set/Outcome and Assessment Information Set (MDS/OASIS) assessment records received and successfully deposited in the database.
   1) The data source for this measure is the *"Monthly Submission Statistics Report"* on the MDS/OASIS Data Management Systems, maintained by the MDS/OASIS Automation Coordinator.
   2) Long term care facilities and home health agencies are required by federal regulation to electronically transmit encoded, accurate, and complete assessments each month in a format that conforms to the Health Care Financing Administration (HCFA) specifications to the State MDS/OASIS system.
   3) The MDS/OASIS System is the repository for collection and storage of assessment data. The "Monthly Submission Statistics Report" is a standard management report available on the system that calculates the number of assessments received and successfully deposited in said database.

B. The number of surveyors and providers completing training sessions.
   1) The data source for this measure is the "*HSQU (Health Standards and Quality Unit) Personnel Database,*" an Access database maintained by the HSQU State Training Administrator.
   2) **Surveyors:** Each state agency training session and its participants are tracked in an Access database. A query for the number of participants completing each course provides the total number of surveyors completing training session(s).
      Providers: The appropriate Professional Association for provider training tracks its participants through a registration process. Each association provides the Department with a total number of participants at the completion of the training session. Totals for

state agency participants and provider participants are summed for this measure.

C. The number of nursing home quality of care monitoring visits conducted.
   1) The data source for this measure is the "*Quality of Care Monitoring Program Facility Visit Report,*" a spreadsheet maintained by the HSQU Quality of Care Monitoring Supervisor.
   2) Nurse monitoring staff record into the designated spreadsheet the facility name, date of visit, off-hour entrance time/day, date report submitted, date of other contact, and referrals made. The Nurse Monitor submits the report monthly to the HSQU Quality of Care Monitoring Supervisor.
   3) Totals for the number of quality of care monitoring visits are summed from all Field Office Quality of Care Monitors.

VALIDITY:

A. The number of MDS/OASIS assessment records received and successfully deposited in the database.
   1. As a condition of licensure/certification, there is a requirement to assess residents/patients in specific health care settings. Assessment information is available to both providers and surveyors in order to direct on-site quality patient care and survey activities. Evidence of that assessment completion is electronically transmitted to the MDS/OASIS database in the form of assessment records.
   2. A count of the number of assessments received and successfully deposited in the database is indicative of the licensure requirements being met and delivery of services.

B. The number of surveyors and providers completing training sessions.
   1. As a condition of licensure/certification, there is a requirement to train state agency staff and providers. Training of providers and state agency staff provide consistency in the application of the regulatory process enabling both providers and evaluators to "know the rules" governing certification and licensure requirements, as well as ensure that qualified individuals are performing surveys. Evidence of completion of training sessions is tracked via the "HSQU Personnel Training Database" and provider registration files.
   2. A count of the number of participants trained is indicative of having met the requirement for the provision of training sessions.

C. The number of nursing home quality of care monitoring visits conducted.
   1. Florida Statute established the Quality of Care Monitoring Program as a means to monitor the provision of quality care and services in nursing homes. The state monitors are registered nurses trained and experienced in nursing home regulations, Standards of Practice, and evaluation of resident care. This program enhances compliance with licensure/certification requirements, as well as focusing internal quality improvement efforts that reduce the threat to the health

and safety of residents. Evidence of monitoring visits conducted is tracked via the spreadsheet designed for this purpose.

2. A count of the number of monitoring visits conducted is indicative of the on-site activities of the state monitors focused on issues of the resident's quality of care and quality of life.

RELIABILITY:

A. The number of MDS/OASIS assessment records received and successfully deposited in the database
   1. Collection of assessment data employs a universally developed, tamper-proof assessment tool, encoded in a software package that utilizes strict edits to minimize invalid, inconsistent, or missing data elements.
   2. Monthly electronic transmission of assessment data is required for all assessments conducted during the previous month. Reports are available to assess for "missing assessments" as well as "anticipated assessment volume." Strict data specification edits are enforced by the state system to minimize the acceptance of records containing errors. Providers are expected to correct records containing errors that prevent successful transmission, and re-submit until accepted by the system.

B. The number of surveyors and providers completing training sessions
   1. Collection of training attendance data employs a specifically developed database designed for the sole purpose of tracking training information. A list of proposed attendees is submitted the HSQU State Training Administrator. These attendees are entered into the "HSQU Personnel Database" for each training session which is assigned a unique number. After the class, the information is reconciled against the training session's sign-in sheet. This method is used as it is a measure of checks and balances and is easily accessed.
   2. Keying of information into this database is limited to authorized users. The data can be accessed repeatedly, yielding the same results. The data can be formatted in a variety of ways such as by Field Office, alphabetically, surveyors attending a specific training course over a period to time, etc.

C. The number of nursing home quality of care monitoring visits conduct
   1. There is a clear definition of what constitutes a "visit" in the Monitor's Protocol. There is a performance standard that a *visit form* be completed by each State Monitor at the time of each visit. Copies are forwarded to the facility representative and the monitor's supervisor. This serves as an attestation that a visit was conducted.
   2. Keying of information, from the visit forms, into the designated spreadsheet is limited to authorized users and supervised by the monitor's supervisor. There is a standard report developed to query the spreadsheet. Results are published monthly.

The measure is reliable.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Plans and Construction

MEASURE: Number of Reviews Performed

DATA SOURCES AND METHODOLOGY:
Reviews performed include those for nursing homes, hospitals, and ambulatory surgical centers. All plans and construction projects are tracked on the Office of Plans and Construction Review Tracking System (OPCRTS). This is an electronic database that contains an accounting of all projects, facilities, submissions and time invoiced by all reviewers. Data in this system can be accessed for any timeframe for various facility types of reviews. AHCA produces monthly reports using this data source. A query is made in the system to generate the number of submissions to which time was billed during the period. A submission occurs when a project is logged into the system and each time a review of plans and construction sites occurs.

VALIDITY:

Two administrative secretaries input the submissions. The total number of projects is logged into the system by facility number, project number, and submission number. There can be multiple projects and submissions per facility. This is the best available measure of the number of plans and construction reviews performed. The measuring instrument was specifically developed to measure this indicator.

RELIABILITY:
Project time sheets are reviewed and approved by the supervisors. One person enters the data from these sheets into the data system. There are various electronic flags in the system that signal false data entry, i.e., incorrect date, incorrect log number, projects already closed, etc. The Office of Program Policy Analysis and Government Accountability (OPPAGA) reviewed the reliability of this measure. The reliability of data entry was improved according to OPPAGA's recommendations. External factors related to available funding for health care construction have a direct impact on the number of projects submitted for review each year. Electronic data has

been randomly checked against manual source material and been found to be substantially error free. The measure is reliable.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Managed Health Care

MEASURE: Number of HMO and Workers' Compensation Arrangement Surveys

DATA SOURCES AND METHODOLOGY:
The commercial HMO unit and the workers' compensation unit keep monthly logs of their survey activities. Survey activities are recorded and summarized.

