Long-Range Program Plan

Fiscal Years 2006-2007 through 2010-2011

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Preliminary LRPP

AGENCY FOR HEALTH CARE ADMINISTRATION

LONG-RANGE PROGRAM PLAN

FOR

FY 2006-2007 THROUGH FY 2010-2011

September 30, 2005

Preliminary LRPP

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Agency Mission

The Agency for Health Care Administration Champions Accessible, Affordable, Quality Health Care for All Floridians.

“Purchase, Provide and Protect”

Agency Priorities

1. **Medicaid Reform**: How can the vital health care safety net for Florida's low-income, elderly and disabled citizens be maintained while moving toward a more consumer-centric system which introduces market forces to boost access to services?

2. **Long-Term Care Delivery Systems**: How can we develop an integrated long-term care plan?

3. **Create a Transparent Health Care Delivery System**: How can we shine a light on the cost to delivery health care services and effectively communicate that information to health care consumers?

4. **Disparity in Health Care Delivery**: How can we eliminate gender, racial, ethnic, economic, social and cultural disparities in the health care delivery system?

5. **Performance Measures**: How can we use performance and outcome measures as a basis to reallocate resources, to reward or sanction providers, and to assist Floridians in making informed health care decisions?

6. **Safety Net**: How can we support the viability of safety net providers, particularly those hospitals and programs in rural areas?

7. **Technology in Health Care Delivery**: How can we use technology to improve access to health care delivery and management systems?

8. **Efficiency in Health Care Delivery**: How will we manage reduced Medicaid budgets without adversely affecting the balance between reducing benefits and reducing beneficiaries?

9. **Prescription Drug Management**: How can prescription drug management be used to reduce short-term and long-term medical costs?

Agency Goals Listed in Order of Priority

Priority	Agency Goal	Goal Description	Program
1.	**Goal 1**	To be a prudent purchaser of quality health care services for low-income Floridians	Health Care Services (Medicaid)
2.	**Goal 2**	To maximize the use of Agency resources by increasing the efficiency and effectiveness of Agency operations to achieve required outcomes and eliminate unnecessary health facility regulations	Health Care Regulation (Health Quality Assurance)
3.	**Goal 3**	To increase the public's access to health care information	Administration and Support (Chief of Staff)
4.	**Goal 4**	To combat fraud, waste and abuse in the Florida Medicaid Program	Administration and Support (Inspector General)
5.	**Goal 5**	To promote and advance the mission and objectives of the Agency through increased communication with the general public, media, Agency stakeholders, and federal and state policy makers	Administration and Support (Chief of Staff)

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(Division of Medicaid)

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Health Care Services

(Division of Medicaid)

Goal 1: To be a prudent purchaser of quality health care services for low-income Floridians.

Objective 1. A: To limit the increase in per-case-month expenditures for Medicaid recipients to less than five percent per year for FY 2006-07 through FY 2010-11.

Service Outcome Measure 1. A: Medicaid expenditures per-case-month.

Service Outcome Measure Projection Table 1. A: Medicaid expenditures per-case-month

Baseline/Year FY 2004-05	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
$568.72 Expenditures per-case-month at 5% increments	$597.15	$627.01	$658.36	$691.28	$725.84

Objective 1. B: To improve baseline performance on 95 percent of all outcome measures developed under performance-based budgeting by FY 2010-11

Service Outcome Measure 1. B: Percent improvement in Medicaid's 58 performance-based outcome indicators.

Service Outcome Measure Projection Table 1. B: Performance Based Budgeting (PB^2) Medicaid Outcome Indicators tracked over time.

Baseline/Year FY 2002-03	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
58 Number of PB^2 outcome measures	58	58	58	58	58
36 Number of outcome measures improved upon	41	45	49	52	55
62%	75%	80%	85%	90%	95%

Percent of outcomes with improvements					

Objective 1. C: To slow the growth in long-term care expenditures by $1,540 million, by converting a portion of the institutional care budget to community-based long-term care, by FY 2010-11.

Service Outcome Measure 1. C: Long-term care savings in millions over current projections.

Service Outcome Measure Projection Table 1. C: Projected Long Term Care (LTC) Expenditures (in millions)

Baseline/Year FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
$2,677 Current LTC Projections	$2,972	$3,299	$3,662	$4,065	$4,512
$2,534 Revised LTC Projections	$2,785	$3,061	$3,364	$3,697	$4,063
$143 LTC Savings	$187	$238	$298	$368	$449

Table excludes nursing home crossover payments from Medicare. Please note that Baseline/Year has been changed from the FY 2002-03 information that was in last year's LRPP.

Objective 1. D: To improve recipients reported satisfaction with access to specialty care services to 85 percent by FY 2010-11.

Service Outcome Measure 1. D: Percent of MediPass adult patients who needed specialty care who reported it was not a problem to obtain specialty care.

Service Outcome Measure Projection Table 1. D:

Baseline/Year FY 2002-03	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
63% Percent of MediPass patients that reported satisfaction with access to specialty care.	64%	70%	75%	80%	85%

Objective 1. E: To increase the percentage of the Medicaid budget used for capitated services to 35 percent by FY 2010-11.

Service Outcome Measure 1. E: Percent of the Medicaid budget paid through capitated payments.

Service Outcome Measure Projection Table 1. E:

Baseline/Year FY 2003-04	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
11.6% Percent of the Medicaid budget paid through capitated payments	18%	20%	23%	25%	35%

Objective 1. F: To increase the extent of consumer directed care to at least nine programs/services, to include development of alternative options to Medicaid such as Health Flex through which low–income recipients can obtain coverage, by FY 2010-11.

Service Outcome Measure 1. F: Number of services/programs available to low–income recipients that utilize principals of consumer driven care.

Service Outcome Measure Projection Table 1. F:
(Services/programs with consumer directed incentives)

Baseline/Year FY 2003-04	FY 2006-07	FY 2007-08	FY 2008-09	2009-10	FY 2010-11
1 Services/programs with consumer directed incentives	4	5	6	7	9

Objective 1. G: To increase physician use of electronic records and adherence to evidence based medicine by promoting the use of hand-held wireless devices by Medicaid enrolled physicians to 60 percent by FY 2010-11.

Service Outcome Measure 1. G: Percent of physicians enrolled in Medicaid who uses hand-held wireless devices to assist in prescribing.

Service Outcome Measure Projection Table 1. G:

Baseline/Year FY 2004-05	FY 2006-07	FY 2007-08	2008-09	FY 2009-10	FY 2010-11
8%	25%	33%	42%	50%	60%

Linkage of Agency Goals and Programs to Governor's Priorities

	Governor's Priorities and Goals	Name of Agency Goals and/or Programs
1.	Improve education	
2.	Strengthen families	**Goal 1:** To be a prudent purchaser of quality health care services for low-income Floridians.
3.	Promote economic diversity	
4.	Reduce violent crime and illegal drug use	
5.	Create a smaller, more effective, more efficient government	**Goal 1:** To be a prudent purchaser of quality health care services for low-income Floridians.
6.	Enhance Florida's environment and quality of life	**Goal 1:** To be a prudent purchaser of quality health care services for low-income Floridians.

Trends and Conditions Statement

Authority for the Florida Medicaid Program is established in Chapter 409, F.S., (Social and Economic Assistance) and Chapter 59G (Medicaid) of the Florida Administrative Code. The statutes that mandate the management and administration of state and federal Medicaid programs, child health insurance programs, and the development of plans and policies for Florida's health care industry include Chapters 20, 216, 393, 395, 400, 408, 409, 440, 627 and 641, F.S.

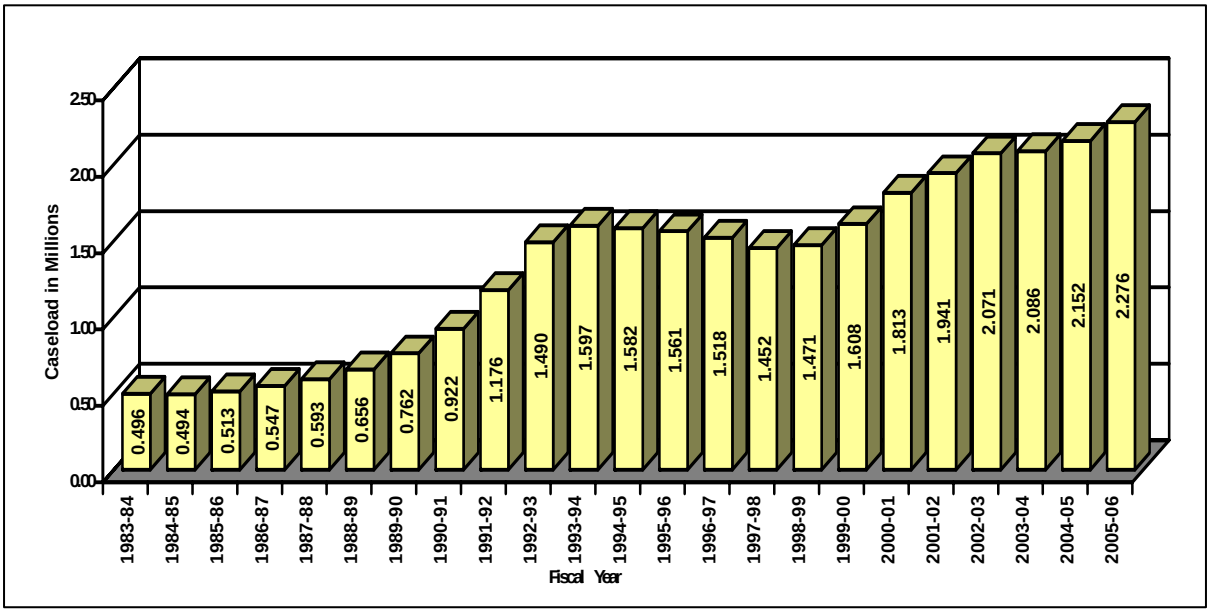
Medicaid must meet federal standards or obtain a federal waiver to receive federal financial participation in the program. Although rates of federal participation vary each year, 58.9 percent of the cost of most Medicaid services will be reimbursed with federal funds in FY 2005-06. The federal government reimburses 50 percent of most administrative cost expenditures. Information technology projects and services such as family planning are reimbursed at higher levels.

In April 2005 Florida's population was estimated to be 17,844,137 million, making it the fourth most populous state in the nation. Projections indicate that Florida will become the third most populous state by CY 2025. Florida's population growth rate is among the highest in the nation. Between CY 2002 and CY 2003 the population grew 1.9 percent compared to .9 percent for the nation overall.

As population grows so does the need for health services. Furthermore, Florida, at 17.6 percent has one of the nation's highest percentages of elderly populations. The population over age 65 is projected to grow to 3,572,641 by CY 2010 as the baby–boom generation reaches retirement age and will represent 18.4 percent of the population. Since the elderly use more health resources than younger populations, the demand for health care will be even greater than the population growth alone would predict.

While Medicaid caseloads dropped in the 1990s as a result of welfare reform, they have risen sharply since CY 1999, primarily due to population growth, the economic downturn, a higher percentage of the population is below the poverty line, and outreach for the State Child Health Insurance Program, KidCare. The number of Florida Medicaid beneficiaries grew to 2.276 million in FY 2004-05. See Table 1 below for trends in average monthly caseloads.

Table 1. Growth in Average Medicaid Monthly Caseload



Florida Medicaid is one of the most cost-efficient programs in the country. Florida Medicaid per enrollee costs at $4,697 in CY 2002 was well below the national average of $5,985. Medicaid also controlled the rate of growth in per enrollee cost better than most states. The rate of growth in per enrollee costs between CY 1998 and CY 2002 was 1.9 percent compared to 5.1 nationally.

Even with Florida's relatively good track record, the downturn in the economy combined with rising caseloads and medical costs put pressure on the state budget. Medicaid consumed 25.3 percent of the state's FY 2004-05 budget and will be 23.87 percent of the FY 2005-06 budget under current programs. These rates compare to only 13.8 percent of the state's budget in FY 1991-92.

Florida is not alone. Almost all states have faced difficulties in funding Medicaid. Many states had to sustain major cuts. Florida fared better than most. Cuts in benefit levels were limited although across the board rate reductions from normally scheduled rate increases were authorized for FY 2004-05.

Budget constraints also resulted in a cap being placed on enrollment in the Florida's State Children's Health Insurance Program (SCHIP), a component of KidCare, as of June 30, 2003. The CY 2004 Florida Legislature increased the cap to allow 90,000 children on a wait list to enroll in SCHIP. At the same time, program restrictions were put into place, which require families to provide additional documentation during the application and renewal process. In addition, families who have access to employer-based family health insurance coverage will not be allowed to enroll their children if the cost of such coverage is less than 5 percent of their family incomes.

The CY 2005 Florida Legislature reinstated year round enrollment for the Title XXI KidCare programs. Enrollment in the Title XXI programs will cease when enrollment reaches the GAA target enrollment ceiling. Enrollment cannot begin again until the Social Services estimating Conference deems there is sufficient funding to allow for increased enrollment.

Except for the Medicaid component, KidCare is not an entitlement; it requires participants to contribute to the cost of their monthly premiums. Several entities partner with Medicaid to implement KidCare.

Implementation of KidCare is credited with the number of uninsured children in Florida dropping by 5.8 percent in CY 1997 to 14.5 percent in CY 2002 - the most recent Current Population Survey (CPS). The percent of uninsured children dropped more than the 3.4 percent in U.S. overall in the same time period. The drop occurred while the percent of uninsured Florida adults under 65 rose to over 22.9 percent. Florida's overall rate of uninsurance at 2.8 million or 17.5 percent in CY 2002 is above the national average of 14.7 percent. Six states-Texas, New Mexico, California, Louisiana, Oklahoma, and Alaska have higher rates.

"The Agency has updated the Florida Heath Insurance Study for CY 2004 and KidCare is credited with the decrease in the uninsured rate for children over the past five years, from 13.9 percent in CY 1999 to 12.1 percent in CY 2004. While this reduction is clearly positive, it is noteworthy that over half a million children are still without health insurance. Uninsurance in children has long-term implications for the state since inadequate health screenings and developmental assessments may result in lifelong health problems.

Uninsurance rates may vary by socio-economic and demographic characteristics. Particularly high rates of uninsurance are found among Hispanic children, children in very low-income families, and children between ages 10 to 18.

Employer-sponsored insurance, which covers over half of Florida children under 19, declined notably during CY 1999-2004. This decline mirrors national trends, since participation in Medicaid and other Title XXI programs has increased, along with individually purchased health insurance coverage for children.

Between 1999 and 2004, notable changes in the rates of health insurance coverage were observed:

- Overall, the statewide percentage of Floridians under age 65 who are uninsured rose from 16.8 percent to 19.2 percent.

- Miami- Dade County now has the highest rate of uninsurance in the state at 28.7 percent (up from 24.6% in 1999). Most districts had an increase, with slight decreases in the rates being observed in District 3 (Alachua and Marion Counties) and District 13 (the rural counties around Lake Okeechobee).

- Rates of uninsurance increased slightly or were stable for people at either end of the income spectrum, but increased markedly for middle-income families, especially working families with annual incomes between $15,000 and $45,000.

- As in 1999, Hispanics had the highest rate of uninsurance. The rate of uninsurance among Hispanics is 31.8 percent, followed by Blacks at 22.6 percent. For White non-Hispanics, the percentage lacking health coverage was 14.3 percent.

- Florida adults born outside the United States have a rate of uninsurance double that of those born in the United States (37.9% vs. 17.5%)."

More information regarding the findings of the Florida Health Insurance Study is available on the Agency's web site at:

http://ahca.myflorida.com/Medicaid/quality_management/mrp/Projects/fhis2004/reports.shtml.

Medicaid Reform

Florida's Medicaid Reform program will create an efficient and effective statewide delivery system that empowers patients while enhancing quality of care. As such, Medicaid Reform will ultimately impact virtually every aspect of Florida's current Medicaid program. Because of the magnitude of the changes, the state has adopted a measured approach to implementation, using a geographic and population phase-in. Implementation and expansion are contingent upon Legislative approval.

Senate Bill (SB) 838 authorizes the Agency to seek a demonstration project waiver, pursuant to s. 1115 of the Social Security Act, to create a statewide initiative to provide for a more efficient and effective services delivery system that enhances quality of care and client outcomes in the Florida Medicaid program. Medicaid Reform will create programs that center on care coordination, align financial incentives, and provide direct incentives to individuals to take an active role in their own health care.

This legislation contains specific requirements regarding implementation phases and necessary legislative approval. As specified in SB 838, the state will initially implement Medicaid Reform in two counties: Broward and Duval. It is expected that these two counties will become operational in the fourth quarter of FY 2005-06, April through June 2006. Within a year of implementation in Duval County, Medicaid Reform will expand to include three counties contiguous to Duval County: Baker, Clay and Nassau Counties. The state will comply with all statutory requirements regarding expansion of the program and will expand only as authorized by the Legislature.

Upon full implementation, Medicaid Reform will serve the vast majority of Medicaid enrollees, including:

- TANF and TANF related enrollees
- Aged and disabled enrollees
- Enrollees residing in nursing homes and other institutional settings;
- Enrollees receiving hospice services;
- Enrollees receiving sub-acute inpatient psychiatric services; and,
- Dual-eligibles.

Medicaid Reform will be the state's primary delivery system, with only a few groups of recipients continuing in the fee-for-service delivery system. Fee-for-service will be limited to groups such as the Medically Needy and those with retroactive eligibility.

This implementation timeline provides an outline of pre-implementation activities, the initial phases of implementation, and consideration for future expansion. The Florida Legislature must approve any expansion beyond the initial phase-in. Through on-going coordination and reporting, CMS will be notified in advance as additional phases proceed.

The Agency has already submitted a 1115 demonstration waiver to the Centers for Medicare and Medicaid Services to allow Florida to use non-state workers for eligibility determination for Medicaid. The waiver would allow Florida to secure a private vendor who can conduct eligibility determination in a more cost-efficient manner. The Department of Children and Families (DCF) has been delegated responsibility for Medicaid eligibility determination and will be responsible for implementing the waiver.

The Agency is also considering the utilization of electronic health care information to promote innovations that will facilitate evidence-based medicine. To reflect the Agency's commitment, the Agency is adopting (Objective I G): "To increase physician use of electronic records and adherence to evidence based medicine by promoting the use of hand-held wireless devices by Medicaid enrolled physicians to 60 percent by FY 2010-11." Use of the hand-held devices will facilitate both recommendations of the taskforce. The Agency started this initiative

In FY 2003-04 with a contract with Gold Standard Multimedia (GSM), a Florida company, who in partnership with Sprint provided hand-held wireless devices to 1,000 high volume Medicaid prescribers and expanded to 3,000 in FY 2004-05. The hand-held wireless devices allow prescribers to access all medications their patients received in the prior six months through Medicaid. Prescribers can check for the medical appropriateness of proposed prescriptions

given potential interactions with those drugs. The system was updated in FY 2004-05. Updates permit electronic submission of the prescription to the recipient's pharmacy or hard copy printing the prescription so that errors due to handwriting are reduced.