VALIDITY:
The purpose of this measure is to determine the productivity level of the managed health care program. Although there are additional workload issues involved in the process, the number of surveys completed annually is the most appropriate measure to assess productivity. The purpose of the managed health care program is to monitor managed care programs for compliance with statutory and regulatory provisions and surveys are the most appropriate activity to assess managed care plans' compliance with these provisions.

RELIABILITY:
Survey activities are logged and can be verified through travel records. This measure is very reliable and can be independently verified.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_X_ When data sources or measurement methodologies change,
_____ When requesting new measures, and
_X_ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Organ and Tissue Donor

MEASURE: Number of Donor Designations

DATA SOURCES AND METHODOLOGY:
Donor registrations are received from the Department of Highway Safety and Motor Vehicles (DHSMV) and from individuals who download the form from AHCA's or the DHSMV's web sites, and on-going community projects. DHSMV provides the data on registered donors in tape format to AHCA. AHCA staff manually enters registration forms received from other sources. The change in donor registrations is calculated mathematically from year-to-year.

In previous years, the Agency used a cumulative number for donor designations rather than the actual number of donor designations received in a year. Once a donor designation is received and input, there is no further work required. The Agency is now utilizing an actual per year number rather than a cumulative. Therefore, the number of donor designations noted will be drastically lower than prior year LRPP submissions.

VALIDITY:
Donor registrations transmitted by tape from DHSMV are deemed valid because a DHSMV employee normally witnesses the donor registration form and inputs the designation into the DHSMV database. Donor registrations received from other sources are followed up with a letter of verification before entry into the database. This measure indicates the change in number of donor registrations and is the only available measure of the effectiveness of the program's outreach and education efforts.

RELIABILITY:
Donor registrations transmitted by tape from DHSMV are deemed reliable because a DHSMV employee normally witnesses the donor registration form & inputs the designation into the DHSMV database. Donor registrations received from other sources are followed up with a letter

of verification before entry into the database to confirm intent of registrant. The measure is as reliable as the data sources permit.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Background Screening

MEASURE: Number of Requests for Screening

DATA SOURCES AND METHODOLOGY:
Data are obtained from the Agencyt's Health Care Provider Registry (HCPR) and Florida Regulatory and Enforcement System (FRAES/LicenseEase) data systems. These databases are updated daily with results of Level 1 and Level 2 screening requests submitted to the Agency by licensed healthcare facilities, providers, and suppliers. The Background Screening Unit staff inputs this information.

For Level 1, requests are submitted via electronic modem to the Florida Department of Law Enforcement (FDLE). After two days results are retrieved via modem from FDLE and results are reviewed and input into HCPR. For Level 2, actual fingerprint cards are batched and forwarded to FDLE. Results are returned by FDLE/FBI in hard copy to the Unit and results are input into HCPR.

HCPR and FRAES/LicenseEase are Informix databases. HCPR is linked to FRAES/LicenseEase in identifying demographic data associated with each licensee's request. Data entry into HCPR produces stored information of each level of screening request associated with the licensee and an employee or owner of that health care facility.

Results are ultimately classified and mailed to each requestor and are accessible by the licensee through the background screening unit website using a unique provider user code and password.

To be eligible for employment, an individual must have an FDLE and/or a FBI "OK."
If an individual is determined to be "NOT OK," he/she must apply and be granted an exemption <u>before</u> becoming eligible for employment.

VALIDITY:
This measure indicates the productivity of the background screening unit. The numbers of screening requests that are received are tracked by type using Microsoft Access software. Screening results by type and reports mailed to third party vendors and facilities are captured by HCPR.

RELIABILITY:
The numbers of results reviewed and entered for Level 1 and 2 are gathered weekly in an administrative report and monthly in a division performance tracking report. They are then recorded in a spreadsheet for annual reporting. The data are a representation of the database on the day of reporting and results printed for mailing. Database corrections identified by Unit staff or providers are corrected in the HCPR system the day the request is made. Unit staff verifies data by determining that all documents are complete and sufficient fees are attached. The HCPR system identifies each screening work product completed by a data entry operator, batch number, date, fee amount, social security number, facility or third party requestor. The measure is reliable.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form under the following circumstances **[check one]**:

_____ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
__X__ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Subscriber Assistance Panel

MEASURE: Number of Cases

DATA SOURCES AND METHODOLOGY:
Health Maintenance Organization (HMO) subscribers file grievances with the program. Each grievance requires a file to be created which contains all documents pertinent to the grievance. Each case file is entered in an Access database that contains summary data regarding the case. The case files are tracked in the database and the number of cases opened in a fiscal year is counted.

VALIDITY:
The case files are tangible objects that can be easily tracked while accurately reflecting the measure being monitored. Cases may be opened, settled and closed; opened, heard and closed; opened, withdrawn and closed; or opened, determined to be out of jurisdiction and closed. They are all included in the "number of cases" measure reflected above. Since the caseload reflects the major function of the unit, this is the only appropriate measure of productivity.

RELIABILITY:
Case files can be physically counted if the reliability of the data needs verification. The measure is therefore reliable and can be backed up. They are also numbered and tracked in the computer system and the status of cases is reported to management monthly in the Critical Business Processes Report.

PERFORMANCE MEASURE VALIDITY and RELIABILITY FORM

INSTRUCTIONS: This form is designed to provide information regarding the validity and reliability of a measure. Agencies use this form when submitting the long-range program plan for all existing approved measures, when requesting revisions to approved measures, and when requesting new measures.

__X__ When requesting revisions to approved measures,
_____ When data sources or measurement methodologies change,
_____ When requesting new measures, and
_____ When providing backup for performance outcome and output measures.

AGENCY: Agency for Health Care Administration

PROGRAM: Health Care Regulation

SERVICE: Health Care Regulation

ACTIVITY: Medicaid Options Enrollment Program

MEASURE: Number of Medicaid beneficiaries receiving assistance in plan enrollment and plan changes annually.

DATA SOURCES AND METHODOLOGY:

The Agency is requesting a name change from the current Medicaid Choice Counseling Activity to Medicaid Options Enrollment. This activity name change will more clearly describes the program is more representative of the actual activities involved in this program and is consistent with the statutory changes made by the 2001 Legislature to Chapter 409.912, F.S. Prior to the change subsection 409.912(25) specified that the agency shall perform choice counseling, enrollments, and disenrollments for Medicaid beneficiaries. In 2001, the words "choice counseling" were stricken from this subsection. In addition, paragraph 409.9122 (2)(e) was stricken in its entirety from the statute. This paragraph read as follows: "Prior to requesting a Medicaid beneficiary who is subject to mandatory managed care enrollment to make a choice between a managed care plan or MediPass, the agency shall contact and provide choice counseling to the beneficiary." These statutory changes clearly eliminate the authority of the agency to provide choice counseling. Instead, the focus of the program is on Medicaid beneficiary enrollment. One reason for the change relates to the confusion the term "choice counseling" has caused. Enrollment specialists provide Medicaid beneficiaries with information about what health plans are available in their counties, but they are prohibited from recommending any plans to the beneficiary, or giving advice ("counsel") to beneficiaries on what plan to choose. The agency has contracted with an enrollment broker to operate a call center, enroll eligible Medicaid beneficiaries, and assist beneficiaries in changing plans provided good cause reasons are met. With over 1.2 million Medicaid beneficiaries enrolled in Medicaid HMOs and MediPass, the program is vital to the Medicaid program.

The agency is also requesting a change in the performance and unit cost measure from 'Number of New Enrollees Provided Choice Counseling' to 'Number of Medicaid beneficiaries receiving assistance in plan enrollment and plan changes annually.' Again, this change will more accurately reflect the actual activities involved in this program.

The data sources are the Concera/ACS contractor. The contractor is required by contract to collect the data and report the data weekly and monthly. The contractor keeps daily logs of all activities, including the number of enrollment activities and plan changes.

VALIDITY:
The purpose of this measure is to determine the productivity level of the Medicaid Options Enrollment Program under contract with the Agency.

The purpose of the Medicaid Options Enrollment Program is to assist eligible Medicaid beneficiaries in choosing and enrolling in a health plan. The number of beneficiaries receiving assistance in plan and enrollment plan changes is the most appropriate measure to assess productivity. While the contractor is responsible for additional activities, including mailing of new eligibility packages to each newly eligible Medicaid beneficiary and staffing a toll-free hotline that answered over 700,000 calls during FY 2001-2002, the proposed measure best reflects the productivity level of the program.

RELIABILITY:

AHCA reviews weekly and monthly reports from the data sources. The data are reviewed for internal consistency on a regular basis. The measure has been proven to be highly reliable during the four-year contract period.

BUDGET ENTITY	PROGRAM COMPONENT	APPROP CAT	FUND	FSI	CURR YR EST EXP 2002-03 OVER(UNDER) BACK UP OF A02 ALL FUNDS	CURR YR EST EXP 2002-03 ALL FUNDS	EST EXP FY 2002-03 ALL FUNDS	CURR YR EST EXP 2002-03 OVER(UNDER) EST EXP FY 2002-03 ALL FUNDS	CURR YR EST EXP 2002-03 OVER(UNDER) EST EXP FY 2002-03 FTE
68200000	1602000000	010000	1000	1		1,220,039	1,220,039		
				2		472,739	472,739		
			2003	1		5,508,198	5,508,198		
				3		1,388,945	1,388,945		
			2021	2		515,915	515,915		
				3		1,381,180	1,381,180		
			2122	2		14,889	14,889		
		030000	1000	1		115,000	115,000		
			2003	1		238,888	238,888		
				3		129,000	129,000		
			2021	2		151,947	151,947		
				3		120,817	120,817		
		040000	1000	1		550,923	550,923		
				2		123,456	123,456		
			2003	1		2,179,446	2,179,446		
				3		50,080	50,080		
			2021	2		201,025	201,025		
				3		217,613	217,613		
			2122	2		5,742	5,742		
		060000	1000	2		3,478	3,478		
			2003	1		46,678	46,678		
			2021	2		3,765	3,765		
				3		7,244	7,244		
		103241	1000	1		13,212	13,212		
			2003	1		122,178	122,178		
			2021	3		13,214	13,214		
		107040	1000	1		3,565	3,565		
			2003	1		34,763	34,763		
			2021	2		7,799	7,799		
	1603000000	010000	1000	1		209,642	209,642		
				2		350,035	350,035		
			2003	1		2,014,363	2,014,363		
				3		25,039	25,039		
			2021	2		348,978	348,978		
				3		674,115	674,115		
		030000	1000	2		58,917	58,917		
			2003	1		25,469	25,469		
			2021	3		58,917	58,917		
		040000	1000	1		50,333	50,333		
				2		306,505	306,505		
			2003	1		1,821,367	1,821,367		
				3		5,532	5,532		
			2021	2		292,388	292,388		
				3		598,527	598,527		
			2122	2		5,161	5,161		
		060000	1000	2		196,878	196,878		
			2003	1		111,133	111,133		

BUDGET ENTITY	PROGRAM COMPONENT	APPROP CAT	FUND	FSI	CURR YR EST EXP 2002-03 OVER(UNDER) BACK UP OF A02 ALL FUNDS	CURR YR EST EXP 2002-03 ALL FUNDS	EST EXP FY 2002-03 ALL FUNDS	CURR YR EST EXP 2002-03 OVER(UNDER) EST EXP FY 2002-03 ALL FUNDS	CURR YR EST EXP 2002-03 OVER(UNDER) EST EXP FY 2002-03 FTE
68200000	1603000000	060000	2021	2		1,426	1,426		
				3		706,814	706,814		
			2122	2		106,260	106,260		
		103241	1000	2		8,085	8,085		
			2003	1		24,891	24,891		
			2021	3		8,085	8,085		
		210010	2003	1		390,603	390,603		
			2021	2		23,840	23,840		
68500100	1301000000	040000	1000	2		395,373	395,373		
			2122	2		704,548	704,548		
			2474	3		2,661,779	2,661,779		
		100031	1000	2		29,707,815	29,707,815		
			2122	1		13,500,000	13,500,000		
				2		54,919,651	54,919,651		
			2474	3		236,501,134	236,501,134		
		102340	1000	2		1,159,721	1,159,721		
			2122	2		8,170,634	8,170,634		
			2339	2		3,814,800	3,814,800		
			2474	3		22,579,205	22,579,205		
		102342	1000	2		2,549,087	2,549,087		
			2122	2		10,251,578	10,251,578		
			2339	2		818,900	818,900		
			2474	3		30,977,258	30,977,258		
68500200	1602000000	010000	1000	2		11,312,611	11,312,611		
			2003	1		297,146	297,146		
			2021	1		506	506		
				2		3,038,698	3,038,698		
				3		17,305,924	17,305,924		
			2122	2		115,915	115,915		
			2339	2		74,524	74,524		
				3		116,839	116,839		
		030000	1000	1		132,707	132,707		
				2		515,992	515,992		
			2003	1		237,668	237,668		
			2021	2		6,101,063	6,101,063		
				3		16,122,810	16,122,810		
			2122	2		29,806	29,806		
			2339	2		5,081,457	5,081,457		
		040000	1000	1		486,961	486,961		
				2		6,068,010	6,068,010		
			2003	1		22,114	22,114		
			2021	2		7,729,211	7,729,211		
				3		26,772,776	26,772,776		
			2122	2		217,530	217,530		
			2339	2		4,491,804	4,491,804		
				3		35,081	35,081		
		060000	1000	2		65,798	65,798		