Other efforts to increase use of electronic records include working closely with the Governor's Health Information Infrastructure Advisory Board to ensure that Florida Medicaid is at the forefront of electronic medical record implementation. Simultaneously, plans are being developed to re-engineer the claims processing system as part of the required re-procurement of a fiscal agent contract in CY 2007. The goal of re-engineering is to increase the systems ability to respond rapidly to change. Currently, it can take six months or longer to modify the system.

The Medicaid program continues to pursue other cost containment measures such as prior authorization of services, changes in the pharmacy program, and increased use of managed care. These measures are anticipated to facilitate Medicaid meeting (Objective 1. A) "To limit the increase in per-case-month expenditures for Medicaid recipients to less than five percent per year for FY 2006-07 through FY 2010-11."

One of the most comprehensive of these initiatives has targeted prescribed drug costs, which, at the time controls were started, was the fastest growing item in Florida's Medicaid budget. Medicaid has achieved substantial savings with the limits that have been imposed. Table 2 compares growth in pharmacy to growth in other costs. As can be seen, pharmacy costs have grown less in the last few years compared to total costs.

Per-enrollee cost for prescribed drugs grew 278 percent between FY 1994-95 and FY 2003-04. Medicaid mental health drug spending exceeded $568 million in FY 2004-05, for a decrease of two percent from FY 2003-04 expenditures. Effective FY 2005-06, Medicaid mental health drugs previously exempt from limits imposed on other drug classes, are subject to prior authorization with supporting documentation for those drugs not listed on the preferred drug list (PDL).

To further offset the increases in drug costs, the CY 2005 General Appropriations Act authorized Medicaid to pursue the following cost saving measures:

- Modify the preferred drug list (PDL) to include additional cost effective therapeutic options, step therapies and prior authorization of drugs not on the PDL;

- Remove mental health drugs from exemption status and negotiate supplemental rebates for inclusion on the PDL. (The majority of mental health drugs have met this requirement.);

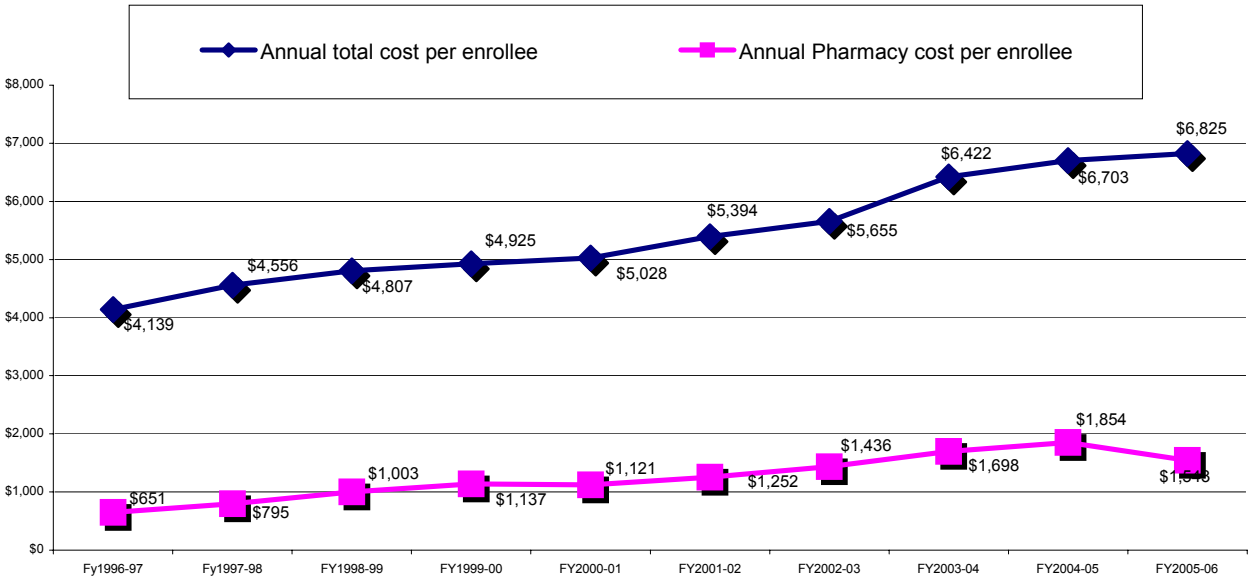
- Limit the dosage frequencies and amounts for certain drugs in accordance with the Food and Drugs Administration guidelines;

- Require prior authorization of certain drugs, as well as recipient age related prior authorization requirements as necessary for certain drugs;

- Coordinate the pharmacy lock-in program wherein recipients who appear to be problem users are limited to one pharmacy with the physician lock-in program, wherein these recipients are limited to one physician or select group of physicians so that drug prescribing and use can be better monitored; and

- Continue the use of the wireless handheld clinical pharmacology drug information database along with the provision of a web-based real time prescription tracking and dispensing system.

Table: 2 Annual Cost Per Enrollee: FY 1996-97 through 2005-06



Reducing pharmacy and other health care expenses is especially challenging in the face of the needs of people with chronic illnesses. The Florida Medicaid Program was a pioneer in developing and implementing disease management initiatives to improve health care for this population while controlling costs. Focusing on prevention, education and increased self-management for Medicaid recipients, the Agency has contracted with several disease management organizations to provide services for various disease states that include HIV/AIDS, hemophilia, diabetes, asthma, hypertension, and congestive heart failure. Currently Medicaid is working with the Department of Health on a hepatitis C program and plans to contract with a specialty pharmacist to manage beneficiaries with hemophilia.

The Agency is also participating in a national project to explore the effects of disease management on expenditures for those individuals dually eligible for both Medicaid and Medicare. Dual eligibles are among the most expensive Medicaid populations and are more likely to have a chronic condition. Previously, this population was excluded from Medicaid disease management. Without the national demonstration, disease management would increase costs to Medicaid and savings would occur to Medicare, which is primarily responsible for dual eligible's physician and hospital costs.

Since the diseases targeted by disease management initiatives disproportionately affect racial and ethnic minorities, disease management initiatives also serve to reduce racial and ethnic disparities in health status as well as improve performance on the Agency's outcome measures

(Objective 1.B): "To improve baseline performance on 95 percent of all outcome measures developed under performance-based budgeting by FY 2010-11."

The Agency is committed to eliminating disparities and tracks progress and performance in terms of the 58 performance based budgeting outcome measures adopted by the Agency.

Improvement as measured by these outcomes has been steady. The most recent report on these 58 outcome measures can be found at:

http://www.fdhc.state.fl.us/Medicaid/deputy_secretary/recent_presentations/2003_Medicaid_Outcome_Measures.pdf

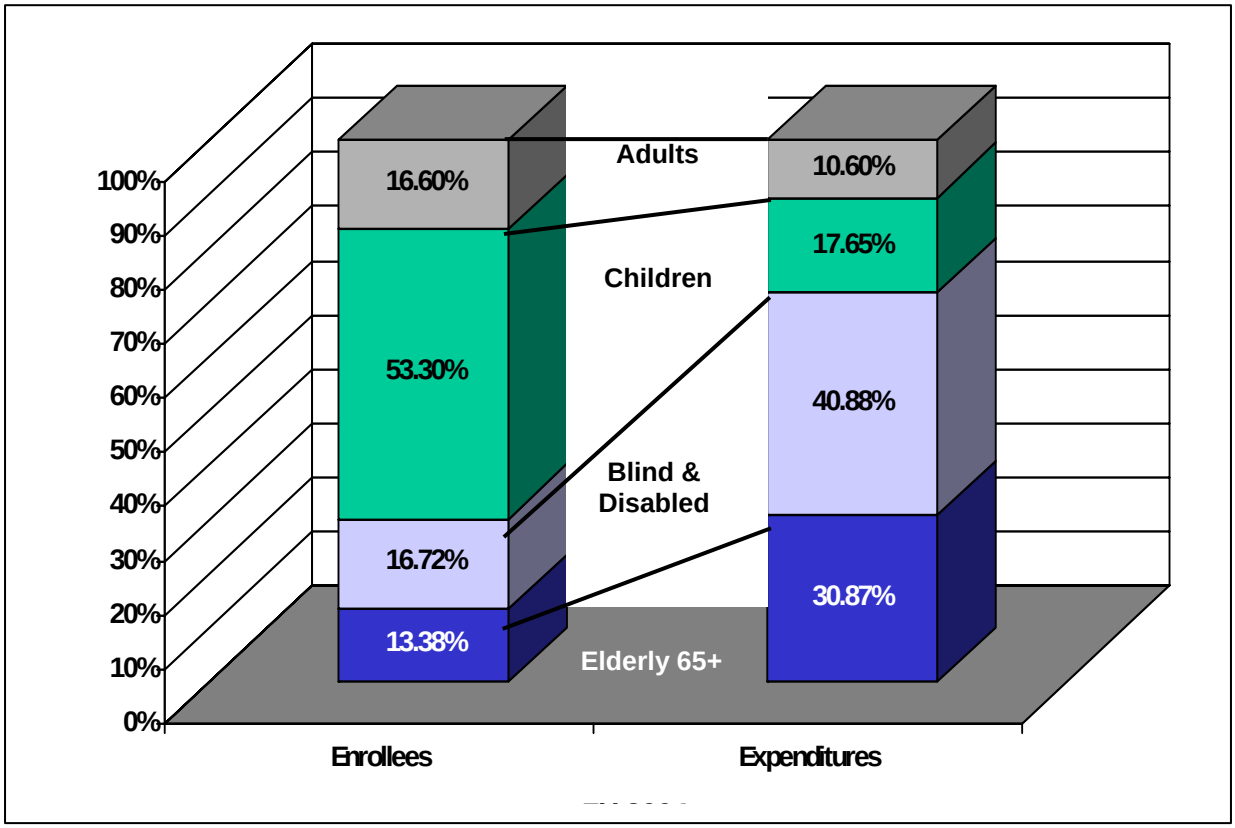
A major objective of Medicaid Reform is (Objective 1.D): "To improve recipients reported satisfaction with access to specialty care services to 85 percent by FY 2010-11." The 2002 Report on *Access to Medicaid Physician Specialists* found that access to needed dental care for children, and specialty physician services was critically below industry standards. Gaps are increasing according to recipients. The number of recipients reporting no problems in accessing needed specialty care dropped from 63 percent in FY 2002-03 to 50 percent in FY 2003-04. The drop occurred despite small provider fee increases and efforts to enroll more providers. Given the declining access, additional revenues were appropriated for FY 2004-05 to allow the Agency to raise specialty reimbursement in areas of critical shortage.

The Agency is also testing the use of capitated dental plans to increase access. The Agency selected a vendor to provide capitated dental services to most children enrolled in Medicaid in Miami-Dade County. The capitated dental plan is required to provide preventive services to 60 percent of its enrollees. The Agency plans to provide financial incentives to providers in the plan that provides preventive services to 80 percent of the children enrolled with them. It is anticipated that this will increase access for children as well as contribute to meeting Objective 1.E: "To increase the percentage of the Medicaid budget used for capitated services to 35 percent by FY 2010-11."

Capitation of the Medicaid budget is expected to reduce costs and bring stability to Medicaid expenditures. For example, through a demonstration project in Area 6, the Tampa/Hillsborough area, the Agency demonstrated that savings could be achieved by capitating behavioral health services to carve out a behavioral health plan without sacrificing outcomes. In FY 2002-03, the program was expanded to Area 1-the Panhandle. The Agency is taking action to extend the program statewide in the coming year. Expansion is expected to result in nine percent savings over current fee-for-service expenditures for behavioral health.

Developing new models for long-term-care is critical. Over 70 percent of current expenditures are for the elderly and disabled as is illustrated in Table 3. Significant reductions in the growth of the Medicaid budget will not be achieved without addressing the aged or disabled population.

Table 3 Medicaid Budget - How it is Spent FY 2004-05



Long-term care use is greatest in the population over age 85. The 85 plus population is expected to grow significantly by CY 2025. Although studies of the elderly suggest that impairment levels at each age cohort are diminishing, the decline may not be enough to offset the population growth. This, combined with recent court decisions such as Olmstead, which interprets the Americans with Disabilities Act to require that alternatives to institutional care be made available to those needing long-term care due to disability, puts pressure on federal and state health programs to develop cost effective alternatives for those in need of long-term care, including the provision of personal care and home health services.

The Agency has done a remarkable job in controlling long-term care costs given its large elderly population and 60 percent growth in the past ten years of the oldest-old who are more likely to need nursing home assistance. For example, Florida ranks 44 out of 50 states in total Medicaid long-term care expenditures. Furthermore, Medicaid reimbursement represents a declining share of resident days and nursing home occupancy rates are declining.

Growth in the nursing home budget slowed with expansion of Medicaid alternatives. Even so, Florida's relatively low expenditures have been concentrated in nursing home care, indicating that additional savings are achievable. By continuing to develop options for serving the frail elderly and developmentally disabled in less restrictive settings which are generally less costly than residential or Nursing Home settings, the Agency hopes to meet Objective 1.C: "To slow the growth in long-term care expenditures by $1,540 million, by converting a portion of the institutional care budget to community-based long-term care, by FY 2010-11."

The Agency has been particularly successful in this regard for the developmentally disabled. As of July 2004, 24,059 individuals were being served in community based options under a federal waiver for persons over the age of three with the following disabilities: an IQ of 59 or less; primary disability of either autism, cerebral palsy, spina bifida, or Prader-Willi syndrome; or these conditions in combination with other handicapping functional limitations. Although the waiver has increased the number served in the community by over 24 percent, there is still a waiting list of 15,000. Funding was appropriated to reduce the waiting list by 156 in FY 2004-05. The Agency hopes to free up about $7 million in additional funding through prior authorization of all support plans. Support plans are developed based on a client's assessed needs.

In the CY 2004 legislative session, the Agency for Persons with Disabilities (APD) was formed and administration of the waiver was transferred to the new agency from the Department of Children and Families (DCF). The goal is to make services more flexible with less paperwork needed to change service packages, increase consumer direction in service provision, improve assessment, and improve the rate structure and billing process.

The Medicaid program seeks to meet the recipients' needs for access to affordable quality health care, while controlling costs. In fact, improving access and quality may reduce costs. For example, the Agency expanded coverage to more seniors under the Silver Saver Drug program, using savings from cost containment strategies.

One way to accomplish this is thorough Objective 1. F to "To increase the extent of consumer directed care to at least nine programs/services, to include development of alternative options to Medicaid such as Health Flex through which low–income recipients can obtain coverage, by FY 2010-11." By involving beneficiaries in costs or decisions about their care, recipients have incentives for appropriate utilization that meets their needs. Currently, the Agency participates in a federal demonstration project testing the ability of beneficiaries to select their own providers within a fixed budget. Providers do not have to be a Medicaid provider and may be a family member. An independent evaluation of program outcomes shows that consumer direction reduces unmet needs, maintains or improves quality of care, does not cost more than traditional home and community based services, and dramatically improves consumer satisfaction with care.

In February 2004, the Agency increased the fee Medicaid beneficiaries pay when they inappropriately use the emergency room for non-urgent care, thus reducing the costs to the Agency. The Agency is continuing to explore how Health Flex, a program which allows entities other than traditional insurance companies to offer reduced benefit packages to increase the affordability of alternative sources of coverage for low-income individuals; thus reducing the demand for publicly funded services. The Agency is working with local safety net programs to develop alternatives for coverage of low-income recipients. Such programs would accomplish two goals - strengthening the safety net providers, and promoting individual responsibility for their own health care.

Other steps the Agency is taking to improve purchasing and access to quality services that are medically necessary include:

- Continuing to test new delivery systems, such as exclusive provider organizations (EPOs) and the Pediatric Emergency Room Diversion project;

- Developing strategies to reduce payment and eligibility errors;

- Redesigning Medicaid's quality improvement and monitoring activities to improve comprehensiveness and coordination of initiatives;

- Identifying opportunities to prevent disability or need for public coverage;

- Exploring methods for expanding services utilizing existing state and local revenues as a base for federal financial participation;

- Reducing costs through selective contracting for laboratory and other services; and

- Exploring and adopting technological solutions for improving efficiency and reducing costs.

Implementing new strategies is hindered by an antiquated claims payment system. Currently, implementation of simple changes require significant lead time and delay. The Agency is required to reselect a fiscal agent in CY 2007. As part of this process the Agency plans to require that the system be updated to be more flexible.

List of Potential Policy Changes Affecting Agency Budget Requests

Number	Potential Policy Changes	Reference LRPP Goals	The Legislative Budget Requests (LBR) Affected	Impact on Policy if LBR Request is not Approved
1	The Centers for Medicare and Medicaid Services (CMS) is increasingly requiring the use of actuaries to prepare rates and cost effectiveness estimates for waivers	1	Medicaid	The Agency's Medicaid program will have greater difficulty in getting MediPass and other waivers approved if not prepared by an actuary. Without these waivers, the Agency cannot implement many cost saving strategies.
2	Continuation of Developmental Services redesign initiative	1	Medicaid, and the Department of Children and Families	Program will remain as it is.
3	Physician fee increase for adults and children	1	Medicaid	Physician access will be jeopardized for Medicaid recipients.
4	Continue funding for programs that were funded with non-recurring funds in the 2005 legislative session	1	Medicaid	Medicaid recipients and providers will be adversely affected.
5	Implement the new enrollment criteria for KidCare	1	Medicaid	Applicants will continue to wait approximately 6 to 8 weeks to be notified of the acceptance or denial of their application. An incomplete and improperly completed application will continue to be put on hold while the missing or correct information is obtained.