BUDGET ENTITY	PROGRAM COMPONENT	APPROP CAT	FUND	FSI	CURR YR EST EXP 2002-03 OVER(UNDER) BACK UP OF A02 ALL FUNDS	CURR YR EST EXP 2002-03 ALL FUNDS	EST EXP FY 2002-03 ALL FUNDS	CURR YR EST EXP 2002-03 OVER(UNDER) EST EXP FY 2002-03 ALL FUNDS	CURR YR EST EXP 2002-03 OVER(UNDER) EST EXP FY 2002-03 FTE
68500200	1602000000	060000	2021	2		51,158	51,158		
				3		271,923	271,923		
			2339	2		12,500	12,500		
		094657	1000	2		1,025,000	1,025,000		
			2021	3		825,000	825,000		
		100549	1000	1		155,372	155,372		
			2122	1		1,250,000	1,250,000		
			2474	3		466,115	466,115		
		100693	1000	2		656,779	656,779		
			2021	3		656,779	656,779		
		102086	1000	1		200,000	200,000		
				2		21,220,996	21,220,996		
			2021	2		532,080	532,080		
				3		49,656,228	49,656,228		
			2122	2		298,196	298,196		
			2579	3		112,234	112,234		
		102093	1000	2		950,000	950,000		
			2021	2		83,317	83,317		
				3		3,199,951	3,199,951		
		103241	1000	2		234,334	234,334		
			2021	3		234,335	234,335		
		107040	1000	2		24,825	24,825		
			2021	2		111,689	111,689		
			2339	2		755	755		
68501400	1301000000	100060	1000	2		7,629,741	7,629,741		
			2474	3		10,812,948	10,812,948		
			2579	3		242,255	242,255		
		100216	2474	2		2,300,632	2,300,632		
				3		3,260,479	3,260,479		
		100311	1000	2		29,554,446	29,554,446		
			2122	2		12,953	12,953		
			2474	2		519,041	519,041		
				3		38,001,248	38,001,248		
			2579	3		8,655	8,655		
		100436	1000	2		64,244,000	64,244,000		
			2122	2		33,612	33,612		
			2474	2		7,998,724	7,998,724		
				3		102,466,167	102,466,167		
			2579	3		81,136	81,136		
		100616	1000	2		22,464,583	22,464,583		
			2474	3		31,837,046	31,837,046		
			2579	3		188,158	188,158		
		100919	2122	2		843	843		
			2474	2		3,894,627	3,894,627		
				3		5,521,588	5,521,588		
			2579	3		203	203		
		101029	1000	2		45,468,982	45,468,982		

BUDGET ENTITY	PROGRAM COMPONENT	APPROP CAT	FUND	FSI	CURR YR EST EXP 2002-03 OVER(UNDER) BACK UP OF A02 ALL FUNDS	CURR YR EST EXP 2002-03 ALL FUNDS	EST EXP FY 2002-03 ALL FUNDS	CURR YR EST EXP 2002-03 OVER(UNDER) EST EXP FY 2002-03 ALL FUNDS	CURR YR EST EXP 2002-03 OVER(UNDER) EST EXP FY 2002-03 FTE
68501400	1301000000	101029	2122	2		83,788	83,788		
			2474	3		64,646,060	64,646,060		
			2579	3		308,392	308,392		
		101240	1000	2		720,185	720,185		
			2122	2		500,000	500,000		
			2339	2		4,751,302	4,751,302		
			2474	3		6,746,679	6,746,679		
		101246	1000	2		1,008,373	1,008,373		
			2122	2		421	421		
			2474	3		9,079,149	9,079,149		
			2579	3		28,679	28,679		
		101400	2339	2		8,600,001	8,600,001		
			2474	3		12,288,998	12,288,998		
		101554	2474	3		14,826,156	14,826,156		
		101561	1000	2		33,678,822	33,678,822		
			2122	2		3,226,868	3,226,868		
			2474	3		52,157,506	52,157,506		
			2579	3		85,250	85,250		
		101575	1000	2		49,599,810	49,599,810		
			2474	3		70,293,370	70,293,370		
		101582	1000	2		185,912,039	185,912,039		
			2122	2		8,088,785	8,088,785		
			2339	2		223,828,412	223,828,412		
			2474	2		19,380,521	19,380,521		
				3		1,138,323,882	1,138,323,882		
			2565	2		364,500,000	364,500,000		
			2579	3		2,556,064	2,556,064		
		101583	2339	2		55,518,556	55,518,556		
			2474	3		79,333,415	79,333,415		
		101585	1000	2		3,590,353	3,590,353		
			2474	3		5,088,287	5,088,287		
		101589	1000	2		44,162,064	44,162,064		
			2122	2		217	217		
			2474	3		62,587,479	62,587,479		
		101596	1000	2		137,416,459	137,416,459		
			2122	2		860,676	860,676		
			2339	2		38,335,514	38,335,514		
			2474	3		250,350,449	250,350,449		
			2579	3		1,244,157	1,244,157		
		101938	1000	2		1,360,790	1,360,790		
			2122	2		212	212		
			2474	3		1,929,052	1,929,052		
		102212	1000	2		2,344,029	2,344,029		
			2122	2		478	478		
			2474	3		3,323,163	3,323,163		
			2579	3		2,927	2,927		
		102234	1000	2		428,409	428,409		