List of Changes that Would Require Legislative Action

Number	Changes in Current Programs	Statutory Reference	Changes in Current Services	Changes in Current Activities	Substantive Legislative Action Required to Support Changes
1	None				

List of All Task Forces and Studies in Progress

Item Number	Bill Number	Legislative Language	Division
1.	HB 17 Page 3 Lines 62-70 Webpage	The Agency shall work with the Agency for Persons with Disabilities to develop a model home and community-based waiver to serve children who are diagnosed with familial dysautonomia or Riley-Day syndrome caused by a mutation of the IKBKAP gene on chromosome 9. The Agency shall seek federal waiver approval and implement the approved waiver subject to the availability of funds and any limitations provided in the General Appropriations Act. The Agency may adopt rules to implement this waiver program.	Medicaid
2.	SB 404 Page 64 Lines 21-30 Webpage	Section 409.912(39)(a)(14), F.S., is created to read: The Agency, in conjunction with the Pharmaceutical and Therapeutics Committee, may require age-related prior authorizations for certain prescribed drugs. The Agency may preauthorize the use of a drug for a recipient who may not meet the age requirement or may exceed the length of therapy for use of this product as recommended by the manufacturer and approved by the Food and Drug Administration. Prior authorization may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug.	Medicaid
3.	SB 404 Pages 7-71 Lines 25-7 Webpage	Section 409.9124(2), F.S., is amended to read: Each year prior to establishing new managed care rates, the Agency shall review all prior year adjustments for changes in trend, and shall reduce or eliminate those adjustments which are not reasonable and which reflect policies or programs which are not in effect.	Medicaid
4.	SB 404 Pages 4-5 Lines 21-4 Webpage	The Department of Health shall establish an oversight workgroup for the personal care attendant program to oversee the implementation and administration of the program. The workgroup shall be composed of one representative from the Brain and Spinal Cord Injury Program in the Department of Health, one representative from the Department of Revenue, one representative from the Florida Medicaid Program in the Agency for Health Care Administration, one representative from the Florida Endowment Foundation for Vocational Rehabilitation, one representative from the Florida Association of Centers for Independent Living, one representative from the Division of Vocational Rehabilitation of the Department of Education, and two members who are persons with traumatic spinal cord injuries or are family members of persons with traumatic	Medicaid

		spinal cord injuries.	
5.	SB 838 Page 6 Lines 8-13 Webpage	Section 409.912, F.S., is amended to include that the Agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the Agency, to improve patient care and reduce inappropriate utilization. The Agency may seek federal waivers necessary to administer these policies.	Medicaid
6.	SB 838 Page 16 Lines 5-12 Webpage	By December 1, 2005, the Agency for Health Care Administration, in partnership with the Department of Elderly Affairs, shall create an integrated, fixed-payment delivery system for Medicaid recipients who are 60 years of age or older. The Agency for Health Care Administration shall implement the integrated system initially on a pilot basis in two areas of the state. In one of the areas enrollment shall be on a voluntary basis.	Medicaid
7.	SB 838 Page 23 Lines 4-11 Webpage	The Agency shall develop a procedure for determining whether health care providers and service vendors can provide the Medicaid program a business case that demonstrates whether a particular good or service can offset the cost of providing the good or service in an alternative setting or through other means and therefore should receive a higher reimbursement.	Medicaid
8.	SB 838 Page 29 Lines 8-20 Webpage	By April 1, 2006, the Agency shall contract with an entity to design a database of clinical utilization information or electronic medical records for Medicaid providers. This system must be web-based and allow providers to review on a real-time basis the utilization of Medicaid services, including, but not limited to, physician office visits, inpatient and outpatient hospitalizations, laboratory and pathology services, radiological and other imaging services, dental care, and patterns of dispensing prescription drugs in order to coordinate care and identify potential fraud and abuse. The Agency may apply for any federal waivers needed to administer this paragraph.	Medicaid
9.	SB 838 Page 49 Lines 5-15 Webpage	The Agency shall implement a Medicaid prescription-drug-management system. The Agency may contract with a vendor that has experience in operating prescription-drug-management systems in order to implement this system. Any management system that is implemented in accordance with this subparagraph must rely on cooperation between physicians and pharmacists to determine appropriate practice patterns and clinical guidelines to improve the prescribing, dispensing, and	Medicaid

		use of drugs in the Medicaid program. The Agency may seek federal waivers to implement this program.	
10.	SB 838 Page 51 Lines 20-26 Webpage	S. 409.912(15)(2004 Florida Statutes), relating to the return and reuse of pharmaceuticals program, is amended to state that the Agency shall determine if the program has reduced the amount of Medicaid prescription drugs which are destroyed on an annual basis and if there are additional ways to ensure more prescription drugs are not destroyed which could safely be reused. The Agency's conclusion and recommendations shall be reported to the Legislature by December 1, 2005.	Medicaid
11.	SB 838 Pages 56-57 Lines 22-10 Webpage	The Agency is authorized to seek experimental, pilot, or demonstration project waivers, pursuant to s. 1115 of the Social Security Act, to create a statewide initiative to provide for a more efficient and effective service delivery system that enhances quality of care and client outcomes in the Florida Medicaid program pursuant to this section. Phase one of the demonstration shall be implemented in two geographic areas. One site shall include only Broward County. A second site shall initially include Duval County and shall be expanded to include Baker, Clay, and Nassau Counties within 1 year after the Duval County program becomes operational. This waiver authority is contingent upon federal approval to preserve the UPL funding mechanism for hospitals, including a guarantee of a reasonable growth factor, a methodology to allow the use of a portion of these funds to serve as a risk pool for demonstration sites, provisions to preserve the state's ability to use intergovernmental transfers, and provisions to protect the disproportionate share program authorized pursuant to this chapter.	Medicaid
12.	SB 838 Pages 65-66 Lines 30-03 Webpage	In the context of County health departments delivering school-based services pursuant to ss. 381.0056 and 381.0057, F.S. the Agency, the Department of Health, and the Department of Education shall develop procedures for ensuring that a student's capitated managed care network provider receives information relating to services provided in accordance with ss. 381.0056, 381.0057, 409.9071, and 1011.70. F.S.	Medicaid
13.	SB 838 Page 71 Lines 1-7 Webpage	Pilot Project Waiver Review Process: All waiver applications shall be provided for review and comment to the appropriate committees of the Senate and House of Representatives for at least 10 working days prior to submission. All waivers submitted to and approved by the United States Centers for Medicare and Medicaid Services under this section must be approved by the Legislature.	Medicaid

14.	SB 838 Page 71 Lines 7-12 Webpage	Pilot Project Waiver Review Process: Federally approved waivers must be submitted to the President of the Senate and the Speaker of the House of Representatives for referral to the appropriate legislative committees. The appropriate committees shall recommend whether to approve the implementation of any waivers to the Legislature as a whole.	Medicaid
15.	SB 838 Page 71 Lines 13-20 Webpage	Pilot Project Waiver Review Process: The Agency shall submit a plan containing a recommended timeline for implementation of any waivers and budgetary projections of the effect of the pilot program under this section on the total Medicaid budget for the 2006-2007 through 2009-2010 state fiscal years. This implementation plan shall be submitted to the President of the Senate and the Speaker of the House of Representatives at the same time any waivers are submitted for consideration by the Legislature.	Medicaid
16.	SB 838 Page 77 Lines 1-20 Webpage	The Agency for Health Care Administration shall submit to the Legislature by December 15, 2005, a report on the legal and administrative barriers to enforcing section 409.9081, Florida Statutes. The report must describe how many services require co-payments, which providers collect co-payments, and the total amount of co-payments collected from recipients for all services required under section 409.9081, Florida Statutes, by provider type for the 2001-2002 through 2004-2005 fiscal years. The Agency shall recommend a mechanism to enforce the requirement for Medicaid recipients to make co-payments, which does not shift the co-payment amount to the provider. The Agency shall also identify the federal or state laws or regulations that permit Medicaid recipients to declare impoverishment in order to avoid paying the co-payment and extent to which these statements of impoverishment are verified. If claims of impoverishment are not currently verified, the Agency shall recommend a system for such verification. The report must also identify any other cost-sharing measures that could be imposed on Medicaid recipients.	Medicaid
17.	SB 838 Pages 77-78 Lines 21-4 Webpage	The Agency for Health Care Administration shall submit to the Legislature by January 15, 2006, recommendations to ensure that Medicaid is the payer of last resort as required by section 409.910, Florida Statutes. The report must identify the public and private entities that are liable for primary payment of health care services and recommend methods to improve enforcement of third-party liability responsibility and repayment of benefits to the state Medicaid program. The report must estimate the potential recoveries that may be achieved through third-party liability efforts if administrative and legal barriers are removed. The	Medicaid

		report must recommend whether modifications to the agency's contingency-fee contract for third-party liability could enhance third-party liability for benefits provided to Medicaid recipients.	
18.	SB 838 Pages 78-79 Lines 20-5 Webpage	The Agency for Health Care Administration shall identify how many individuals in the long-term care diversion programs that receive care at home have a patient-responsibility payment associated with their participation in the diversion program. If no system is available to assess this information, the Agency shall determine the cost of creating a system to identify and collect these payments and whether the cost of developing a system for this purpose is offset by the amount of patient-responsibility payments that could be collected with the system. The Agency shall report this information to the Legislature by December 1, 2005.	Medicaid
19.	HB 869 Page 3 Lines 56-70 Webpage	The Agency for Health Care Administration shall conduct a chronic disease study on Medicaid coverage for therapies required by patients with inflammatory bowel disease, such as ostomy supplies, parenteral nutrition, enteral nutrition, medically necessary food products, and therapies approved by the Food and Drug Administration for Crohn's disease and ulcerative colitis. The study will take into consideration the appropriate outpatient or home health care settings, identify gaps in Medicaid coverage that impact the health and quality of life for inflammatory bowel disease patients, and empower the inflammatory bowel disease community to pursue appropriate changes in the Medicaid reimbursement policy. The Agency shall submit a report of its findings to the Governor, the President of the Senate, and the Speaker of the House of Representatives by February 1, 2006.	Medicaid
20.	SB 1208 Pages 2-3 Lines 27-26 Webpage	The Agency for Health Care Administration is directed to establish the Florida Long-term Care Partnership Program. The Agency for Health Care Administration shall develop a plan for implementation of the Florida Long-term Care Partnership Program. The Agency shall present the plan in the form of recommended legislation to the President of the Senate and the Speaker of House of Representatives prior to the commencement of the next legislative session.	Medicaid
21.	SB 1314 Pages 11-12 Lines 29-5 Webpage	The Independent Living Services Advisory Council shall conduct a study to determine the most effective way to address the health insurance needs of young adults who are in the Independent Living Program of the Department of Children and Family Services once the young adults are no longer eligible for the Florida KidCare program. The department and the Agency for Health Care Administration shall assist the advisory	Medicaid

		council in conducting the study. The advisory council shall provide a report containing recommendations to the Legislature by January 2, 2006.	
22.	SB 2600 Page 56, Line 190 Webpage	From the funds in Specific Appropriation 190, the Agency is authorized to test, on a pilot basis in one or more contiguous counties, a specialized, comprehensive obstetrical management program for high-risk pregnancies of Medicaid eligible women. The project may be designed to identify high-risk pregnancies of Medicaid eligible women, improve birth outcomes, and reduce costs associated with complicated pregnancies and pre-term births. The program may include the use of risk assessment, patient education, case management, home nursing visits, home uterine activity monitoring, telemedicine approaches, acuity-based clinical interventions for the management of pre-term labor, diabetes in pregnancy, pregnancy-induced hypertension, nausea and vomiting in pregnancy, and coagulation disorders, 24-hour telephone support, and patient management systems. The Agency is authorized to seek federal Medicaid waivers as necessary to implement this program.	Medicaid
23.	SB 2600 Page 56 Line 190 Webpage	From the funds in Specific Appropriation 190, the Agency for Health Care Administration, within existing resources, may contract with an integrative medical management provider to develop and implement a pilot integrated therapies program to improve the quality of care and cost-effectiveness of the MediPass disease management initiative. The disease management model may use the best practices of conventional and complementary and alternative medicine. The demonstration project shall be for three years from the date of implementation. The Agency is authorized to seek federal Medicaid waivers and any state plan amendment necessary to implement this program. The Agency shall report annually to the Executive Office of the Governor, the chair of the Senate Ways and Means Committee, and the chair of the House Fiscal Council as to the cost-effectiveness of the pilot. The Agency may expand the pilot based on favorable annual progress reports and federal approval.	Medicaid
24.	SB 2600 Page 59 Line 198 Webpage	From the funds in Specific Appropriation 198, the Agency for Health Care Administration shall continue a program to assess HIV drug resistance for cost-effective management of anti-retroviral drug therapy.	Medicaid

25.	SB 2600 Page 60 Line 204 Webpage	From the funds provided in Specific Appropriation 204, the Agency may continue the no-cost contract for a prescription drug education demonstration project in Miami-Dade county. The demonstration project may focus on mental health patients and HIV/AIDS patients, and must include an educational component to train individuals on how to properly take prescribed drugs, potential side effects, and possible drug interactions. Each participating pharmacist must provide space to ensure reasonable patient privacy, must have received special training on the new practice model from the University of Florida College of Pharmacy, and must provide clinical data and performance data as required at no cost to the state. The project shall be evaluated for actual cost savings by the agency by January 1, 2006. If savings are documented, the Agency shall retain 40 percent of actual savings, 40 percent of the savings shall be paid to participating pharmacists and 20 percent of the savings shall be paid to the University of Florida College of Pharmacy, Department of Pharmacy Practice.	Medicaid

Health Care Regulation

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Health Care Regulation

(Division of Health Quality Assurance)

Goal 2: To maximize the use of Agency resources by increasing the efficiency and effectiveness of Agency operations to achieve required outcomes and eliminate unnecessary health facility regulations.

Old Objective 2. A: To implement a quality improvement process in nursing homes which, by FY 2006-07, reduces the percentage of conditional days in nursing homes by a total of 50 percent.

Service Outcome Measure: The number of conditional days in Florida nursing homes.

Service Outcome Measure Projection Table:

Baseline/Year FY 2000-01	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10
11,670 Number of conditional nursing home days	7,002	5,835	Completed in previous year	Completed	Completed
0% Percent of Reductions	40%	50%	Completed in previous year	Completed	Completed

As conditional licensure reflects a level that is below standard, the number of days a nursing home remains on conditional status is a reasonable measure of the quality of care the facility provides. Conditional status for a nursing facility license means that a facility, due to the presence of one or more Class I or Class II deficiencies, or Class III deficiencies not corrected within the time established by the Agency, is not in substantial compliance at the time of the survey with criteria established by law or rule. If the facility has no Class I, Class II, or Class III deficiencies at the time of the follow-up survey, a standard licensure status may be assigned. An objective to reduce the number of conditional days in Florida nursing facilities would thus be a measure of the improvement statewide in nursing facility quality of care. This objective ties to the Agency's performance measures, which include a standard related to the number of serious deficiencies in skilled nursing facilities. As of June 30, 2005, the Agency had already reached its 50 percent reduction goal for the original five-year plan, with a total number of conditional days of 5,727 for the fiscal year. Although efforts to reduce conditional days will continue and the quality assurance program will remain fully operational, the original goal has been reached and the Agency has selected a new goal to pursue as Objective 2.A.

New Objective 2. A: To receive 50 percent of all facility license renewal applications electronically via the Internet within five years.

Service Outcome Measure 2. A: The number of license applications received electronically via the Internet.

Service Outcome Measure Projection Table 2. A:

Baseline/Year FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
9,744 Average annual number of renewal applications	975	1,949	2,923	3,898	4,872
0% Percent applications received via Internet	10%	20%	30%	40%	50%

The agency currently receives all applications from health care facilities in hard copy, including renewals. Each form must be signed and, depending upon the program, some must also be notarized before they can be accepted. In order to accept electronic applications over the Internet, the agency will need to establish a web based linking program connected to FRAES/LicenseEase and develop/manage software and individual passwords to enable provider use of such programming. Those efforts are currently in process and the Agency anticipates a legislative budget request in the 2006 Legislative session to begin this project. In order for the project to be a success, it must also include the ability to accept e-payments from the Internet site. E-applications of this type have met with success in other states as well as in other Florida agencies; thus we anticipate a 50 percent e-renewal application rate by FY 2010-11.

Objective 2. B: To reduce the volume of Health Facility Regulation public record requests handled using Agency resources (AHCA staff time and contract staff time) by 50 percent by FY 2009-10.

Service Outcome Measure 2. B: The number of public record requests handled by AHCA Division of Health Quality Assurance.

Service Outcome Measure Projection Table 2. B:

Baseline/Year FY 2003-04	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
3,256 Number of public record requests handled by the Division of Health Quality Assurance	2,605	2,279	1,954	1,628	Completed in previous year
Percentage reduction in the public records requests handled by the Division of Health Quality Assurance	20%	30%	40%	50%	Completed in previous year

This service measure relates to streamlining the operations of Agency staff to enable increased productivity within existing FTE resources. Failure to streamline operations will result in the need to increase staffing in order to meet the increasing demands of licensure and regulation programs. Automation of document management is one way in which streamlining will be accomplished. The first segment of a new automated document management system was put into place in the Long Term Care Unit during FY 2004-05. The system is so new that significant results will not be experienced until FY 2005-06.

Objective 2. C: To increase to 100 percent the percentage of managed care plans that meet the statewide average on each reported measure by FY 2007-08.

Service Outcome Measure 2. C: The percentage of health care plans that reach or exceed the statewide average each year on the reported HEDIS measures.

Service Outcome Measure Projection Table 2. C:

Baseline/Year FY 2000-01	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
53.0% Percentage of Medicaid HMOs that reach the statewide average on the reported HEDIS measures	85.2%	100%	Completed	Completed	Completed

Objective 2. D: To increase the numbers of fully operational health flex plans to 20 by FY 2010-11.

Service Outcome Measure 2. D: The numbers of health flex plans that are fully operational at the end of FY 20010-11.

Service Outcome Measure Projection Table 2. D:

Baseline/Year FY 2003-04	FY 2006-07	FY 2007-078	FY 2008-09	FY 2009-10	FY 2010-11
4 The number of approved, fully operational health flex plans	7	10	15	17	20

During the 2004 session of the Florida Legislature, legislators spent significant amounts of time working on and passing House Bill 1629. As it expanded the option to implement Health Flex Plans statewide, the Agency anticipates working to approve additional plans over the next five years. As no additional plans were approved during FY 2003-04, we anticipate the need to extend the time frame to meet our goal of 20 plans to FY 2010-11.

Linkage of Agency Goals and Programs to Governor's Priorities

	Governor's Priorities and Goals	Name of Agency Goals and/or Programs
1.	Improve education	
2.	Strengthen families	
3.	Promote economic diversity	**Goal 2**: To maximize the use of Agency resources by increasing the efficiency and effectiveness of Agency operations to achieve required outcomes and eliminate unnecessary health facility regulations.
4.	Reduce violent crime and illegal drug use	
5.	Create a smaller, more effective, more efficient government	**Goal 2**: To maximize the use of Agency resources by increasing the efficiency and effectiveness of Agency operations to achieve required outcomes and eliminate unnecessary health facility regulations.
6.	Enhance Florida's environment and quality of life	**Goal 2**: To maximize the use of Agency resources by increasing the efficiency and effectiveness of Agency operations to achieve required outcomes and eliminate unnecessary health facility regulations.

Goal 2 links to several of the Governor's Priorities, including creating a smaller, more effective, more efficient government that fully harnesses the power of technology; helping the most vulnerable among us; and enhancing the quality of life for Floridians. With the increasing consumer awareness created by Internet access comes an increase in consumers' perception of need for government intervention into the activities of regulated providers. Since resources are limited by budgetary constraints and competing priorities, there is little ability to increase staffing to address the increasing demand for services. Consequently, one of the Agency's top priorities is to increase the efficient use of resources for the provision of statutorily required services. These services include requirements to approve, inspect and/or survey and investigate complaints against health care facilities and health maintenance organizations mandated by Chapters 381, 383, 390, 391, 394, 395, 400, 408, 409, 483, and 641, F.S. In the case of some facilities, such as nursing homes and hospitals, the Agency must also meet federal requirements for survey completion.