BUDGET ENTITY	PROGRAM COMPONENT	APPROP CAT	FUND	FSI	CURR YR EST EXP 2002-03 OVER(UNDER) BACK UP OF A02 ALL FUNDS	CURR YR EST EXP 2002-03 ALL FUNDS	EST EXP FY 2002-03 ALL FUNDS	CURR YR EST EXP 2002-03 OVER(UNDER) EST EXP FY 2002-03 ALL FUNDS	CURR YR EST EXP 2002-03 OVER(UNDER) EST EXP FY 2002-03 FTE
68501400	1301000000	102234	2122	2		62	62		
			2474	3		607,297	607,297		
		102324	1000	2		11,539,202	11,539,202		
			2122	2		671,397	671,397		
			2474	3		17,308,693	17,308,693		
			2579	3		318,842	318,842		
		102387	1000	2		40,635,894	40,635,894		
			2122	2		63,435	63,435		
			2474	3		57,746,296	57,746,296		
			2579	3		141,422	141,422		
		102528	1000	2		827,876	827,876		
			2122	2		625	625		
			2474	3		1,174,817	1,174,817		
			2579	3		3,907	3,907		
		102538	1000	2		7,699,807	7,699,807		
			2122	2		328	328		
			2474	3		10,913,058	10,913,058		
		102540	1000	2		4,882,801	4,882,801		
			2122	2		4,602	4,602		
			2474	3		6,931,329	6,931,329		
			2579	3		396	396		
		102541	1000	2		171,548,787	171,548,787		
			2122	2		44,629,743	44,629,743		
			2474	3		304,879,551	304,879,551		
			2579	3		2,651,865	2,651,865		
		102681	1000	2		598,607,851	598,607,851		
			2122	2		7,038,669	7,038,669		
			2339	2		230,497,217	230,497,217		
				3		281,003,591	281,003,591		
			2474	3		859,341,967	859,341,967		
			2579	3		2,890,526	2,890,526		
		102685	1000	2		60,871,035	60,871,035		
			2122	2		13,812	13,812		
			2474	3		86,301,189	86,301,189		
			2579	3		2,273	2,273		
		103276	1000	2		19,420,037	19,420,037		
			2122	2		28,935	28,935		
			2474	3		27,593,742	27,593,742		
			2579	3		38,327	38,327		
		103529	1000	2		8,072,286	8,072,286		
			2122	2		871	871		
			2474	3		11,442,282	11,442,282		
			2579	3		639	639		
		103558	1000	2		10,838,096	10,838,096		
			2122	2		10,291	10,291		
			2474	3		16,532,780	16,532,780		
			2579	3		62,157	62,157		

BUDGET ENTITY	PROGRAM COMPONENT	APPROP CAT	FUND	FSI	CURR YR EST EXP 2002-03 OVER(UNDER) BACK UP OF A02 ALL FUNDS	CURR YR EST EXP 2002-03 ALL FUNDS	EST EXP FY 2002-03 ALL FUNDS	CURR YR EST EXP 2002-03 OVER(UNDER) EST EXP FY 2002-03 ALL FUNDS	CURR YR EST EXP 2002-03 OVER(UNDER) EST EXP FY 2002-03 FTE
68501400	1301000000	103606	2339	2		4,435,000	4,435,000		
			2474	3		6,337,407	6,337,407		
		103634	1000	1		78,300	78,300		
			2122	2		90,000	90,000		
			2339	2		3,000,000	3,000,000		
			2474	3		4,286,859	4,286,859		
		103724	1000	2		202,231,555	202,231,555		
			2122	2		804	804		
			2474	3		254,620,773	254,620,773		
		103740	1000	2		5,535,046	5,535,046		
			2122	2		2,050	2,050		
			2474	3		7,849,391	7,849,391		
		103742	1000	2		22,246,459	22,246,459		
			2122	2		18,137	18,137		
			2474	3		31,572,706	31,572,706		
			2579	3		283,779	283,779		
		105445	2474	3		50,000,000	50,000,000		
68501500	1303000000	100602	2474	2		13,598,836	13,598,836		
				3		19,272,413	19,272,413		
		101554	1000	2		16,685,020	16,685,020		
			2122	2		182	182		
			2474	2		329,712,037	329,712,037		
				3		490,917,821	490,917,821		
		101557	2474	2		13,083,321	13,083,321		
				3		18,541,819	18,541,819		
		101644	2474	2		58,141,904	58,141,904		
				3		82,399,320	82,399,320		
		102233	1000	2		889,276,219	889,276,219		
			2122	2		4,000,000	4,000,000		
			2474	2		3,500,000	3,500,000		
				3		1,270,920,708	1,270,920,708		
		103556	2474	2		2,667,354	2,667,354		
				3		3,780,201	3,780,201		
		103559	2474	3		53,362,198	53,362,198		
		103602	2474	3		2,444,444	2,444,444		
		105440	2474	2		171,664	171,664		
				3		243,285	243,285		
		109970	1000	2		10,576,502	10,576,502		
			2474	2		1,050,790	1,050,790		
				3		16,478,321	16,478,321		
68501600	1301000000	102671	1000	2		223,250,652	223,250,652		
			2474	3		316,393,176	316,393,176		
		102672	1000	2		285,183,056	285,183,056		
			2122	2		4,422,273	4,422,273		
			2474	3		411,126,019	411,126,019		
			2579	3		7,481,443	7,481,443		
68700700	1204010000	010000	1000	1		764,488	764,488		

BUDGET ENTITY	PROGRAM COMPONENT	APPROP CAT	FUND	FSI	CURR YR EST EXP 2002-03 OVER(UNDER) BACK UP OF A02 ALL FUNDS	CURR YR EST EXP 2002-03 ALL FUNDS	EST EXP FY 2002-03 ALL FUNDS	CURR YR EST EXP 2002-03 OVER(UNDER) EST EXP FY 2002-03 ALL FUNDS	CURR YR EST EXP 2002-03 OVER(UNDER) EST EXP FY 2002-03 FTE
68700700	1204010000	010000	1000	2		473,039	473,039		
			2003	1		22,751,812	22,751,812		
				2		293,082	293,082		
				3		879,269	879,269		
			2021	2		43,575	43,575		
				3		391,156	391,156		
		030000	2003	1		26,788	26,788		
		040000	1000	1		206,114	206,114		
				2		428,389	428,389		
			2003	1		2,541,755	2,541,755		
				2		427,370	427,370		
				3		2,489,638	2,489,638		
			2021	2		10,882	10,882		
				3		55,144	55,144		
		060000	1000	2		29,204	29,204		
			2003	1		45,265	45,265		
				2		24,444	24,444		
				3		29,204	29,204		
		100778	1000	1		925,000	925,000		
		100859	1000	1		6,000,000	6,000,000		
		101113	2522	1		776,720	776,720		
		102100	2003	1		111,820	111,820		
		103241	2003	1		294,443	294,443		
			2021	3		599	599		
		106026	1000	2		184,750	184,750		
			2003	3		184,750	184,750		
		107040	1000	1		5,282	5,282		
			2003	1		130,376	130,376		
			2021	2		1,006	1,006		
	1204020000	010000	2509	1		69,887	69,887		
		040000	2509	1		301,006	301,006		
	1205010000	010000	2003	1		406,361	406,361		
		030000	2003	1		10,265	10,265		
		040000	2003	1		31,994-	31,994-		
		103241	2003	1		112,251	112,251		
		107040	2003	1		69,005	69,005		
	1205020000	010000	1000	1		11,117	11,117		
				2		235,067	235,067		
			2003	1		2,262,493	2,262,493		
				2		98,696	98,696		
			2021	2		57,021	57,021		
				3		452,899	452,899		
			2122	2		9,758	9,758		
		030000	2003	1		77,488	77,488		
		040000	1000	1		119,782	119,782		
				2		3,508,837	3,508,837		
			2003	1		618,924	618,924		