Trends and Conditions Statement

Health Care Facilities

The Agency licenses, investigates, reviews, evaluates, monitors, and surveys facilities and approves facilities' construction plans, while it works to decrease the numbers of facilities in which deficiencies pose a serious threat to health, safety and welfare of Floridians. In doing so, the Agency promotes a spirit of cooperation and involvement with a complex array of stakeholders that includes the provider community, associations and advocacy groups. Statutory authority for regulation of health care facilities exists under Chapters 381, 383, 390, 395, 400, 408, and 483, F.S. These chapters cover facility types ranging from hospitals, health care clinics and adult day care centers to prescribed pediatric extended care centers and skilled nursing facilities.

Nurse staffing shortages and shortages in available specialty physicians continue to affect health care in Florida. According to the Florida Hospital Association's most recent survey (January 2005), 8.2 percent of the registered nursing positions in Florida hospitals were vacant in February 2004. This represents significant improvement over the 15.6 percent overall vacancy rate experienced in CY 2001. With the exception of Florida's Panhandle, all regions of the state experienced a drop in the registered nurse vacancy rate. The vacancy rate varies significantly by nursing specialty; however, FHA reported that turnover statistics fell dramatically from CY 2003 to CY 2004 (12.9 percent to 10.8 percent), an indication of improved nursing retention rates. As we move into FY 2005-06, it appears that there are plenty of nursing jobs available and many qualified students wanting to pursue nursing careers, but the shortage of nursing faculty in Florida's nursing schools is creating waiting lists for entry into nursing programs (Florida Trend, August 2005). Florida must be particularly vigilant in its recruitment and retention efforts because of the State's large senior population. State agencies find themselves in stiff competition for staff with the very facilities they regulate. Steps taken to address the nursing shortage, including creation of the Center for Nursing, appear to be having a positive effect. Additional funding in the form of nursing pay increases appropriated by the 2005 Legislature may further improve the ability of state agencies to attract and retain these health care professionals responsible for maintaining quality regulation.

Florida's population potentially in need of long term care is significantly greater than that of other states. Our over-85 population is almost double the national average and the annual growth of Florida's low-income elderly population is eight times the average. Through its licensure program the Agency will continue to take administrative action against nursing homes with serious deficiencies. The Agency does not anticipate that this will have fiscal implications, as the overall occupancy rate of nursing facilities in Florida for the CY 2004 was 88.12 percent, up by less than one half of one percent since the prior year. As of March 1, 2005, there were 80,160 licensed and 596 approved community nursing home beds in Florida. This represents a decrease from the prior year of 3,002 beds, or 3.6 percent of last year's total available beds. Medicaid occupancy for CY 2004 was 63.48 percent; six-month occupancy was 63.67 percent during the period July 2004 through December 2004. Any increase in expenditures required to improve quality would likely be offset by increased efficiencies obtained from higher occupancy levels for existing beds and fewer beds in the system.

Overall, Florida's facilities are improving. For FY 2004-05, the most recent year for which complete information is available, conditional days in nursing homes were down by slightly more than 50 percent from the initial assessment of such days in FY 2000-01. More oversight and

more open communication between the Agency and providers, including joint training sessions, have enhanced improvements in all types of facilities—but nursing homes are the most obvious example. Although the Agency had, by June 30, 2005, met its objective to reduce conditional days by 50 percent it will continue these efforts and the quality assurance program will remain fully operational.

The Agency is required to report annually to the Legislature on adverse incidents and to publish a semi-annual report on nursing homes regarding notices of intent (NOI) reported, regulatory deficiencies cited and federal quality information. The FY 2004-05 report, entitled "Nursing Home and Assisted Living Facility: Adverse Incidents & Notices of Intent Filed**,"** specifically notes the following:

July 1, 2004 to June 30, 2005

- 4,528 reported adverse incidents occurring with associated outcomes.
- 51 on-site visits to nursing homes and 44 on-site visits to assisted living facilities specifically in response to adverse incident requiring investigations.
- 115 practitioner cases opened by the Department of Health in response to adverse incident reports with 39 license revocations or suspensions.
- 39 percent of nursing homes reported receiving a notice of intent to litigate.

July 1, 2001 to June 30, 2005

- 177 assisted living facility notice of intent reports and 3,288 nursing home notices of intent reports were received by the Agency.
- 24 percent annual decrease in the number of nursing homes reporting receipt of notices of intent to litigate (NOIs) between the last two fiscal years. Declines over the past fours years of nursing homes reporting receipt of multiple NOIs: 38 percent in nursing homes reporting two to four NOIs and 87 percent decline in number of nursing homes reporting five to nine NOIs.
- 50 percent decline between July 1, 2004 and June 30, 2005 in the numbers of nursing home complaints filed with the Clerks of the County Courts received by the Agency.
- 71 percent decline in the most serious nursing home deficiencies cited and continued decline in the number of nursing homes listed in the quarterly Nursing Home Watch List.

Adverse incident reporting enables Agency staff to observe the facility's risk management process without actually being on-site. Risk management is a facility's mechanism to identify problem areas, to enhance resident safety and prevent recurrence of adverse events.

Technology, Public Information, Privacy and Document Management

As part of its mission to promote accessible, affordable, quality health care, the Agency aims to improve the quality of Florida's health care regardless of the location where such care is provided. The Agency must take advantage of all available technologies to speed the process

of licensing facilities, reduce duplication of effort and ensure that monitoring, evaluation and investigation systems are effective. In the past, the Agency improved the efficiency of operations by consolidating area offices and allowing tele-working. Such consolidation enabled staff and office space reductions; however, it did not necessarily improve efficiency of handling the documents and paper files that are so much a part of the licensure and regulatory effort. In addition to the need to survey, license and regulate facilities, the Agency is tasked with responding to public information requests filed under chapter 119, F.S., and the federal Freedom of Information Act, for all the programs and facilities it regulates. This responsibility has grown in complexity over time, and in FY 2004-05, the Agency tracked 2,788 public information requests made to the Division of Health Quality Assurance.

As demonstrated repeatedly by the failure of legislation to restrict public access to records held by state agencies and by efforts to expand the types of information available to the general public, Florida's citizens have a fundamental interest in obtaining Agency records they believe would be useful in securing and managing their health care. In addition, as a result of the increasingly litigious environment in which we operate, attorneys and others cognizant of the value of such records are prone to request significant numbers of public records on behalf of their clients.

In the past, the Agency used a contractor to redact and scan documents deemed to be available for public information for submission to the requestors. Over time, the costs for such requests have increased substantially and a significant amount of staff time is spent to pull, redact, copy and re-file reams of paper documents. Often, multiple sequential requests will be made for the same documents, necessitating duplication of effort.

To streamline this process, the Agency elected to develop its own document management system. The initial segment of this process began with a request for $93,000 in funding in FY 2003-04. Additional funding in the amount of $428,447 was secured for FY 2005-06. Anticipating that this system will be successful at the central office and at the two area office pilot sites selected this year, the agency has requested a third and final year of funding for the document management system in FY 2006-07. Such funding will enable the Agency to establish electronic scanning, redaction and storage of documents for easy retrieval and response to public records requests. At some future point, such redacted documents will be made available on the Internet. Over time, implementation of this system will enable the Agency to reduce storage facility costs, contracted redaction and scanning services, and the labor associated with pulling and refilling documents.

In addition to improving internal operations, electronic technology potentially allows easy access to information from other states and other programs. Such information is important in the review of facility construction plans for compliance with codes and standards and in the determination of whether changes should be made in those codes and standards. However, electronic transfer of confidential information requires an increased level of awareness and implementation of additional protections, including the federal privacy requirements contained in the Health Insurance Portability and Accountability Act (HIPAA).

While Florida attempts to decrease the number of regulatory constraints, the federal government is increasing them. HIPAA is one example of a federal law that has had a significant cost and operational impact on the Agency. AHCA elected to become a single entity for HIPAA purposes, and met the requirements of the Act by April 14, 2003. The new privacy requirements of the Act placed a significant burden upon all who possess confidential health care information to protect it, gain permission for its release, and track its release. The U.S.

Department of Health and Human Services required implementation of the HIPAA Security Rule, which affects all electronic data systems, effective April 21, 2005. Security and privacy requirements further complicate the already complex process of public information request responses.

In an additional effort to streamline operations, the Agency is planning to offer provider facilities the opportunity to renew their licenses online. This requires the technology to create an online identity management application as well as new programming. The Agency has developed a legislative budget request to obtain the appropriate resources for this project.

Managed Health Care Operations

Chapter 641, F.S., gives the Agency joint responsibility with the Department of Financial Services, Office of Insurance Regulation for regulating managed care organizations. As of December 2004, there were 30 licensed and operational Health Maintenance Organizations (HMOs). Five additional HMOs have been approved as of June 30, 2005. Not all of these 30 HMOs were fully operational for the entire year of CY 2004. The following statistics are based on data available for 26 operational HMOs. Statistics show enrollment in Florida's HMOs declined from 4.5 million in CY 2001 to 4.2 million in CY 2003; and further declined to 4.04 million in CY 2004 (Florida Hospital Association (FHA); AHCA and OIR Data Reports). Health Options had the largest market share with 566,378 enrollees, followed by Aetna with 554,315, United Health Care with 527,923 and Humana Medical Plan with 455,056 enrollees. Well Care and HealthEase reported separate enrollment figures although they are wholly owned subsidiaries of the same parent organization. The combined enrollment for Wellcare and HealthEase is 529,707, which would place WellCare third.

The decline in enrollment did not negatively affect the profitability of Florida's HMOs. Of the 26 licensed and operational HMOs, a total of 19 HMOS were profitable. In CY 2004, the HMO industry reported an overall net income of $724.9 million, up from $478.6 million in CY 2003. HMOs clearly recovered from the losses incurred in earlier years. The most profitable HMO in Florida was Humana with a net income of $164.9 million, followed by Aetna Health Plan with a net income of $131.3 million.

As of December 2004, 16 of the HMOs offered commercial managed care, 16 provided a Medicare product and 11 offered Medicaid plans. Six HMOs offer all three product lines, three offer Medicare only, and three offer Medicaid only.

Over the past seven years there has been a steady increase in Medicaid enrollment reflective of the growing Medicaid population. Medicaid HMO enrollment increased from 585,532 as of December 2001, to 760,207 in December 2004, or 29.8 percent. HealthEase and Staywell, both product lines of WellCare, had the largest market share with 401,442 enrollees or 52.8 percent, followed by AMERIGROUP with 161,133, or 21.2 percent.

Medicaid HMOs showed overall operating income of $13.2 million in CY 2004 for the Medicaid product line only. The consolidated HMO operating income for the 11 HMOs over all product lines was $125 million in CY 2004.

Since implementation of the mandatory requirement for placement of most Medicaid patients in MediPass or in managed care plans (Section 409.9122, F.S.), the Agency has been concerned with the issue of assessing care quality in commercial and Medicaid managed care plans and MediPass. The Agency has collected required Health Plan Employer Data and Information Set

(HEDIS) quality of care measures from all HMOs since these requirements became effective during the year CY 2000. All HMOs have to be accredited by a national accreditation organization approved by the Agency. Medicaid HMOs have to report additional quality of care data as specified in the Medicaid HMO contract.

One of the outcome measures the Agency will concentrate on over the next five years is to bring individual health plans up to the current statewide averages on selected HEDIS measures. The State Center for Health Statistics collects 25 indicators on quality of care. Each year, the managed care plans are required to report data on five indicators. In the past, these indicators measured the size of an eligible population that had received specific types of care. In CY 2004, the Agency revised the rating system for these indicators. The Agency calculated the average score for each indicator over all plans. Plans were then given check marks from 1 to 5 based upon their ranking in relation to the average score. A plan receives one check mark if it falls 1 or more standard deviations below the average score, and a check mark of 5 if it falls 1 or more standard deviations above the average score for that indicator.

Florida law further specifies that subscribers who are dissatisfied with the care provided by an HMO or are denied care, have the right to access an HMO's internal grievance process. If the subscriber is not satisfied with the outcome of the HMO's internal grievance process, he/she has the right to access an external appeal process. Currently, the external consumer grievance process employed by the state is run through the Agency using the Subscriber Assistance Program mandated under Section 408.7056, F.S. In FY 2004-05, this program reviewed more than 372 cases. The availability of the Internet as a research tool for HMO subscribers has made subscribers generally more informed, confident, and knowledgeable consumers. As a result, cases brought before the Subscriber Assistance Panel involving medical necessity, experimental procedures, and unusual treatment protocols are more complex than ever. The use of specialist physicians as members of the panel has allowed panel members to focus on highly complex medical issues. Other trends include increases in cases that involve drug formularies, physical, occupational and respiratory therapies and contract interpretations. This latter trend appears to have evolved from the industry consolidation in the managed health care market. Providers disputing the findings of the external grievance program can appeal the decision to the Division of Administrative Hearings.

In addition to the Subscriber Assistance Panel, the Agency has a call center to register HMO complaints. However, emphasis shifted from resolving problems to requiring the managed care plans, which are paid for problem resolution, to provide appropriate services to their subscribers. While the Agency still tracks complaints, it requires individual and plan responsibility for health care needs and decisions. These policy changes appear to have resulted in improved accountability on the part of the managed care organizations. The Agency has been assisted in this regard by volunteer organizations known as District Managed Care Ombudsman Committees, which serve as consumer advocates to assist consumers with obtaining services from their HMOs.

In addition, in CY 2001, the Legislature established the Statewide Provider and Managed Care Organization Claim Dispute Program, a private contractor selected by the Agency to resolve claims disputes between providers and HMOs, prepaid health plans, exclusive provider organizations, and other major health insurers. Organizations disputing the findings of the dispute resolution program can appeal the decision to the District Court of Appeals. All program costs are borne by the parties involved in the disputes. This program is growing, and handled a total of 96 cases in CY 2003; in CY 2004, 174 cases were filed.

The Bureau of Managed Health Care also houses the Workers' Compensation Managed Care Unit and the Medical Services Unit. The Managed Care Unit is responsible for regulating and monitoring managed care arrangements that provide services to injured workers. The Medical Services Unit is responsible for reviewing utilization complaints from carriers, resolving reimbursement disputes between carriers and providers, certifying providers to provide services to injured workers and providing administrative support to the Workers' Compensation Three Member Panel that sets reimbursement rates for providers. This program operates outside of the managed care workers' compensation environment. The Medical Services Unit will move back to the Department of Financial Services as of October 1, 2005 under an agreement being developed between the Agency and the Department.

Health Insurance Premiums, Health Care Costs and the Prevalence of Uninsurance

According to the CY 2004 survey of employer health benefits published annually by the Kaiser Family Foundation (January 2005), the rate of growth of health care premiums moderated slightly during CY 2004. The percentage of workers receiving health care coverage from their employers fell from 65 percent in CY 2001 to 61 percent in CY 2004 due in part to a decline in the numbers of small firms offering health insurance to their employees. Between spring of 2003 and spring 2004, premiums for employer-sponsored health insurance rose by 11.2 percent. Although lower than the 13.9 percent increase for CY 2003, this still reflects a fourth consecutive year of double digit inflation in health care premiums (Kaiser Family Foundation). The Milliman 2004 Group Health Insurance Survey indicated an anticipated CY 2005 renewal rate increase of 11 percent for HMOs, down from 15 percent in CY 2003, and 13 percent for PPOs. HMO administrative expenses dropped to 12 percent of the premium, the lowest level in the 13-year history of the Milliman survey.

National health spending in CY 2005 is projected to reach $1.9 trillion. (Centers for Medicare and Medicaid Services, Office of the Actuary) reflecting nearly a 48 percent increase over these same costs in CY 2000 and 15.6 percent of the Gross Domestic Product of the United States. Over the past 20 years, the share of health care costs spent on hospital care has shrunk, while the share spent on prescription drugs has more than doubled. As health care becomes more expensive, health insurance follows suit.

The Kaiser Commission on Medicaid and the Uninsured estimated that health insurance coverage in Florida was lacking in FY 2002-03 for 23.5 percent of non-elderly adults and 15.6 percent of children for a total uninsurance rate in that year of 21.2 percent. That total in that report compared unfavorably with 19.9 percent for the United States as a whole. However, a more recent Florida Health Insurance Study completed in November 2004 yielded a statewide average of 19.2 percent of Floridians under age 65 who are not covered by insurance. While that still reflects a substantial increase in uninsurance from the original study done in CY 1999, it is substantially less than the rate cited by the Kaiser Commission. Miami-Dade County now has the highest rate of uninsurance in the state at 28.7 percent (up from 24.6 percent in 1999). According to that report, rates of uninsurance increased slightly or were stable for people at both ends of the income spectrum, but increased markedly for middle income families. Hispanics had the highest rate of uninsurance at 31.8 percent, followed by African Americans at 22.6 percent. For white non-Hispanics, the percentage lacking health coverage was only 14.3 percent. Florida adults born outside the U.S. have a rate of uninsurance double that of those born in the U.S. (37.9 percent versus 17.5 percent). For those lacking insurance, the most frequently cited reason (63.1 percent) was cost. Among people not covered by health

insurance, 42 percent reported delaying or not obtaining needed medical care in the past year due to cost.

The uninsured place additional burdens on hospital emergency rooms, where, by federal and state law and regulations, care must be provided in emergency situations regardless of ability to pay.

Status of Regulatory Mandates

The major impact from the CY 2005 Legislative Session was on the Division of Medicaid. The Division of Health Quality Assurance received few additional mandates and only minor changes were made in requirements for health care facilities. For the second year, the Agency attempted to obtain passage of its uniform licensure bill, a bill that would streamline, solidify and provide increased uniformity of health care facility regulation across the more than 35 types of health care providers regulated by the Agency. The following new requirements were placed on the Division pursuant to legislation passed during the CY 2005 session:

- Provision of technical assistance to the Florida Building Code Commission to update construction standards for hospices in the Florida Building Code

- Adoption and enforcement of rules to permit residents in nursing facilities to change their bed placements in their rooms

- Agency participation on the Small Employer Health Reinsurance Program Board

- Establishment and rule making authority for a five-year pilot program to license an intergenerational respite care assisted living facility to provide temporary personal, respite and custodial care to minors and adults with disabilities and elderly persons with special needs who do not require 24-hour nursing services. A report with recommendations on permanent status for the project is to be provided to the Speaker of the House of Representatives and President of the Senate in CY 2009

- Agency authorization of additional off-site emergency departments for hospitals is prohibited until July 1, 2006

Hospital emergency room operations have become a significant source of concern not only for the industry, but also for the Agency. The Florida Hospital Association and the Florida College of Emergency Physicians have twice met with Agency representatives in an effort to address concerns about insufficient emergency room physicians and chronic overcrowding of emergency rooms. The Florida Hospital Association (FHA) has established a Task Force on Challenges in the Emergency Department (ED) in an effort to resolve problems caused by increased patient volume, sicker patients, increased numbers of uninsured patients, insufficient space, inadequate ED staffing and on-call coverage and medical liability; the Agency is a participant on this task force. Statistics from a July 2005 FHA presentation on this topic show that by 2003, emergency room visits in Florida hospitals had increased by 46 percent since 1993 and 59 percent of the patients admitted to Florida hospitals were first seen in the emergency room. During the same period, the number of hospitals with emergency departments decreased from 226 to 214 - a five percent drop in numbers. In CY 2003, more than 19,000 patients were treated each day in Florida's emergency departments—a 30.5 percent increase in numbers of patients per day since 1993. In an effort to alleviate emergency

room overcrowding problems, two hospitals requested and the Agency approved off-site emergency department locations. This approval caused concern in the Legislature, which subsequently prohibited authorization of additional off-site emergency department locations until July 1, 2006, as indicated above. Emergency department issues are apt to be an ongoing discussion between hospital providers and the Agency during future years until a viable, cost-effective solution can be found for ER physician shortages and overcrowding problems.

FY 2004-05 was the second full year of operations for the Health Care Clinic Unit, which was charged in CY 2003 with the regulation of an anticipated 2,600 health care clinics in Florida. In fact, that number decreased with the exemption in CY 2004 of additional numbers of health care clinics. As of the end of July 2005, the Agency has licensed 2,443 clinics and provided exemption certificates to 4,762 health care clinics. The specific type of clinic intended to be licensed and regulated is known as a "PIP" clinic because it specializes in cases involving reimbursement through Personal Injury Protection (PIP) provisions found in no-fault automobile insurance policies. With numerous exemptions, all health care clinics are included. As these clinics are engaged in an area of insurance fraught with allegations of fraud and abuse, much of the Agency's direction is to collect information on its surveys and provide referrals to the Department of Financial Services, Division of Insurance Fraud, for any clinic suspected of engaging in inappropriate billing practices. Since the inception of the program, seven clinic licenses have been revoked, 30 licenses have been denied, and 32 clinics have licensure issues in litigation. All seven revoked licenses were for clinics located in Dade County. In FY 2004-05, the Office of Insurance Regulation, Division of Insurance Fraud, made arrests of individuals associated with more than 90 clinics in the Miami area alone. Of the clinics associated with those arrests, 63 were either licensed by or had exemption certificates from the Agency. Action to deny or revoke licenses will be taken against those clinics whose principals are convicted of the actions for which they were arrested.

List of Potential Policy Changes Affecting Agency Budget Requests

Number	Potential Policy Changes	Reference LRPP Goals	Legislative Budget Requests (LBR) Affected	Impact on Agency Policy if LBR Request is not Approved
1	Implementation of a budget request to increase salaries of survey staff that travel three days or more each week.	2	Clearance pending for presentation to the CY 2006 Legislature.	Inability to recruit and retain qualified surveyors and investigative staff.
2	Implementation of a document management system to manage licensure files for public information requests and storage purposes	2	Clearance pending for presentation to the CY 2006 Legislature.	Inability to manage currently increasing public information requests without additional staff. This is the third of three phases in the document management system.
3	Implementation of an online system for providers to submit renewal applications over the Internet	2	Clearance pending for presentation to the CY 2006 Legislature.	Inability to manage currently increasing application workload without additional staff
4	Implementation of an interagency agreement with the Department of Financial Services (DFS) under which the Workers' Compensation Medical Services Unit currently under the Agency's direction will move to DFS, where its activities are more appropriately placed and resourced.	2	None. This plan has approval from the AHCA Secretary and was a last minute unsuccessful DFS legislative initiative in CY 2005.	Not applicable. Funding source for staff will not change.

List of Changes that Would Require Legislative Action

Number	Changes in Current Programs	Statutory Reference	Changes in Current Services	Changes in Current Activities	Substantive Legislative Action Required to Support Changes
1	None				

List of All Task Forces and Studies in Progress

Number	Bill Cite	Ongoing Task Forces and Studies Required by 2004 Legislation	Division Assigned
1.	SB 182 Page 8 Line 23 Web Page	The Secretary of Health Care Administration shall appoint an advisory group to study the issue of replacing CON review of organ transplant programs operating under this chapter (chapter 408, F.S.) with licensure regulation of organ transplant programs under Chapter 395, F.S. *Further detail: The advisory group shall include three representatives of organ transplant providers, one representative of an organ procurement organization, one representative of the Division of Health Quality Assurance, one representative of Medicaid, and one organ transplant patient advocate. The advisory group shall, at minimum, make recommendations regarding access to organs, delivery of services to Medicaid and charity care patients, staff training, and resource requirements for organ transplant programs in a report due to the Secretary and the Legislature by July 1, 2005.*	Health Quality Assurance
2.	HB 329 Page 40 Line 1160 Web Page	The Agency shall establish a technical advisory panel to develop procedures and standards for measuring outcomes of interventional cardiac programs. Further detail: The panel membership is specified to include representatives of the Florida Hospital Association, Florida Society of Thoracic and Cardiovascular Surgeons, Florida Chapter of the American College of Cardiology, Florida Chapter of the American Heart Association, and others with experience in statistics and outcome measurement.	Health Quality Assurance

3.	HB 329 Page 41 Line 1187 Web Page	The Secretary of Health Care Administration shall appoint an advisory group to study the issue of replacing certificate-of-need review of organ transplant programs under this chapter with licensure regulation of organ transplant programs under Chapter 395, F.S. *Further detail: The advisory group is to consist of seven persons, including three representatives of organ transplant providers, one representative each from an organ procurement organization, the Division of Health Quality Assurance, the Medicaid program and an organ transplant patient advocate, to study the issue of replacing CON review of organ transplantation programs with licensure regulation of organ transplant programs. The advisory group shall, at minimum, make recommendations regarding access to organs, delivery of services to Medicaid and charity care patients, staff training, and resource requirements for organ transplant programs in a report due to the Secretary and the Legislature by July 1, 2005*	Health Quality Assurance
4.	HB 329 Page 42 Line 1167 Web Page	The Agency shall establish a technical advisory panel to develop procedures and standards for measuring outcomes of interventional cardiac programs. *Further detail: The panel membership is specified to include representatives of the Florida Hospital Association, Florida Society of Thoracic and Cardiovascular Surgeons, Florida Chapter of the American College of Cardiology, Florida Chapter of the American Heart Association, and others with experience in statistics and outcome measurement. Based on recommendations from the panel, the Agency shall develop and adopt rules for the interventional cardiac programs.*	Health Quality Assurance
5.	HB 329 Page 42 Line 1201 Web Page	The Secretary of Health Care Administration shall appoint a workgroup to study CON regulations and changing market conditions related to the supply and distribution of hospital beds. The workgroup shall submit a report by January 1, 2005, to the Secretary and the Legislature identifying specific problem areas and recommending needed changes in statutes or rules	Health Quality Assurance

6.	HB 1629 Page 47 Line 1274 Web Page	Requires that the Agency and Office of Insurance Regulation shall jointly submit a program evaluation report regarding the Health Flex program to the Governor, the Speaker of the House of Representatives, and the President of the Senate by January 1, 2005, and annually thereafter.	Health Quality Assurance
7.	HB 1629 Page 47 Line 1513 Web Page	Patient Safety Corporation shall prepare an implementation plan to be submitted to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Agency by September 1, 2005.	Health Quality Assurance
8.	HB 1629 Page 52 Line 1411 Web Page	Patient Safety Corporation: Requires the Agency to assist the corporation in its organizational activities, and provides that the board of directors must conduct its first meeting no later than August 1, 2004.	Health Quality Assurance
9.	HB 1629 Web Page	The Office of Program Policy Analysis and Government Accountability, the Agency for Health Care Administration, and the Department of Health shall develop performance standards by which to measure the success of the corporation in fulfilling the purposes established in this section. Using the performance standards, the Office of Program Policy Analysis and Government Accountability shall conduct a performance audit of the corporation during 2006 and shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2007. Further detail: These performance measures relate to the Patient Safety Corporation.	OPPAGA has the lead on this issue. Health Quality Assurance will assist.

	Bill Cite	Task Forces and Studies Required by 2005 Legislation	Division
10.	HB 811 Page 15 Lines 389-397 Web Page	Revises the membership of the small employer health reinsurance program board, adding an Agency Representative. The board shall consist of the director of OIR or his or her designee; five members shall be representatives of health insurers licensed under Chapter 624, F.S. or Chapter 641, F.S. Two members shall be agents who are actively engaged in the sale of health insurance. Four members shall be employers or representatives of employers. One member shall be a person covered under an individual health insurance policy issued by a licensed insurer in this state. One member shall represent the Agency for Health Care Administration and shall be recommended by the Secretary of Health Care Administration. The board shall issue a report to the office on the state of the health insurance market by September 1 each year. The report shall include recommendations for changes in the health insurance market, results from implementation of previous recommendations, and information on health insurance markets.	Health Quality Assurance

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(Executive Direction, and the Division of Administrative Services)
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Executive Direction

Chief of Staff

Goal 3: To increase the public's access to health care information (State Center for Health Statistics)

Objective 3. A: To increase by six percent annually through FY 2010-11 the number of persons who receive health care information from www.FloridaHealthStat.com.

Service Outcome Measure 3. A: The average number of sessions begun on the Agency for Health Care Administration's web site www.FloridaHealthStat.com each day. (This measure more accurately reflects the number of people who access the web site, instead of the number of times any page within the web site is opened. Ordinarily, a person will have one session, in which many pages are opened.)

Service Outcome Measure Projection Table 3. A:

Baseline/Year FY 2000-01	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
1,250 Average number of sessions begun on the web site per day	1,774	1,880	1,993	2,113	2,240
Annual percent of increase in the number of sessions begun per day	6%	6%	6%	6%	6%

Objective 3. B: To increase by 50 percent annually, through FY 2010-11, the number of patient records accessed by practitioners through the Florida Health Information Network (FHIN)*

Service Outcome Measure 3. B: The number of patient records accessed by practitioners through the Florida Health Information Network.

Service Outcome Measure Projection Table 3. B:

Baseline/Year FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 20010-11
400,000 Number of patient records accessed through the Florida Health Information Network	600,000	900,000	1,350,000	2,025,000	3,037,500
Annual percent of increase in the number of records accessed.	50%	50%	50%	50%	50%

*This objective was changed from the one used in the Agency's LRPP for FY 2004-05 through FY 2009-10. This objective uses the metrics described in the Agency's grant proposal submitted to the Office of the National Coordinator for Health Information Technology (ONCHIT) for support of a Florida Health Information Network. Baseline estimates are proposed and are not currently operational.

Objective 3. C: To increase by FY 2010-11 the average annual monthly number of visitors to MyFloridaRx.com

Service Outcome Measure 3. C: The average annual monthly number of persons who visit MyFloridaRx.com

Service Outcome Measure Projection Table 3. C:

Baseline/Year FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 20010-11
14,632 The average annual monthly number of persons who visit MyFloridaRx.com	TBD	TBD	TBD	TBD	TBD
Annual monthly percent of increase	TBD	TBD	TBD	TBD	TBD

The purpose of this objective and its projection table is to monitor consumers' use of the MyFloridaRx.com (Florida Prescription Drug Prices) web site. The Office of the Florida Attorney General hosts this site. Mandated in HB 1629 the site was developed through cooperation between the Office of the Attorney General and the Agency for Health Care Administration. The site went live on June 1, 2005. Although the Office of the Attorney General host and maintain the site the pharmacy data is derived from Agency for Health Care Administration resources. The objective is included in the agency's LRPP because the site supports the agency's mandate to implement health transparency and provide information that consumers may use to health informer health care selection and purchasing decisions.

The baseline data is for a limited period of observation. A new baseline may be established later. The projection estimate for FY 2006-07 is based upon current trend information. The projections for FY 2007-08 through FY 2010-11 will be completed after more information is available to support estimates.

Linkage of Agency Goals and Programs to Governor's Priorities

	Governor's Priorities and Goals	Name of Agency Goals and/or Programs
1.	Improve education	**Goal 3:** To increase the public's access to health care information
2.	Strengthen families	
3.	Promote economic diversity	
4.	Reduce violent crime and illegal drug use	
5.	Create a smaller, more effective, more efficient government	**Goal 3:** To increase the public's access to health care information
6.	Enhance Florida's environment and quality of life	**Goal 3:** To increase the public's access to health care information.

Trends and Conditions Statement

In recent years the need to create transparency in healthcare information has become more immediate and compelling to all healthcare constituencies. In the public sector, that awareness has fostered an appreciation that reports should be designed to support public policy objectives, healthcare purchasing decisions by consumers and organizations, and quality/cost improvement efforts within the healthcare sector. The Agency for Health Care Administration using the Agency for Healthcare Research and Quality (AHRQ) quality indicators to guide public, but other measures used by employer and healthcare industry groups. These dynamics raise important questions for Florida's health data agencies. Which quality indicators have the most utility for public reporting and how do we standardize usage throughout the state.

Through implementation of health transparency and adoption of electronic health records (EHR) as mandated in the CY 2004 HB 1629 the legislature demonstrated its sensitivity to the need to address the gap between the current state of healthcare information delivery, and what would be possible with the effective use of information technology. This recognition has given rise to a consensus among Florida's providers, consumers, and other stakeholders that information technology can improve healthcare.

This unique public and private relationship affords Florida an opportunity for collaboration among healthcare stakeholders to develop an effective health information system, and there have been many calls from among political leaders and policymakers for development of a system that will provide consumers more access to information that will help them make informed healthcare purchasing and selection decisions.

The Governor's Task Force on Access to Affordable Health Insurance called for the utilization of electronic health information and encouraged the development of electronic medical records (EMR's) by providing financial incentives and promoting the use of digital technology and information systems. In addition, the Select Committee on Affordable Health Care for Floridians, in its final recommendations to the Speaker of the House, recommended the adoption and use of technology supporting a single medical record. Both recommendations gave rise to the passage of House Bill 1629 in May 2004, which requires the Agency for Health Care Administration to develop and implement a strategy to adopt and use electronic health records.

On May 4, 2004, by Executive Order No. 04-93, Governor Jeb Bush created the Governor's Health Information Infrastructure Advisory Board. The Board's mission expressed in the Executive Order is to i) advise and support AHCA as it develops a strategy to adopt and use EHRs and create a plan to promote the development and implementation of a Florida health information infrastructure (HII), including measures to promote greater adoption of EHR information systems among the state's healthcare providers; ii) identify obstacles to the implementation of an effective HII in the state and provide policy recommendations to remove or minimize those obstacles; iii) advise the Executive and Legislative branches on issues related to the development and implementation of the Florida HII; and iv) assist AHCA in ensuring that the development strategy and plan preserve the privacy and security of health information as required by law.

1. Collection of Patient Data

Hospital Inpatient Data Collection

Hospital inpatient data collection is authorized under 408.061(1)(e), F.S., and is implemented under Chapter 59E-7, Florida Administrative Code.

The hospital inpatient database is the most widely used of the State Center databases. The inpatient data forms the basis of many of the reports in the *Health Outcomes Series.* The data is used for many special data requests within the Agency, the Legislature, researchers and the general public. A deidentified version of the data (limited data set) is available for purchase. The database contains patient-level information for all discharges from approximately 242 acute care hospitals (initiated in 1988) and short-term psychiatric hospitals (initiated in 1997) in Florida. This number varies from year to year as new hospitals open and others close.

Among other information, records include patient demographics, admission information, medical information, discharge information, and charge data. Patient demographics include the patient's race, birth date, gender and zip code. Admission information includes type of admission, admission source, and admission date. Medical information includes principal and secondary diagnosis codes, principal and secondary procedure (ICD-9-CM) codes, principal procedure date, and attending and operating Florida physician license numbers. Discharge information includes discharge date and discharge status.

Charge data include total charges, and charges broken down by individual revenue charge categories. Revenue charge categories include room and board, nursery, intensive care unit (ICU), pharmacy, medical/surgical supplies, oncology, laboratory, pathology, diagnostic radiation, therapeutic radiation, nuclear medicine, computerized tomography (CT) scans, operating room services, anesthesia, respiratory therapy, physical therapy, occupational therapy, emergency room services, cardiology, magnetic resonance imaging (MRI), recovery room, labor room, and other charges. A principal payer code (e.g., Medicaid, Medicare, and Commercial HMO) is also reported.

Other information includes a hospital-generated record identification number, the patient's social security number, and an infant linkage identification number. The hospital number, the reporting year, and the quarter are also included in each record.

The Health Insurance Portability and Accountability Act (HIPAA) limits the release of protected patient health information; therefore, not all reported information is available to the public.

The number of hospital inpatient discharge records submitted increased from 2,155,123 records in 1999 to 2,443,926 records in 2003, for a percentage increase of 13.4 percent, 1999-2003. The number of records is steadily increasing. Inpatient services remain an important part of health care in Florida. Over the next several years, this database will continue to provide consumers, researchers, analysts, policymakers, and others with the data necessary to make well-informed health care decisions.

Beginning in 2004, the process to amend the rules governing hospital inpatient data collection (Ch. 59E-7, F.A.C.) was initiated. An initial rule development workshop was held in November 2004. The target date for implementation of the rule amendments is January 2006. The proposed amendments will improve the completeness and quality of the data reported. Also beginning in 2004, rule making to collect data on hospital-acquired infections (Ch. 59B-15, F.A.C.) was initiated. The proposed rules will require hospitals to report Surgical Infection Prevention (SIP) measures to the Agency.

Ambulatory Patient Data Collection

Ambulatory patient data collection is authorized under 408.061(1)(e), F.S., and is implemented under Chapter 59B-9, Florida Administrative Code.

The ambulatory patient data collection database (initiated in 1997) is a companion to the hospital inpatient database. Technological advancements have brought about dramatic changes in health care delivery. Procedures that once required several days in a hospital are now performed in an outpatient setting. As the health care delivery system continually evolves, the ambulatory patient database is expected to become increasingly more important in studying the trends in Florida health care.

Along with hospital inpatient data, ambulatory patient data is used in many reports including the *Health Outcomes Series.* The data is used for many special data requests within the Agency for Health Care Administration, the Legislature, researchers and the general public. As with hospital inpatient data, a deidentified version of the ambulatory data (limited data set) is available for purchase.

Through 2004, the ambulatory patient database contains patient-level information for reportable patient visits to approximately 500 freestanding ambulatory surgery centers, short-term acute care hospitals, lithotripsy centers and cardiac catheterization laboratories in Florida. This number varies from year to year as new facilities open and others close.

Reportable procedures are defined as having a primary procedure in any of the following ranges corresponding to Current Procedural Terminology (CPT) codes 10000 through 69999 and 93500 through 93599. These code ranges include surgical procedures, cardiac catheterization and lithotripsy. Facilities with fewer than 200 reportable visits can request to be exempted from reporting for a given quarter.