PGENLP02 LAS/PBS SYSTEM
BUDGET PERIOD: 1993-2004
STATE OF FLORIDA

LRPP AUDIT
(A02 = A38)

BUDGET ENTITY	PROGRAM COMPONENT	APPROP CAT	FUND	FSI	CURR YR EST EXP 2002-03 OVER(UNDER) BACK UP OF A02 ALL FUNDS	CURR YR EST EXP 2002-03 ALL FUNDS	EST EXP FY 2002-03 ALL FUNDS	CURR YR EST EXP 2002-03 OVER(UNDER) EST EXP FY 2002-03 ALL FUNDS	CURR YR EST EXP 2002-03 OVER(UNDER) EST EXP FY 2002-03 FTE
68700700	1205020000	040000	2021	2		10,400	10,400		
				3		3,717,017	3,717,017		
			2122	2		2,768	2,768		
		060000	2003	1		2,515	2,515		
		103241	1000	2		9,630	9,630		
			2003	1		28,324	28,324		
			2021	3		9,630	9,630		
		107040	2003	1		13,835	13,835		
			2021	2		3,773	3,773		
	1602000000	010000	1000	1		40,153	40,153		
				2		80,672	80,672		
			2003	1		33,682	33,682		
				3		464,779	464,779		
			2021	2		11,520	11,520		
				3		159,393	159,393		
		040000	1000	1		9,632	9,632		
				2		64,195	64,195		
			2003	1		853,349	853,349		
			2021	2		14,072	14,072		
				3		175,462	175,462		
		060000	1000	2		3,478	3,478		
			2021	2		2,377	2,377		
				3		5,854	5,854		
		100565	2003	1		1,490,264	1,490,264		
		103241	1000	2		3,281	3,281		
			2003	1		6,397	6,397		
			2021	3		2,684	2,684		
		107040	1000	1		251	251		
			2003	1		2,600	2,600		
			2021	2		2,516	2,516		
REPORT TOTAL:						12,073,415,885	12,073,415,885		

*** END OF REPORT ***

BUDGET ENTITY	PROGRAM COMPONENT	APPROP CAT	FUND	FSI	ACT APPR(2) NR 2002-03 ALL FUNDS	EST EXP N/R FY 2002-03 ALL FUNDS	ACT APPR(2) NR 2002-03 OVER(UNDER) EST EXP N/R FY 2002-03 ALL FUNDS
68200000	1602000000	040000	2021	2	2,659	2,659	
				3	2,659	2,659	
		060000	2021	2	1,389	1,389	
				3	1,389	1,389	
68500200	1602000000	030000	1000	2	224,580	224,580	
			2021	3	673,740	673,740	
		040000	1000	1	450,000	450,000	
				2	1,476,044	1,476,044	
			2021	2	406,647	406,647	
				3	2,528,610	2,528,610	
		060000	1000	2	5,276	5,276	
			2021	2	3,472	3,472	
				3	24,587	24,587	
			2339	2	12,500	12,500	
		094657	1000	2	1,025,000	1,025,000	
			2021	3	825,000	825,000	
		102086	1000	2	259,627	259,627	
			2021	3	778,883	778,883	
			2579	3	5,568	5,568	
68501400	1301000000	100060	1000	2	7,629,741	7,629,741	
			2474	3	10,812,948	10,812,948	
			2579	3	242,255	242,255	
		101246	1000	2	25,041	25,041	
			2474	3	225,374	225,374	
		101561	1000	2	1,808,701	1,808,701	
			2474	3	2,404,957	2,404,957	
		101582	1000	2	35,152,438	35,152,438	
			2474	3	49,818,406	49,818,406	
		101589	1000	2	3,898,785	3,898,785	
			2474	3	5,525,398	5,525,398	
		101596	1000	2	8,519,629	8,519,629	
			2474	3	12,005,385	12,005,385	
		102212	1000	2	47,620	47,620	
			2474	3	67,488	67,488	
		102324	1000	2	146,286	146,286	
			2474	3	207,318	207,318	
		102387	1000	2	98,154	98,154	
			2474	3	139,104	139,104	
		102528	1000	2	16,553	16,553	
			2474	3	23,459	23,459	
		102541	1000	2	21,119,358	21,119,358	
			2474	3	28,232,363	28,232,363	
		102681	1000	2	36,605,804	36,605,804	
			2339	2	11,207,655	11,207,655	
				3	15,883,607	15,883,607	
			2474	3	51,791,801	51,791,801	
		103276	1000	2	192,543	192,543	

PGENLP02 LAS/PBS SYSTEM
BUDGET PERIOD: 1993-2004
STATE OF FLORIDA

LRPP AUDIT
(NONRECURRING G62 = A39)

BUDGET ENTITY	PROGRAM COMPONENT	APPROP CAT	FUND	FSI	ACT APPR(2) NR 2002-03 ALL FUNDS	EST EXP N/R FY 2002-03 ALL FUNDS	ACT APPR(2) NR 2002-03 OVER(UNDER) EST EXP N/R FY 2002-03 ALL FUNDS
68501400	1301000000	103276	2474	3	272,873	272,873	
		103724	1000	2	3,055,130	3,055,130	
			2474	3	4,329,762	4,329,762	
		103742	1000	2	140,659	140,659	
			2474	3	199,343	199,343	
68501500	1303000000	101554	1000	2	2,700,000	2,700,000	
			2474	3	3,826,468	3,826,468	
		102233	1000	2	11,139,221	11,139,221	
			2474	3	15,786,621	15,786,621	
68700700	1204010000	040000	1000	2	250,000	250,000	
		100778	1000	1	300,000	300,000	
		100859	1000	1	6,000,000	6,000,000	
REPORT TOTAL:					360,555,878	360,555,878	