As with inpatient data, ambulatory patient data records include patient demographics, medical information, and charge data, as well as other information. Patient demographics include race, birth date, gender and zip code. Medical information includes principal and secondary diagnosis (ICD-9-CM) codes, primary and secondary procedure (CPT) codes, patient visit date, and attending and operating Florida physician license numbers. Charge data include total charges, and charges broken down by individual revenue charge categories. Revenue charge categories include pharmacy, medical/surgical supplies, radiation oncology, laboratory, CT scans, operating room services, anesthesia, MRI, recovery room, treatment or observation room, and other charges. A principal payer code (e.g., Medicaid, Medicare, and Commercial HMO) is also reported.
Other information includes a facility-generated record identification number and the patient's social security number. The facility number, the reporting year, and the quarter are also included in each record.

The Health Insurance Portability and Accountability Act (HIPAA) limits the release of protected patient health information; therefore, not all reported information is available to the public. More information about data confidentiality issues is presented in the "Data Dissemination" chapter.

The number of ambulatory patient records submitted increased from 2,118,515 records in 1999 to 2,650,929 records in 2003, for a percentage increase of 25.1 percent, 1999-2003. Procedures related to radiation therapy and procedures performed during emergency department visits are not included in these figures.

Ambulatory patient services have become an important aspect of health care in Florida. This database provides consumers, researchers, analysts, policymakers, and others with the information necessary to make informed health care decisions.

Planning for modification of the rule (Ch. 59B-9, F.A.C.) occurred throughout 2003 and early 2004, and on April 18, 2004 the rule was amended to become effective on January 1, 2005. Two of the rule changes relate to data transmission. First, data must be reported using the file format "XML." Second, beginning January 1, 2006, data must be transmitted electronically via the Internet. Other substantial changes relate to the addition, deletion and modification of specific data elements, codes and standards. Please see Appendix A: *Facility Performance Status Report* for more details on changes to this rule.

Emergency Department Data Collection
Emergency Department data collection is authorized in 408.061(1), F.S., and is implemented under Chapter 59B-9, Florida Administrative Code.

The most significant change to the ambulatory patient data rule is a requirement for reporting hospital emergency department data beginning January 1, 2005. Emergency department data will provide an important resource for analyzing utilization patterns, access to care and costs for disease and injury surveillance and for the management of chronic diseases. Data elements include hour of arrival, patient's chief complaint, principal diagnosis, race and ethnic status, and external causes of injury. The rule requires the reporting of "all emergency department visits in which emergency department registration occurs and the patient is not admitted for inpatient care." The reporting record format is the same one as used for reporting of ambulatory patient surgery (Chapter 59B-9, F.A.C.).

Implementation of emergency department data collection will have a significant effect on the total number of ambulatory data records collected. In 2003, approximately 2.6 million records were collected. Adding emergency department visit records is expected to increase this annual total to over eight to nine million records.

Comprehensive Inpatient Rehabilitation Data Collection
Comprehensive inpatient rehabilitation data collection is authorized under 408.061(1)(e), F.S., and is implemented under Chapter 59E-7 Part II, Florida Administrative Code.

The comprehensive inpatient rehabilitation database (initiated in 1993) is a companion to the hospital inpatient and the ambulatory patient databases. Although there are far fewer comprehensive inpatient rehabilitation records than hospital inpatient or ambulatory, rehabilitation care continues to be an important feature in the health care delivery system in Florida.

The comprehensive inpatient rehabilitation data is primarily for special requests and *ad hoc* reporting. These requests come from within the Agency, the Legislature, researchers, and the general public.

The comprehensive inpatient rehabilitation data contains patient-level discharge information from Florida's 15 licensed comprehensive inpatient rehabilitation centers. These centers are defined as any hospital licensed as a class III special rehabilitation hospital. Rehabilitation units of acute care hospitals are excluded from this database. Nursing homes and hospital-based skilled nursing units are also not included.

As with hospital inpatient and ambulatory data collections, the comprehensive inpatient rehabilitation data records include patient demographics, admission information, medical information, discharge information and charge data, as well as other information. Patient demographics include race, birth date, gender and zip code. Admission information includes the admission date and a code for the admission source. Medical information includes a primary condition code and the attending Florida physician license number. Discharge information includes the discharge date and a code for the patient's discharge status. A principal payer category and the total charge are also reported.

Other information includes a facility-generated record identification number and the patient's social security number. The facility number, the reporting year, and the quarter are also included in each record.

HIPAA limits the release of protected health information; therefore, not all reported information is available to the public. The number of comprehensive inpatient rehabilitation discharge records submitted increased from 17,258 in 1999 to 21,774 in 2003, for a percentage increase of 26.2 percent.

2. Collection of Health Plan Data

Health Management Organizations

Health plan quality indicator data collection is required under 641.51(9), F.S., and is implemented under Chapter 59B-13, Florida Administrative Code.

Quality indicator data include a measure of the percentage of eligible members who have received a specific health care service during the measurement period. Quality indicator measurement specifications are prescribed in the Health Plan Employer Data & Information Set (HEDIS) technical specifications manual available from the National Committee for Quality Assurance (NCQA). Technical specifications are updated annually to reflect medical coding changes, to clarify requirements and to improve the quality measures.

The indicators reported to the Agency include measures of chronic disease management, preventive health care, prenatal care and checkups for infants, children and adolescents. Chronic disease management indicators address diabetes care, asthma medications, controlling high blood pressure, and use of beta-blocker medication after a heart attack. Preventive health care indicators include breast cancer screening, cervical cancer screening, and chlamydia screening in women.

Per HEDIS specifications, selected measures are not reported annually. A rotation schedule issued by NCQA notifies health plans of the indicators that are not required for the subsequent reporting cycle. Rotated measures are usually reported biennially.

Quality indicator data submitted to the Agency also includes supplementary information such as the confidence intervals, number of eligible members, sample size, and whether administrative data or sampling was used to calculate the reported rate. The rate is the percentage of eligible members for each quality indicator.

The health plan quality indicator data is reported each October 1 for the previous measurement year or other measurement period as specified by HEDIS. Since 2001, a statement from an independent auditor approved by the Agency must certify that the indicator data is a fair and accurate representation of the specified health care services afforded to Florida members of the health maintenance organization.

State Center staff reviews the reports and certification documents for completeness and consistency with reporting requirements. Missing or small values are checked to determine whether the health plan had an eligible population of sufficient size to report a valid indicator. HMOs are asked to explain or resubmit their report if there are any anomalies.

An annual survey of HMO members is required by 641.58(4), F.S. AHCA is required to conduct the survey to determine the satisfaction of health plan members.

Consumer Assessment of Health Plan Survey Data
The Consumer Assessment of Health Plan Survey (CAHPS) data contains the results of an annual statewide survey of a sample of the members in each Florida licensed health maintenance organization (HMO) including Florida Medicaid members and a separate survey of commercial members. Results from the survey are incorporated in *Choosing A Quality Health Plan: Florida HMO Report*.

The CAHPS data contains the responses of members to a set of about 50 questions regarding their individual experience with the health plan. The CAHPS includes questions about the health care utilization of the member, access to care, access to specialists, communicating with health care providers, customer service, and overall satisfaction with the health plan.

The CAHPS survey instrument was developed by the federal Agency for Healthcare Research and Quality and the National Committee for Quality Assurance. Public release version 3.0 is used by the Agency. The Medicaid and commercial versions of the CAHPS are used as appropriate, and a Spanish language version is also used as required. The commercial version of CAHPS inquires about the experience of the member for the previous year whereas the Medicaid version inquires about the experience of the member for the previous six months.

The Agency contracts with the survey program at the University of Florida to conduct the survey by telephone interview. Since 2001, the survey interviews have begun October 1 with results reported to the Agency by January 31 of the following year.

A survey of members of the Florida Healthy Kids insurance program was added in 2003.
As a result of changes to the Florida Statutes in 2004 (408.05(3)(1), F.S.), the State Center will make available to consumers and group purchasers the following: performance measures, member satisfaction survey data, benefit design and premium cost data from other types of commercial health plans in Florida, in addition to data from HMOs. This new information shall be released no later than March 1, 2006. The data are intended to assist consumers and group purchasers in assessing the value of these products and available options.

3. Publications

Health Outcome Series

The *Health Outcome Series* fulfills the requirements of 408.05(5), F.S., which directs the State Center for Health Statistics to disseminate the data it collects and analyzes and to periodically make available health statistics publications of general interest.

The *Health Outcome Series* is written for the technically oriented consumer. The series consists of reports on trends in health care delivery in Florida and provides key statistical information to the reader. The reports range from 25 to 140 pages long. They contain statistical information with tables, narrative, a reference page, and appendices for further information. The reports typically contain information derived from the State Center's hospital inpatient database and occasionally from the ambulatory patient database. The reports released during CY 2003 and CY 2004 are summarized below. The titles of reports published prior to 2003 are listed below the new reports.

Chronic Obstructive Pulmonary Disease (COPD) Hospitalizations
The *COPD Hospitalizations* report examines discharges, CY 1992 to CY 2002, where COPD was the principal diagnosis. COPD is a group of respiratory illnesses including chronic bronchitis and emphysema. The report presents data on trends in hospitalization rates, diagnoses and procedures, charges and in-hospital deaths. Data on hospitalizations by age, gender and race are also displayed.

Hysterectomy Hospitalizations
The *Hysterectomy Hospitalizations* report presents data on hysterectomies in Florida for 2002 and examines historical trends since 1993. Patient demographics (age and race) associated medical diagnoses, specific surgical procedures performed, length of hospital stays, and hospital charges are discussed.

Women and Cardiovascular Disease Hospitalizations
The *Women and Cardiovascular Disease Hospitalizations* report examines trends in cardiovascular hospitalizations (stroke, circulatory-related disorders and heart disease), 1992 through 2000, focusing on women. Age-specific hospitalization rates and in–hospital death rates are displayed by gender and race. Additionally, data on insurance status, reasons for hospitalization, procedures performed and charges are presented.

Cesarean Deliveries in Florida Hospitals
This annual report examines trends in cesarean and vaginal delivery hospitalizations, 1993 through 2003, focusing on data from CY 2003. Demographics of patients, associated medical diagnoses, length of hospital stays, hospital charges and variations in the cesarean rate are discussed. Delivery rates are presented by county, individual hospital and statewide.

Combating Health Disparities Series
The *Health Disparities Series* is published on the Internet at www.FloridaHealthStat.com. The series includes a variety of articles, statistical reports and data charts. Materials published in CY 2003 and CY 2004 include:

Minority Organ & Tissue Donation
Minorities make up approximately 50 percent of the patients seeking organ and tissue donation. This initiative is aimed at increasing organ and tissue donation among minorities.

Minority Donor Statistics
This article describes the need for organ and tissue donations in Florida and the United States and presents statistics on donations in CY 2002. Resources related to donations are listed.

National Minority Health Month Messages
This article contains facts about health disparities in Florida and sources for more information. It aims to inform health care providers, members of minority groups, and the general public about minority health in Florida.

Doctor Visits and Other Utilization Statistics
This article shows data that compares the frequency of doctor visits in the United States by race and ethnicity, age, and gender.

Births in Florida Hospitals
This article shows trends in premature live births and full-term live births with complications from CY 1995 to CY 2002 by race and ethnicity.

Other Publications

The State Center for Health Statistics publishes and periodically makes available to agencies and individuals health statistics publications of general interest. These activities directly support Goal 3 of increasing the public's access to health care information, and Goal 5 of increasing communication with media, stakeholders and policy makers. These publications and consumer brochures, as stated in s. 408.063, F.S., assist consumers to make informed decisions in the selection and use of health care providers, facilities, and services. Providing useful information to consumers on the performance of health care providers is intended to leverage the health care market to improve quality of care and efficiency in the delivery of services. For example, the Florida Health Management Organization (HMO) Report displays information on member satisfaction and the quality of plan services that help guide consumers to choose the best health plan available. Plans that are poor performers will be encouraged to improve their quality of care or perhaps lose market share.

Many of the publications of the State Center provide health statistics on topical health policy issues, as well as health status profiles of the people in this state. The State Center also publishes and disseminates the results of special health surveys, health care research, and health care evaluations. This information, whether it is a delineation of specific health care services that show large increases in spending, or a description of racial and ethnic disparities in hospital delivery outcomes, is valuable in the review of public policy issues. When informed with data on health care disparities or expenditures, among other topics, policy makers can better target scarce resources to help those in greatest need.

Consumer Awareness Series: The Florida Agency for Health Care Administration licenses and regulates health care facilities and health maintenance organizations (HMOs) across the state. AHCA also administers the Florida Medicaid program that provides health care to Florida's low-income and disabled citizens. AHCA's mission is to champion accessible, affordable, quality health care for all Floridians. To help achieve this mission, AHCA publishes the *Consumer Awareness Series*. This series consists of brochures designed to assist the public in making well-informed health care decisions.

A Patient's Guide to a Hospital Stay: This brochure provides information that can help individuals prepare for a stay in the hospital. Persons are encouraged to use all available resources to obtain information about a hospital stay prior to entering the hospital.

Resources include physicians, insurance companies and a contact listed in the back of the brochure.

Topics covered in the brochure include:

- A Hospital Checklist
- Questions to Ask your Physician and Hospital
- Consumer Tips
- Patients' Bill of Rights and Responsibilities
- Kid's Stay in the Hospital
- Resource Directory

Patient Safety: This brochure looks at medical errors and steps individuals can take to protect themselves. Persons are encouraged to use all available resources to learn more about patient safety. Resources include health care providers, pharmacists, local library, and Internet, as well as contacts listed in the brochure's resource directory.

Topics covered in the brochure include:

- What constitutes an emergency?
- What to do if a medical emergency arises?
- When to go to a hospital emergency room and what to take?
- What choices are there for non-urgent medical care?
- What about insurance coverage or what if I don't have insurance?
- Resource Directory

Consumer's Guide to Health and Human Services Programs: This pamphlet introduces consumers to various health and human services programs available through eight Florida state agencies. It includes information on health care facilities; financial and health care assistance; insurance; services for elders, disabled persons, children, and veterans; and other useful information. The pamphlet also includes web sites that provide connections to other state and federal programs.

Emergency Medical Care: This brochure provides information for anyone who may need help during a medical emergency. Persons are encouraged to use all available resources to obtain information on emergency care prior to an emergency. Resources include physicians, insurance companies and contacts listed in the brochure.

Topics covered in the brochure include:

- What constitutes an emergency?
- What to do if a medical emergency arises?
- When to go to a hospital emergency room and what to take?
- What choices are there for non-urgent medical care?
- What about insurance coverage or what if I don't have insurance?
- Resource Directory

Women and Heart Disease: This brochure provides information about women and heart disease. Persons are encouraged to use all available resources to be more informed about heart disease. Resources include health care providers, women's health organizations, as well as contacts listed in the brochure resource directory.

Topics covered in the brochure include:

- Risk Factors of Heart Disease
- Preventing Heart Failure
- Symptoms of a Heart Attack
- Taking Aspirin To Prevent a Heart Attack
- Tips for a Healthier Heart
- Resource Directory

Florida Medicaid - A Reference Guide: This brochure is an initial reference to provide general information about the Florida Medicaid program. It is intended to encourage citizens to use all available resources and organizations to help them obtain the health care services they need.

Long-Term Care: This brochure is an initial reference to assist persons in selecting a long-term health care provider. They are encouraged to use all available resources and organizations to help them find the health care services that best suit their needs. Resources are listed in the brochure's resource directory as well as contacts in the back of the brochure.

Topics covered in the brochure include:

- Adult Day Care
- Adult Family-Care Homes
- Assisted Living Facilities
- Continuing – Care Retirement Communities
- Home Health Care and Nurse Registries
- Hospice
- Nursing Homes
- Resource Directory

Understanding Prescription Drug Costs: This brochure is an initial reference for everyone that needs or might need to take prescription drugs. They are encouraged to use all available resources to obtain information on prescription drugs. Many of these resources are listed in the brochure's resource directory.

This brochure contains information for everyone who needs or might need to take prescription drugs. The purpose of this brochure is to help them know what cost-saving options there are and what questions to ask.

Topics covered in the brochure include:

- The prescription drug market
- Questions to ask your health plan
- Questions to ask your physician
- Questions to ask your pharmacist
- Annual prescription drug review — a checklist
- Glossary of drug and insurance terms
- Resource Directory

What to Consider When Choosing an Assisted Living Facility: This brochure provides information to assist individuals and their family in selecting an Assisted Living Facility (ALF). They are encouraged to use all available resources to find the ALF that best suits their needs. Resources can include your physician, your insurance company, and the contacts listed in the resource directory at the back of this brochure.
Topics covered in the brochure include:

- Staffing Concerns
- Financial Concerns
- Questions to Ask the ALF
- Questions about the Physical Environment
- Questions about Staff
- Questions about Activities
- Questions about meals
- Resource Directory

What You Should Know About Home Health Care: This brochure provides information about health care services provided in the home. Persons are encouraged to use all available resources to help them find the home health care services they need. Such services may be needed during recuperation after a hospital stay, or to help a disabled or elderly person live independently in their own home.

Topics covered in the brochure include:

- Services that are offered.
- Providers that offer these services.
- A description of quality standards.
- Guidelines for selecting a health care provider.
- Sources of assistance.
- Resource Directory

Health Insurance Guide for Families and Individuals: This brochure is an initial reference to assist consumers in selecting health insurance plans. Persons are encouraged to use all available resources and organizations to help find the health care plan that best suits their needs. Many of these organizations are listed at the back of this brochure.

Topics covered in the brochure include:

- What types of health plans are available?
- What to consider when choosing a health plan?
- How to get the most from your health plan?
- How to resolve health plan problems?
- Frequently asked questions
- Resource Directory

End-of-Life Issues - A Practical Planning Guide: This brochure provides an overview of end-of-life issues and practical planning. Persons are encouraged to use all available resources to prepare for or deal with death and dying. Resources include their physician, religious or spiritual advisor, attorney, family and friends, and hospice. Further information can also be obtained from organizations listed in this brochure

Topics covered in the brochure include:

- Facing Death
- Medical Concerns
- Legal and Practical Concerns
- Grief and Loss
- Final Arrangements

Guide to Ambulatory Procedures and Surgeries at Florida Hospitals and Surgical Centers 2004

Many surgeries and procedures can be performed in a hospital outpatient facility or in a freestanding ambulatory surgical center if an overnight stay is not needed for follow-up care. The type of facility where a surgery or procedure can be performed is determined by its complexity and the patient's condition. Some ambulatory surgeries and procedures can also be performed in a physician's office.

In the *Guide to Ambulatory Procedures and Surgeries at Florida Hospitals and Surgical Centers 2004*, persons will find information about ambulatory procedures and surgeries performed in hospitals and ambulatory surgical centers. The Guide uses data reported by ambulatory surgical centers and hospitals. Data reported includes the patients' diagnoses and the procedures performed. The standards for reporting this data are described by administrative rule.

Cesarean Report:
Cesarean Deliveries in Florida Hospitals, CY 1993 through CY 2003
Section 408.062, F.S., mandates the Agency for Health Care Administration to annually assess the cesarean rate in Florida hospitals. This report presents data on newborn deliveries in Florida for CY 2002 and CY 2003 and examines trends in cesarean and vaginal deliveries. Demographics of patients, associated medical diagnoses, length of hospital stays, hospital charges and variations in the cesarean rate are discussed.

In CY 2003, the cesarean delivery rate was 32.7 percent of all deliveries in Florida, up from 30.2 percent in CY 2002. Cesarean rates were found to be higher among women of Hispanic ethnicity and among women ages 30 years and older. Hospital stays for cesarean deliveries in CY 2003 averaged 3.5 days and 2.3 days for vaginal deliveries, unchanged from CY 2002. The primary cesarean rate in CY 2003 was 23.1 percent among women who had no prior cesarean deliveries, up from 21.4 percent in CY 2002.

Despite efforts to reduce Florida's cesarean rate in the past, it has steadily increased in recent years. New strategies to safely reduce the cesarean rate may be required if it continues to rise.

Florida Health Care Expenditures Report:
In January 2005 the State Center for Health Statistics published the Florida Health Care Expenditures, 2002 Report.

Section 408.063(5), F.S., requires the agency to publish annually a comprehensive report of state health expenditures.

In 2002, personal health care expenditures in Florida reached $83.4 billion, up from $77.3 billion in CY 2001. That represents an increase of 7.9 percent in health care costs, the second largest annual percentage increase in costs in this report's history, beginning in CY 1992. Among health services, expenditures for nursing homes (19.2%), medicinal drugs (13%) and specialized government services (13%) had the highest percentage increases. Medicaid, with a 13.3 percent increase, had the greatest growth in expenditures among payers, along with an increase in the number of people eligible for Medicaid services.

From CY 1992 to CY 2002, personal health care expenditures increased 85.1 percent. Among health services, expenditures for "specialized government and other services" (a miscellaneous category that includes certain Medicaid social services), medicinal drugs and nursing homes had the largest sustained increase. Over the past six years (1997-2002), only medicinal drugs has shown an annual growth rate greater than 10 percent.

For the first time since CY 1995-96, the rate of growth of Medicaid expenditures decreased from the previous year (2001). Although it still was an increase (13.3%), the previous year's growth rate had been 14.7 percent. Since 1998, Medicaid expenditures increased in each year in conjunction with large increases in enrollee caseload. However, since the growth of expenditures exceeded the growth in enrollment from CY 2001 to CY 2002, spending per enrollee increased by 6 percent.

Growth in Medicare expenditures slowed in 2002 (3.5%) as compared with the previous two years (average growth 6.4%). In contrast with Medicaid, the number of beneficiaries has grown by a steady small percentage annually. The result is a relatively small increase in spending per beneficiary (2.2%) over the period 2001-2002.

HMO expenditures were $11.3 billion in CY 2002 down 2 percent from CY 2001, the only annual decrease in spending observed since CY 1992. HMO expenditures include Medicare, Medicaid, and private HMO expenditures. In general, the annual rate of growth of HMO expenditures has declined since CY 1995, but the change in rate from CY 2001 to CY 2002 was the first absolute decrease seen throughout the ten-year period.

Excluding expenditures for health care services delivered to nonresidents, personal health care spending for Florida residents was $83 billion, or $4,967 per capita in CY 2002. Health care spending was 16.8 percent of the total personal income of Florida residents. U.S. personal health care expenditures were $4,654 per capita, accounting for 15.1 percent of personal income.

The higher proportion of elderly residents affects Florida health care spending and Medicare beneficiaries in Florida compared to other states. In CY 2002, the percentage of Florida residents aged 65 years and older was 17.2 percent, compared to 12.4 percent for the United States.

Personal health care expenditures equal total revenues received by health care providers. Health care providers include all practitioners and facilities that offer health care services and medical supplies to individual patients. Public health education and regulation expenditures and health insurance administrative costs are not included in personal health care expenditures.

State Health Data Catalog

The creation of the State Health Data Catalog is authorized in 408.05(4)(g), F.S.

The State Health Data Catalog was developed to assist individuals searching for health data and statistics. Its purpose is to facilitate referrals to the responsible data administrator for detailed information regarding available data and to promote the efficient use of data for research and public policy purposes. The State Health Data Catalog is exclusively available on www.FloridaHealthStat.com.

There are over 110 entries in the catalog representing various health care related databases maintained by state agencies. Each entry contains information on the types of data collected, reporting entities, purpose of the database with statutory or rule references, if applicable, and contact information. If available, website references are provided.

The catalog is updated periodically by an e-mail survey of state agencies. Information is current and checked for accuracy as of the date indicated on each database entry in the catalog.

Data Dissemination

Data dissemination is guided by 408.063, F.S.

Typically, data dissemination requests fall into the following categories: (1) requests for deidentified data (limited data set), (2) requests for standardized reports, (3) requests for customized *ad hoc* reports, (4) requests for publications, and (5) requests for other information. Most of these requests require a service fee.

Requests for data are never processed without written documentation from each customer. Customers may mail, phone, fax, or e-mail their requests to the State Center's Office of Data Dissemination. Since all requests are documented, customers who make their request by telephone are also asked to submit the detailed request via mail, fax, or e-mail. Customers are required to complete a Limited Data Set Data Use Agreement form in order to receive access to deidentified patient data.

Completed customer orders are mailed after payment is received. Prices for data and publications are denoted in the Data Catalog and Price List. Prices for *ad hoc* reports are estimated based on the time required to complete the report. Federal, State, or municipal government agencies are not charged.

Requests for data and publications are typically filled within ten working days of receiving the payment (or the order for customers with standing accounts). Special *ad hoc* queries are completed in a timely manner. The number of days to fill an *ad hoc* request is subject to the time required to run the query and check the results.

The order contains the information requested on the proper media (paper, CD-ROM, diskette, etc.) and the invoice. Orders are available for customer pick-up or sent via e-mail (excluding confidential data), priority mail, Airborne, or Federal Express. Orders sent via Airborne or Federal Express are shipped at the customer's expense.

A detailed log is maintained for tracking purposes. Monies received are handled through the Agency's Bureau of Finance and Accounting. Copies of requests, checks, invoices, shipping labels, and fax receipts are kept on file for each customer.

Request for Deidentified Data
Both the hospital inpatient and the ambulatory patient databases are available for sale to the general public in a non-confidential format (limited data set). To receive data, the requestor must sign a Limited Data Set Use Agreement form. The agreement contains provisions to protect patient's privacy rights as required by law.

When completed, the Data Use Agreement form is forwarded to the State Center's Bureau Chief for signature. Upon authorization, the original Agreement form will be maintained in the State Center's Office of Data Dissemination and the applicant will receive a copy.

The following data items are not included in the deidentified data: patient identification number, the social security number, the infant linkage identification number, date of admission, date of discharge, date of birth, zip codes, if the population is 500 or less, and the principal procedure date.

Some calculated information is added to the database. These include: the state of residence, the county of residence, the age at admission, the day-of-week of the admission, the length-of-stay, and the Diagnostic Related Group (DRG). Under very strict conditions, confidential data is available, but not to the general public.

The patient-level data is sold by quarter and is available on diskette by the facility, county/local health council region, or statewide data on CD-ROM. In CY 2004, the State Center processed 714 requests for deidentified data (compared with 786 requests in 2003 and 742 requests in 2002). The slight decrease in these requests may be due to the availability of much of the data on the www.FloridaHealthStat.com website.

Request for a Standardized Reports
The State Center produces a number of standardized reports.

- **Discharge Data Summary Report.** This report includes demographics, procedures and diagnoses, charge statistics, and the number of discharges, days, and gross charges by Diagnostic Related Groups (DRGs) as well as Major Diagnostic Categories (MDCs). Each report covers one quarter (three months); however, the reports may be aggregated to include up to five quarters. Reports are available at the facility level or aggregated to the county, district, or state level.

- **DRG Report.** This 12-page report includes, the number of discharges, days, and gross charges by payer category (Medicaid, Medicare, Blue Cross and commercial insurance, other payers, and total) for all of the DRGs within the Major Diagnostic Categories (MDCs). Each report covers one quarter (three months); however, the reports may be aggregated to include up to five quarters. Reports are available at the facility level or aggregated to the county, district, or state level.

- **Prior Year Report (Hospital Financial).** This hospital fiscal year financial data report is listed on standardized financial worksheets. Reports are available as a printout or as an e-mail attachment.

- **Audited Financial Statement (Hospital Financial).** An independent auditor prepares this hospital financial report. It includes the auditor's opinion, hospital's balance sheet,

statement of cash flow, statement of revenues and expenses, statement of changes in fund balance, and financial statement notes. Reports are available as a photocopy.

- **Hospital Financial Data.** This hospital report contains fiscal year facility-level information and is available on CD-ROM. The data contains audited information on hospital revenues, expense/expenditures and depreciation, medical staff data, selected discounts and prospective payment arrangements, and other statistics and general data for each hospital.

Request for a Custom *Ad Hoc* Report
Sometimes, a customer is looking for very specific information that is not included on a standardized report, and does not wish to purchase an entire data set to obtain the information. These requests are referred to as custom *ad hoc* reports. An example would be a request for the median age of residents admitted to the hospital with tuberculosis (ICD-9-CM diagnosis 010.0 – 018.6) as principal or secondary diagnosis, by year, from CY 1995 to CY 2000.

By their nature, *ad hoc* requests are very precise and can be very technical. A customer requesting a custom *ad hoc* report might receive a telephone call or e-mail from a State Center staff member with some specific questions about the query. Completed reports may be disseminated on paper, on diskette, on CD-ROM, etc. They vary in length, time to produce, and cost to the requester. Each report is cross-verified and reviewed before release.

Off-the-shelf publications are available as well. Some examples of publications include the Hospital Financial Data Book and the Florida Hospital Uniform Reporting Systems Manual (FHURS).

Florida Health Care Expenditures Report:
In January 2005 the State Center for Health Statistics published the Florida Health Care Expenditures, 2002 Report.

Section 408.063(5), Florida Statutes, requires the agency to publish annually a comprehensive report of state health expenditures.

In CY 2002, personal health care expenditures in Florida reached $83.4 billion, up from $77.3 billion in CY 2001. That represents an increase of 7.9 percent in health care costs, the second largest annual percentage increase in costs in this report's history, beginning in CY 1992. Among health services, expenditures for nursing homes (19.2%), medicinal drugs (13%) and specialized government services (13%) had the highest percentage increases. Medicaid, with a 13.3 percent increase, had the greatest growth in expenditures among payers, along with an increase in the number of people eligible for Medicaid services.

Among health services, expenditures for medicinal drugs (13.0% increase) had the highest percentage increase, nearly 50 percent higher than the percentage rate increase for all other services (7.0%). Among all health care services during the period CY 1997 through CY 2002, only medicinal drugs had an annual growth rate greater than 10 percent. In CY 2005, the Agency for Health Care Administration and the Office of the Attorney General launched the Florida Prescription Drug Prices web site (MyFloridaRx.com), with the goal of helping consumers shop for the lowest prices in their area for prescription drugs. Providing

consumers with previously unavailable, transparent comparative price information should help lower the cost of prescription drugs for both individuals and overall expenditures.

From CY 1992 to CY 2002, personal health care expenditures increased 85.1%. Among health services, expenditures for "specialized government and other services" (a miscellaneous category that includes certain Medicaid social services), medicinal drugs and nursing homes had the largest sustained increase. During the years (1997-2002), only medicinal drugs have shown an annual growth rate greater than 10 percent.

For the first time since FY 1995-96, the rate of growth of Medicaid expenditures decreased from the previous year (2001). Although it still was an increase (13.3%), the previous year's growth rate had been 14.7 percent. Since CY 1998, Medicaid expenditures increased in each year in conjunction with large increases in enrollee caseload. However, since the growth of expenditures exceeded the growth in enrollment from CY 2001 to CY 2002, spending per enrollee increased by 6 percent.

Growth in Medicare expenditures slowed in 2002 (3.5%) as compared with the previous two years (average growth 6.4%). In contrast with Medicaid, the number of beneficiaries has grown by a steady small percentage annually. The result is a relatively small increase in spending per beneficiary (2.2%) over the period 2001-2002.

HMO expenditures were $11.3 billion in CY 2002 down 2 percent from CY 2001, the only annual decrease in spending observed since CY 1992. HMO expenditures include Medicare, Medicaid, and private HMO expenditures. In general, the annual rate of growth of HMO expenditures has declined since 1995, but the change in rate from CY 2001 to CY 2002 was the first absolute decrease seen throughout the ten-year period.

Excluding expenditures for health care services delivered to nonresidents, personal health care spending for Florida residents was $83 billion, or $4,967 per capita in CY 2002. Health care spending was 16.8 percent of the total personal income of Florida residents. U.S. personal health care expenditures were $4,654 per capita, accounting for 15.1 percent of personal income.

The higher proportion of elderly residents affects Florida health care spending and Medicare beneficiaries in Florida compared to other states. In CY 2002, the percentage of Florida residents aged 65 years and older was 17.2 percent, compared to 12.4 percent for the United States.

Personal health care expenditures equal total revenues received by health care providers. Health care providers include all practitioners and facilities that offer health care services and medical supplies to individual patients. Public health education and regulation expenditures and health insurance administrative costs are not included in personal health care expenditures.

4. Creating a Transparent Health Care Delivery System

FloridaHealthStat.com

The Agency website, FloridaHealthStat.com, was developed by the State Center and first became operational in January 2000. The website, specifically designed for consumers, was developed to help meet the State Center's mission of providing accurate and timely information to help the public in making well informed health care decisions.

The website includes a detailed look at hospital and ambulatory patient data; a list of licensed health care facilities and providers in Florida and driving directions; information on insurance, including Medicare and Medicaid; a wide collection of consumer brochures and publications; information on prescription drugs; special sections on children's and senior's health; and much more.

Getting information from FloridaHealthStat.com is easy. Just access the Internet and type FloridaHealthStat.com in the address line of your browser window. A series of buttons/tabs on the top of the screen will allow the user to navigate the site. The website does not require the user to register or provide personal information. Users can request additional information via e-mail.

Available Information on Health Care Facilities or Providers
Users can get a list of Florida health care facilities (providers) on FloridaHealthStat.com. From the home screen, select "Facility Information" or "Provider Locator" on the top button bar. Select the type of facility/provider from the drop down box. A facility/provider type may be selected or one can choose "Not Specified." Selecting other items will help narrow the search. For example, if a county is selected, the result will be limited to that county.

Users can obtain a map showing where the facility/provider is located. When the list of facilities is displayed, click on "Map Location" next to the facility or provider name and a map will be displayed. For written driving directions, put in a starting address, city, state, and zip code in the boxes below the map and click "Take Me There."

Users can also obtain additional information on various health care providers from the "Provider Locator." Once a provider or list of providers is displayed, click on "Provider Profile" next to a provider for information about specific physicians and registered nurses, including education, and license status as maintained by the Florida Department of Health.

Available Standardized Reports - QuickStat
Several standardized reports are available on FloridaHealthStat.com. From the home screen, select "Health Data" on the top button bar. Under "Health Data," select "QuickStat" by clicking on "Go to QuickStat." QuickStat is designed for the user interested in receiving fast preformatted summary information on various medical conditions and/or procedures. Data reports are divided into two categories: Inpatient and Outpatient. Under either category the user can view tables of hospital discharges or ambulatory visits by procedures performed, diagnostic conditions, average charges and length of stay, among other data displays.

Available Ad Hoc Reports – HealthStat Custom Query
Users can produce their own *ad hoc* reports on FloridaHealthStat.com. From the home screen, select "Health Data" on the top button bar. Under "Health Data," select "HealthStat" by clicking on "Go to HealthStat."

Alternatively, the user can click on "Consumer Health Data" from the home page. From that page users can select one of two data query systems: "Health Consumers," which allows for the easy selection of data on the most common diagnoses and procedures in Florida health care facilities or "Researchers and Health Professionals," which requires knowledge of medical coding and terminology. The data query system under "Health Consumers" is new for CY 2004 and is described in the *Facility Performance Status Report*.

The system under "Researchers and Health Professionals" allows the user to custom design their information about medical conditions and/or procedures. Knowledge of medical coding and terminology is strongly recommended. The user can choose between the hospital inpatient data and ambulatory patient data.

The HealthStat Inpatient Hospitalization Query allows you to search by ICD-9-CM codes and DRG codes. Results can be returned by various demographics and other criteria. Basic knowledge of ICD-9-CM diagnosis and procedure codes is essential to inpatient query by code. However, a novice can handle simpler queries that do not use ICD-9-CM codes.

The HealthStat Ambulatory Surgery Query allows users to search by CPT procedure codes and ICD-9-CM diagnosis codes. Results can be returned by various demographics and other criteria. Basic knowledge of CPT procedure codes and ICD-9-CM diagnosis codes is essential to outpatient query by code.

Note that only principal diagnoses and procedures are used in HealthStat. Queries using secondary diagnoses and procedures must be requested from data dissemination. (See "Requests for Data Dissemination," above.) Optional criteria for queries may be selected in the following areas: Medical Condition or Treatment and Patient Subset. Aggregate Calculation and Headers and Columns are required selections. The results will return the most recent four quarters (one year) of data.

Publications Available

Most of the State Center's publications are available on FloridaHealthStat.com. From the home screen, select "Reports & Guides" on the top button bar. This section contains many reports, briefs, journals, and publications. Some of the Publications/Forms are in Portable Document Format (PDF), and require Adobe Acrobat Reader™ in order to view these files.

Under "Reports & Guides," the user can find reports in many categories, including:

- Combating Health Disparities
- Consumer Brochures
- Health Outcome Series Reports
- Health, Safety & Fitness
- Hospital Services
- Insurance
- Long-Term Care/ Home Health Care
- Medicine/ Drugs

Other Information Available on www.FloridaHealthStat.com

The Agency's website, FloridaHealthStat.com, has much more to offer than the information described above. There are special sections for prescription information www.MyFloridaRx.com and insurance issues ("InsuranceStat"). There is information specifically geared toward special populations ("Families" and "Seniors"). For seniors, there is the *Florida Nursing Home Guide*, an interactive resource that allows consumers to search for nursing homes by geographic region and other characteristics. For each facility, data

and ratings are displayed for a variety of performance measures. The website is constantly evolving and new content is periodically added and updated.

On the Agency website, FloridaHealthStat.com, there are various ways the user can view and download patient data information. In October 2004, the data querying function of the website was enhanced to provide more easily obtainable useful information for health care consumers. Thus, a new search tool for consumers ("Health Consumers") was created.

With the previous data query tool (still available under "Researchers and Health Professionals"), it was recommended that users be familiar with medical coding and terminology. With the tool under "Health Consumers," the user picks from a list of the most common diagnoses and procedures in Florida hospitals or ambulatory surgery centers. All data queries display the number of hospitalizations or ambulatory visits in a manner specified by the user.

Querying the data is a simple three-step process. In step one, the user selects from a set of inpatient condition categories, (e.g., Heart & Cardiovascular) or outpatient procedures, (e.g., Cataract Surgery). For inpatient hospitalizations, the user next selects from a group of specific treatments, e.g., Coronary Bypass. Finally, one can select from a subset of patients, based on race, gender, age group or other categories. The query returns the number of hospitalizations or outpatient visits per facility.