*** END OF REPORT ***

BUDGET ENTITY	PROGRAM COMPONENT	APPROP CAT	FUND	ACT PR YR EXP 2001-02 ALL FUNDS	ACT PR YR FY 2001-02 ALL FUNDS	ACT PR YR EXP 2001-02 OVER(UNDER) ACT PR YR FY 2001-02 ALL FUNDS
68200000	1602000000	010000	1000	1,805,926	1,805,926	
			2003	7,364,706	7,364,706	
			2021	1,321,869	1,321,869	
			2122	15,332	15,332	
		030000	1000	38,723	38,723	
			2003	326,875	326,875	
			2021	78,869	78,869	
		040000	1000	314,412	314,412	
			2003	2,076,216	2,076,216	
			2021	238,937	238,937	
			2122	2,928	2,928	
		060000	1000	5,512	5,512	
			2003	53,135	53,135	
			2021	52,028	52,028	
			2122	25,452	25,452	
		103241	1000	9,773	9,773	
			2003	90,114	90,114	
			2021	9,746	9,746	
		104505	1000	53,976	53,976	
	1603000000	010000	1000	283,119	283,119	
			2003	2,045,299	2,045,299	
			2021	934,829	934,829	
		030000	1000	32,537	32,537	
			2003	65,916	65,916	
			2021	30,938	30,938	
		040000	1000	202,133	202,133	
			2003	1,401,805	1,401,805	
			2021	726,497	726,497	
		060000	1000	204,529	204,529	
			2003	101,587	101,587	
			2021	660,519	660,519	
			2122	80,808	80,808	
		103241	1000	5,982	5,982	
			2003	18,359	18,359	
			2021	5,964	5,964	
		210010	2003	390,602	390,602	
			2021	23,840	23,840	
68500100	1301000000	040000	2122	1,119,024	1,119,024	
			2474	2,507,106	2,507,106	
		100031	2122	68,419,651	68,419,651	
			2474	164,042,040	164,042,040	
		102340	2122	7,656,897	7,656,897	
			2339	2,803,834	2,803,834	
			2474	17,560,236	17,560,236	
		102342	2122	10,251,578	10,251,578	
			2339	620,025	620,025	
			2474	23,486,697	23,486,697	

BUDGET ENTITY	PROGRAM COMPONENT	APPROP CAT	FUND	ACT PR YR EXP 2001-02 ALL FUNDS	ACT PR YR FY 2001-02 ALL FUNDS	ACT PR YR EXP 2001-02 OVER(UNDER) ACT PR YR FY 2001-02 ALL FUNDS
68500200	1602000000	010000	1000	10,501,547	10,501,547	
			2003	157,613	157,613	
			2021	16,923,727	16,923,727	
			2122	75,182	75,182	
			2339	183,790	183,790	
		030000	1000	166,979	166,979	
			2003	3,842	3,842	
			2021	13,160,948	13,160,948	
			2122	522	522	
		040000	1000	4,189,731	4,189,731	
			2003	3,368	3,368	
			2021	16,742,009	16,742,009	
			2122	102,222	102,222	
			2339	2,673,916	2,673,916	
		060000	1000	47,386	47,386	
			2021	319,106	319,106	
		100549	2122	7,750,001	7,750,001	
		100609	2021	750,000	750,000	
		100693	1000	656,781	656,781	
			2021	656,781	656,781	
		102086	1000	20,192,959	20,192,959	
			2021	48,732,464	48,732,464	
			2122	421,815	421,815	
			2579	106,666	106,666	
		102093	1000	950,000	950,000	
			2021	3,166,895	3,166,895	
		103241	1000	173,356	173,356	
			2021	172,836	172,836	
68501400	1301000000	100060	1000	6,506,139	6,506,139	
			2122	7,590,242	7,590,242	
			2474	18,272,159	18,272,159	
			2579	517,970	517,970	
		100216	2474	5,561,111	5,561,111	
		100311	1000	29,826,123	29,826,123	
			2122	199,467	199,467	
			2474	38,597,501	38,597,501	
			2579	7,776	7,776	
		100436	1000	66,971,103	66,971,103	
			2122	308,154	308,154	
			2474	106,937,053	106,937,053	
			2579	86,631	86,631	
		100616	1000	23,906,679	23,906,679	
			2122	318,674	318,674	
			2474	31,401,182	31,401,182	
			2579	182,374	182,374	
		100919	2122	3,440	3,440	
			2474	7,678,440	7,678,440	

BUDGET ENTITY	PROGRAM COMPONENT	APPROP CAT	FUND	ACT PR YR EXP 2001-02 ALL FUNDS	ACT PR YR FY 2001-02 ALL FUNDS	ACT PR YR EXP 2001-02 OVER(UNDER) ACT PR YR FY 2001-02 ALL FUNDS
68501400	1301000000	100919	2579	144	144	
		101029	1000	46,694,785	46,694,785	
			2122	343,440	343,440	
			2474	61,308,901	61,308,901	
			2579	313,077	313,077	
		101240	1000	720,185	720,185	
			2122	500,000	500,000	
			2339	4,751,302	4,751,302	
			2474	6,114,973	6,114,973	
		101246	1000	967,184	967,184	
			2122	20,112	20,112	
			2474	8,885,667	8,885,667	
			2579	28,955	28,955	
		101400	2339	8,600,001	8,600,001	
			2474	11,138,353	11,138,353	
		101554	2474	14,826,156	14,826,156	
		101561	1000	34,747,015	34,747,015	
			2122	3,534,181	3,534,181	
			2474	49,653,864	49,653,864	
			2579	116,194	116,194	
		101575	1000	44,264,170	44,264,170	
			2122	9,390	9,390	
			2474	57,387,888	57,387,888	
		101582	1000	132,376,186	132,376,186	
			2122	29,422,308	29,422,308	
			2339	364,051,834	364,051,834	
			2474	1,124,622,727	1,124,622,727	
			2565	358,600,000	358,600,000	
			2579	2,328,019	2,328,019	
		101585	1000	3,797,924	3,797,924	
			2474	4,922,912	4,922,912	
		101589	1000	41,975,409	41,975,409	
			2122	1,758,091	1,758,091	
			2474	56,688,722	56,688,722	
		101596	1000	96,024,972	96,024,972	
			2122	6,279,156	6,279,156	
			2339	62,684,399	62,684,399	
			2474	214,370,299	214,370,299	
			2579	1,103,758	1,103,758	
		101938	1000	1,395,145	1,395,145	
			2122	3,042	3,042	
			2474	1,815,333	1,815,333	
			2579	49	49	
		102212	1000	2,267,108	2,267,108	
			2122	29,396	29,396	
			2474	2,980,142	2,980,142	
			2579	2,215	2,215	

BUDGET ENTITY	PROGRAM COMPONENT	APPROP CAT	FUND	ACT PR YR EXP 2001-02 ALL FUNDS	ACT PR YR FY 2001-02 ALL FUNDS	ACT PR YR EXP 2001-02 OVER(UNDER) ACT PR YR FY 2001-02 ALL FUNDS
68501400	1301000000	102234	1000	427,047	427,047	
			2122	414	414	
			2474	554,483	554,483	
			2579	150	150	
		102324	1000	12,135,443	12,135,443	
			2122	760,329	760,329	
			2474	16,747,413	16,747,413	
			2579	330,767	330,767	
		102387	1000	40,424,513	40,424,513	
			2122	410,643	410,643	
			2474	52,996,090	52,996,090	
			2579	132,755	132,755	
		102528	1000	819,387	819,387	
			2122	10,489	10,489	
			2474	1,079,411	1,079,411	
			2579	3,507	3,507	
		102538	1000	7,949,995	7,949,995	
			2122	9,313	9,313	
			2474	10,326,093	10,326,093	
		102540	1000	5,009,978	5,009,978	
			2122	13,793	13,793	
			2474	6,525,420	6,525,420	
			2579	282	282	
		102541	1000	168,584,631	168,584,631	
			2122	47,905,080	47,905,080	
			2474	281,198,266	281,198,266	
			2579	2,592,252	2,592,252	
		102681	1000	502,692,912	502,692,912	
			2122	20,676,704	20,676,704	
			2339	374,430,581	374,430,581	
			2474	679,022,610	679,022,610	
			2579	2,452,935	2,452,935	
		102685	1000	54,229,278	54,229,278	
			2122	36,422	36,422	
			2474	70,375,595	70,375,595	
			2579	1,653	1,653	
		103276	1000	17,277,525	17,277,525	
			2122	195,019	195,019	
			2474	22,734,416	22,734,416	
			2579	34,392	34,392	
		103529	1000	8,048,059	8,048,059	
			2122	6,461	6,461	
			2474	10,446,710	10,446,710	
			2579	456	456	
		103558	1000	10,180,395	10,180,395	
			2122	97,468	97,468	
			2474	14,565,540	14,565,540	

BUDGET ENTITY	PROGRAM COMPONENT	APPROP CAT	FUND	ACT PR YR EXP 2001-02 ALL FUNDS	ACT PR YR FY 2001-02 ALL FUNDS	ACT PR YR EXP 2001-02 OVER(UNDER) ACT PR YR FY 2001-02 ALL FUNDS
68501400	1301000000	103558	2579	78,150	78,150	
		103604	2339	1,516,000	1,516,000	
			2474	1,963,458	1,963,458	
		103606	2339	4,435,000	4,435,000	
			2474	5,744,022	5,744,022	
		103634	1000	87,000	87,000	
			2122	100,000	100,000	
			2339	3,000,000	3,000,000	
			2474	3,885,472	3,885,472	
		103724	1000	192,934,787	192,934,787	
			2122	1,329,053	1,329,053	
			2474	225,266,668	225,266,668	
		103740	1000	5,636,831	5,636,831	
			2122	8,811	8,811	
			2474	7,326,597	7,326,597	
		103742	1000	20,572,845	20,572,845	
			2122	182,430	182,430	
			2474	26,984,403	26,984,403	
			2579	259,529	259,529	
		105445	2474	41,819,077	41,819,077	
68501500	1303000000	100602	2474	32,871,249	32,871,249	
		101554	1000	16,444,945	16,444,945	
			2122	199	199	
			2474	688,715,446	688,715,446	
		101557	2474	29,486,548	29,486,548	
		101644	2474	133,522,569	133,522,569	
		102233	1000	816,343,893	816,343,893	
			2122	4,000,000	4,000,000	
			2474	1,071,375,724	1,071,375,724	
		103556	2474	6,277,301	6,277,301	
		103559	2474	82,106,302	82,106,302	
		103602	2474	2,444,444	2,444,444	
		105440	2474	350,310	350,310	
		109970	1000	9,132,454	9,132,454	
			2474	17,035,297	17,035,297	
68501600	1301000000	102671	1000	202,365,517	202,365,517	
			2474	262,308,460	262,308,460	
		102672	1000	230,118,582	230,118,582	
			2122	4,422,153	4,422,153	
			2474	306,707,768	306,707,768	
			2579	4,541,461	4,541,461	
68700700	1204010000	010000	1000	799,633	799,633	
			2003	21,926,183	21,926,183	
			2021	326,230	326,230	
		030000	2003	38,689	38,689	
		040000	1000	232,254	232,254	
			2003	6,367,108	6,367,108	

BUDGET ENTITY	PROGRAM COMPONENT	APPROP CAT	FUND	ACT PR YR EXP 2001-02 ALL FUNDS	ACT PR YR FY 2001-02 ALL FUNDS	ACT PR YR EXP 2001-02 OVER(UNDER) ACT PR YR FY 2001-02 ALL FUNDS
68700700	1204010000	040000	2021	175,399	175,399	
		060000	1000	42,936	42,936	
			2003	271,901	271,901	
		100778	1000	800,000	800,000	
		101113	2522	278,791	278,791	
		102100	2003	147,159	147,159	
		103241	2003	217,168	217,168	
			2021	442	442	
		106026	1000	184,750	184,750	
			2003	184,750	184,750	
	1204020000	010000	2509	63,270	63,270	
		040000	2509	168,066	168,066	
	1205010000	010000	2003	10,345,819	10,345,819	
		030000	2003	1,351,595	1,351,595	
		040000	2003	2,933,676	2,933,676	
		060000	2003	40,394	40,394	
		103241	2003	82,792	82,792	
	1205020000	010000	1000	312,742	312,742	
			2003	1,191,039	1,191,039	
			2021	445,249	445,249	
			2122	24,875	24,875	
		030000	2003	44,870	44,870	
		040000	1000	3,730,572	3,730,572	
			2003	243,047	243,047	
			2021	3,736,852	3,736,852	
			2122	3,351	3,351	
		060000	2003	2,515	2,515	
			2021	6,363	6,363	
		103241	1000	7,086	7,086	
			2003	20,891	20,891	
			2021	7,102	7,102	
	1602000000	010000	1000	220,868	220,868	
			2003	688,765	688,765	
			2021	287,119	287,119	
		030000	2003	3,537	3,537	
		040000	1000	59,220	59,220	
			2003	913,257	913,257	
			2021	152,621	152,621	
		060000	1000	6,477	6,477	
			2003	17,949	17,949	
		100565	2003	1,262,163	1,262,163	
		102100	2003	10,379	10,379	
		103241	1000	2,464	2,464	
			2003	4,718	4,718	
			2021	1,980	1,980	
		104505	2003	3,329	3,329	

BUDGET ENTITY	PROGRAM COMPONENT	APPROP CAT	FUND	ACT PR YR EXP 2001-02 ALL FUNDS	ACT PR YR FY 2001-02 ALL FUNDS	ACT PR YR EXP 2001-02 OVER(UNDER) ACT PR YR FY 2001-02 ALL FUNDS
REPORT TOTAL:				10,646,390,858	10,646,390,858	

*** END OF REPORT ***

PGENLP02 LAS/PBS SYSTEM AUDIT A12=A26 & A04=A27 SP 25
BUDGET PERIOD: 1993-2004
STATE OF FLORIDA

BUDGET ENTITY	PROGRAM COMPONENT	APPROP CAT	FUND	FSI	A12-A26 DIFFERENCE ALL FUNDS	A04-A27 DIFFERENCE ALL FUNDS	A12-A26 DIFFERENCE FTE

*** NO RECORDS SELECTED FOR REPORTING ***

*** END OF REPORT ***