If one selects "All Hospitalizations," data are displayed for the number of hospitalizations, average charge per stay and average length of stay. Also displayed is a case-mix score and case-mix adjusted charges and length of stay.

Case mix is a means of describing health facilities based on the costs of all admissions in a year. The case-mix score is a calculated index per facility reflecting the relative costliness of the mix of cases at that facility compared to the statewide mix of cases. Facilities with many complex and costly admissions, e.g., teaching hospitals, will have a higher case-mix score than small community hospitals that mainly perform delivery of infants. Charges and length of stay are adjusted with the case-mix score in order to create a valid comparison among facilities.

Enhancements to Data Dissemination System

The "Consumer Health Data" tool also provides information about definitions of diagnoses and procedures and explanations on why the data may differ from facility to facility.

The addition of the "Consumer Health Data" query system to the FloridaHealthStat.com website is another step the Agency has made in achieving the goal of empowering the consumer to make informed health care decisions. To help reach this goal, the Agency is directed to consult with the Comprehensive Health Information System (CHIS) Advisory Council to determine the specific medical conditions and procedures to include on the website, and the means for adjusting the data to display performance outcomes. Specifically, the statute states the following:

- Develop, in conjunction with the State Comprehensive Health Information System Advisory Council, and implement a long-range plan for making available performance outcome and financial data that will allow consumers to compare health care services…When determining which performance outcomes to disclose, the Agency shall consider such factors as volume of cases; average patient charges; average length of

stay; complication rates; mortality rates; and infection rates, among others, which shall be adjusted for case mix and severity, if applicable. (s.408.05(3)(l), F.S.)

- In CY 2004, the State Center began meeting and consulting with the CHIS Advisory Council specifically on how best to achieve the statutory goals. Topics discussed include the selection of data to be displayed, means for risk adjusting the data, and various ways to display the data in a meaningful way.

- Performance outcome data are measures intended to help consumers make informed decisions regarding comparative performance among health care facilities. Examples of performance outcome measures include:

    - Average length of stay
    - Average patient charges
    - Mortality and morbidity rates
    - Complication rates
    - Hospital-acquired infection rates, and
    - Readmission rates.

Performance outcome indicators must be risk or severity adjusted, using nationally recognized risk adjustment methodologies or software consistent with the standards of the Agency for Healthcare Research and Quality. Advice on the appropriate method for risk adjustment are solicited from the CHIS Advisory Council, who will recommend the best approach for risk adjustment and obtain support for this approach from stakeholders.

In its advisory role to the State Center for Health Statistics, the CHIS Advisory Council addresses various issues concerning the presentation of consumer information and of reporting heath care data. Currently, the following workgroups have been formed to address specific issues of concerns:

Health Care Facility Website Technical Workgroup
The purpose of this workgroup is to advise the Agency on issues concerning performance measures, risk adjustment measures, the appropriate data to report on the Agency website and other issues such as minimum number of cases to report and grouping of data. The workgroup is composed of members representing various entities of the health care industry and government. Specific topics examined by the workgroup include:

- Advise the Agency on the appropriate risk adjustment system to use;
- Determine what complications are relevant to report; and
- Review national performance measures and best practices.

This technical advisory workgroup will evaluate the Agency's consumer website and will make recommendations on the following:

- The risk-adjustment system to use;
- The minimum number of cases to report;
- What complications are relevant to report on the website;
- How data should be grouped; and
- The national measures to use.

Hospital-Acquired Infections Technical Workgroup
The purpose of this workgroup is to advise the Agency on issues concerning hospital-acquired infections. The workgroup is composed of members representing various entities of the health care industry and government. Specific topics to be examined by the workgroup include:

- How to report Surgical Infection Prevention (SIP) measures;
- How to review current systems of reporting infection rates; and
- How to determine the appropriate infection measures to report.

The product of these workgroups will be a set of recommendations to the Agency regarding the best manner of presenting the Agency's health care data to consumers and professionals in order to facilitate informed decision making.

Health Plan Consumer Report Workgroup
The purpose of the CHIS Health Plan Consumer Report Workgroup is to advise the Agency on the dissemination of comparative information about the costs, benefits and performance of health plans throughout Florida.

Public Relations, and Physician Data Technical Workgroup
Two new technical workgroups have been identified and are in the early stages of development. The purpose of the Public Relations Workgroup is to help the State Center for Health Statistics market FloridaHealthStat.com and to develop an ongoing strategy to inform and educate consumers about transparency of health care data and the consumer-oriented information available on the Agency website. The workgroup will be asked to make recommendations on topics pertaining to marketing, consumer education and public relations. The workgroup should work with the AHCA Communications Office, Health Councils around the state, the CHIS Website Workgroup and other stakeholders to develop a marketing campaign for rolling out FloridaHealthStat.com to Florida's consumers. The Physician Data Technical Workgroup will be charged with the responsibility to advise the CHIS Advisory council and the State Center for Health Statistics on what physician data performance measures should be required for mandatory collection and posting on FloridaHealthStat.com.

Hospital Reporting
Beginning in the third quarter of CY 2004, the process to amend the rules governing hospital inpatient data collection (Ch. 59E-7, F.A.C.) was initiated. Proposed changes include the addition of patient data elements, modification of data elements and codes, modification of inpatient data formats and the elimination of certain data elements. An initial rule development workshop was held on November 16, 2004. The target date for facilities to begin collecting data under the amended rule is January 1, 2006.
In CY 2004, rule making to collect data on hospital-acquired infections (Ch. 59B-15, F.A.C.) was initiated. The proposed rules will require hospitals to report quarterly Surgical Infection Prevention (SIP) measures to the Agency for the purpose of providing comparative information to consumers. The methodology used to prepare the measures shall meet the standards of the Centers for Medicare and Medicaid Services. The proposed schedule for reporting data is mid-2005, with data to be published on the Agency's website is early CY 2006.

Ambulatory Reporting
On April 18, 2004 the ambulatory patient data rule (Ch. 59B-9, F.A.C.) was amended effective on January 1, 2005. Two of these changes relate to data transmission. Data must be reported using the file format "XML," and beginning January 1, 2006, data must be transmitted electronically via the Internet. Other substantial changes relate to the specific data elements, codes and standards some of which have been deleted, modified or added. Data elements added to the visit record include: other physician, patient visit beginning and ending date, patient hour of arrival, patient reason for visit, and external cause of injury. See Chapter 59B-9, F.A.C. for complete details of changes to the rule.

Emergency Department Data Collection
The most significant change to the ambulatory patient data rule is a requirement for reporting hospital emergency department visit data beginning January 1, 2005. Emergency department data will provide an important resource for analyzing utilization patterns, access to care and costs for disease and injury surveillance and for the management of chronic diseases. Specifically, the rule requires the reporting of "all emergency department visits in which emergency department registration occurs and the patient is not admitted for inpatient care." The reporting record format is the same one as used for reporting of ambulatory surgery (Chapter 59B-9, F.A.C.). The data collected will be analyzed for a mandated study of emergency department utilization and the implications for hospital costs.

MyFloridaRx.com
Under the provisions of 408.062 (1)(h) F.S., the agency shall collect a statistically valid sample of data on the retail prices charged by pharmacies for the 50 most frequently prescribed medicines from any pharmacy licensed by this state.

The rising cost of prescription drugs is a concern for many Floridians. Consumers are often not aware that prescription drug prices may vary significantly from pharmacy to pharmacy. Many states are now creating websites to help customers to comparison shop among pharmacies.

The Agency for Health Care Administration along with the Office of the Florida Attorney General developed www.MyFloridaRx.com to provide retail pricing information for the 50 most commonly used prescription drugs in Florida reported monthly by pharmacies. Specifically, the mandate calls for 408.062 (1)(h) The collection of a statistically valid sample of data on the retail prices charged by pharmacies for the 50 most frequently prescribed medicines from any pharmacy licensed by this state as a special study authorized by the Legislature to be performed by the agency quarterly. If the drug is available generically, price data shall be reported for the generic drug and price data of a brand-named drug for which the generic drug is the equivalent shall be reported. The Internet website post pharmacy drug prices for a 30-day supply at a standard dose. The data collected shall be reported for each drug by pharmacy and by metropolitan statistical area or region.

The prices are the "usual and customary prices," also known as retail prices, reported monthly by pharmacies. This is the price that an uninsured consumer, with no discount or supplemental plan, would normally pay. To search for prescription drug prices, a consumer will select a county, city, drug name, and then the search function. Then, a list of pharmacies, their location and contact information, a link to a map, and the drug dosage, quantity, price, and date last updated will be displayed for the specified drug in your selected area.

In addition to the search capabilities, the website also feature a list of Frequently Asked Questions and Answers, Medical Discount Card information, website links to helpful information concerning possible side effects, interactions, and precautions that may apply to prescription medication, links to pharmacy assistance and public and private drug discount programs.)

The website allows consumers to compare prices for prescription drugs charged by pharmacies in their city, and even within their individual zip code. The price search and other information are available in both English and Spanish, and the results can be downloaded into a spreadsheet so consumers can review all prices at their convenience. It is designed to assist consumers of all age groups.

Long-Range Plan

The State Center is completing a Long-Range Plan to lay out the strategy of the Agency for promoting transparency in the health care delivery system. The plan will summarize the expectations of the Legislature for reporting health care data over FloridaHealthStat.com and provides a strategic plan for amplifying the data reported. The plan will cover the reporting of health care facility indicators, physician performance indicators, health plan consumer reports and price transparency for facilities, pharmaceuticals and health plans. The plan deals with indicators that should be published on the Agency web site, including charges for different medical procedures, infection rates in hospitals, patient safety and other quality indicators, client satisfaction with health plans and surgical outcomes. The long-range plan will project transparency-reporting activities forward for five years.

Section 408.05 (3)(1) F.S., requires the agency in conjunction with the State Comprehensive Health Information System Advisory Council, to develop and implement a long-range plan for making available performance outcome and financial data that will allow consumers to compare health care services. The performance outcomes and financial data the agency must make available shall include, but is not limited to, pharmaceuticals, physicians, health care facilities, and health plans and managed care entities. The agency shall submit the initial plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2006, and shall update the plan and report on the status of its implementation annually thereafter. The agency shall also make the plan and status report available to the public on its Internet website. As part of the plan, the agency shall identify the process and timeframes for implementation, any barriers to implementation, and recommendations of changes in the law that may be enacted by the Legislature to eliminate the barriers. As preliminary elements of the plan, the agency shall:

- Make available performance outcome and patient charge data collected from health care facilities pursuant to s. 408.061(1)(a) and (2). The agency shall determine which conditions and procedures, performance outcomes, and patient charge data to disclose based upon input from the council. When determining which conditions and procedures are to be disclosed, the council and the agency shall consider variation in costs, variation in outcomes, and magnitude of variations and other relevant information. When determining which performance outcomes to disclose, the agency:
    - Shall consider such factors as volume of cases; average patient charges; average length of stay; complication rates; mortality rates; and infection rates, among others, which shall be adjusted for case mix and severity, if applicable.

- o May consider such additional measures that are adopted by the Centers for Medicare and Medicaid Studies, National Quality Forum, the Joint Commission on Accreditation of Healthcare Organizations, the Agency for Healthcare Research and Quality, or a similar national entity that establishes standards to measure the performance of health care providers, or by other states.

5. Electronic Health Records

Under the provisions of 408.062 (5), F.S., the Agency shall develop and implement a strategy for the adoption and use of electronic health records. The Agency may develop rules to facilitate the functionality and protect the confidentiality of electronic health records.

In 2004, the Florida Legislature directed the Agency to begin an intensive planning process that would ultimately establish a strategy for the implementation of a Florida health information infrastructure that includes the use of electronic health records by individual health care providers and the secure electronic transfer of clinical data between multiple providers. In May of 2004, Governor Jeb Bush created the Governor's Health Information Infrastructure Advisory Board (GHII Advisory Board) consisting of health care professionals and technical experts to advise the Agency and provide for public participation in the planning process.

Since the appointment of GHII Advisory Board members in June 2004, it has actively sought to educate itself and the Agency through workshops and public forums. The Board held a two-day workshop in October 2004 at which national experts and stakeholders spoke about national initiatives, best practices, and trends in the use of electronic health records. At its October meeting, the GHII Advisory Board recommended that the Agency initiate local pilot projects that will leverage existing technology, improve patient care, and promote community-wide adoption of electronic health record systems.

The Board invited state and local representatives of health care provider, payer, and consumer organizations to participate in public forums held in November and December 2004. Speakers presented their experiences in implementing electronic health records including barriers to adoption, current status, and benefits realized. The public forums provided an opportunity for interested parties to contribute their expertise in the development of pilot project criteria.

As part of this strategy, the Agency is providing grant funding for pilot projects that demonstrate the exchange of clinical data among practitioners. Regional Health Information Organizations (RHIO) will manage these local exchange projects. In totality, the local health information exchanges constitute the *Florida Health Information Network*.

The development of local health information exchanges will encourage physicians to use electronic health records by demonstrating the value of this information for patient care. In addition, the local exchange projects will create personal health records so that patients can obtain electronic access to their own records. The goal is to encourage patients to be actively engaged in their health care by giving them access to their health records.

The Agency is proposing new legislation to support the development of the Florida Health Information Network (FHIN) and the implementation of health information exchange among physicians and other health care providers in Florida. This new legislation calls for the State Center for Health Statistics to monitor innovations in health information technology, informatics and health information exchange, and to maintain a repository of technical

resources for support of the FHIN. By keeping track of changes in technological systems, software solutions and innovations in health care data exchange across the nation, the State Center will provide ongoing technical resource support for the FHIN. The legislation also proposes that the State Center publish an annual report on the status of the FHIN for the Governor and the Legislature, as a method of keeping them informed about the status of the network and the ongoing implementation of health information records among providers in the state.

The State Center for Health Statistics will administer and manage grants for health information exchange projects in the state. The Legislature in CY 2005 granted AHCA $1.5 million to create the Florida Health Information Network, which money is being used to fund a grants program for pilot projects across the state. With the expectation of future funding to support the FHIN, the State Center needs to be prepared to post Requests for Proposal, select grantees and manage and evaluate the grants given to health information exchange pilot projects. The State Center is also planning to negotiate the integration of health care databases from each state agency that collects, stores and reports on health care issues, such as the immunization data in the Department of Health. By integrating health care data onto one database server, that data can be made available to health care practitioners through the Florida Health Information Network.

List of Potential Policy Changes Affecting Agency Budget Requests

Number	Potential Policy Changes	Reference LRPP Goals	The Legislative Budget Requests (LBR) Affected	Impact on Policy if LBR Request is not Approved
1.	Expansion of FHIN Grants Program	3	Expansion of FHIN Grants Program	The development of the Florida health information network (FHIN) is unlikely to occur without sufficient funding from both public and private sources.

List of Changes that Would Require Legislative Action

Number	Changes in Current Programs	Statutory Reference	Changes in Current Services	Changes in Current Activities	Substantive Legislative Action Required to Support Changes
1	Expansion of Technical Assistance	408.05 (4), F.S.	SCHS shall serve as a resource center to the Florida Health Information Network (FHIN).	The Agency shall administer the FHIN Grants Program. The Agency shall facilitate the use of state databases by the FHIN.	Incorporate changes in current services and activities in 408.05 (4), F.S.

List of All Task Forces and Studies in Progress

Item Number	Bill Number	Legislative Language	Division
1.	HB 811 Page 2 Line 52 Web Page	Develop, in conjunction with the State Comprehensive Health Information System Advisory Council, and implement a long-range plan for making available performance outcome and financial data that will allow consumers to compare health care services. The performance outcomes and financial data the agency must make available shall include, but is not limited to, pharmaceuticals, physicians, health care facilities, and health plans and managed care entities. The agency shall submit the initial plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2006, and shall update the plan and report on the status of its implementation annually thereafter. The agency shall also make the plan and status report available to the public on its Internet web site. As part of the plan, the agency shall identify the process and timeframes for implementation, and any barriers to implementation, and recommendations of changes in the law that may be enacted by the Legislature to eliminate the barriers.	Chief of Staff
2.	HB 811 Page 4 Line 99 Web Page	Make available performance measures, benefit design, and premium cost data from health plans licensed pursuant to Chapter 627 or Chapter 641, F.S. The agency shall determine which performance outcome and member and subscriber cost data to disclose, based upon input from the council. When determining which data to disclose, the agency shall consider information that may be required by either individual or group purchasers to access the value of the product, which may include membership satisfaction, quality of care, current enrollment or membership, coverage areas, accreditation status, premium costs, plan costs, premium increases, range of benefits, co-payments and deductibles, accuracy, and speed of claims payment, credentials of physicians, number of providers, names of network providers, and hospitals in the network. Health plans shall make available to the agency any such data or information that is not currently reported to the agency or the office. The data specified shall be released no later than October 1, 2006.	Chief of Staff

Item Number	Bill Number	Legislative Language	Division
3.	HB 811 Page 5 Line 115 Web Page	Determine the method and format for public disclosure of data reported pursuant to this paragraph. The agency shall make its determination based upon input from the Comprehensive Health Information Systems Advisory Council. At a minimum, the data shall be made available on the agency's Internet web site in a manner that allows consumers to conduct an interactive search that allows them to view and compare the information for specific providers. The web site must include such additional information as is determined necessary to ensure that the web site enhances informed decision making among consumer and health care purchasers, which shall include, at a minimum, appropriate guidance on how to use the data and an explanation of why the data may vary from provider to provider. The data specified shall be released no later than January 1, 2006, for the reporting of infection rates.	Chief of Staff
4.	HB 811 Page 5 Line 115 Web Page	Determine the method and format for public disclosure of data reported pursuant to this paragraph. The agency shall make its determination based upon input from the Comprehensive Health Information Systems Advisory Council. At a minimum, the data shall be made available on the agency's Internet web site in a manner that allows consumers to conduct an interactive search that allows them to view and compare the information for specific providers. The web site must include such additional information as is determined necessary to ensure that the web site enhances informed decision making among consumer and health care purchasers, which shall include, at a minimum, appropriate guidance on how to use the data and an explanation of why the data may vary from provider to provider. The data specified shall be released no later than October 1, 2005, for the reporting of mortality rates and complication rates.	Chief of Staff

Inspector General

Goal 4: To combat fraud, waste and abuse in the Florida Medicaid Program

Objective 4: To increase by seven percent annually through FY 2010-11, the collection of Medicaid dollars overpaid to fraudulent and abusive Medicaid providers.

Service Outcome Measure 4: Amount of overpayments recovered by the Agency for Health Care Administration.

Service Outcome Measure Projection Table 4:

Baseline/Year FY 2003-04	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
$16,674,293 Actual Collections	$20,427,497	$21,857,422	$23,387,442	$25,024,562	$26,776,282
Percent of Projection Increase	7%	7%	7%	7%	7%

In the Long Range Program Plan for FY 2005-06 through FY 2009-10, the Payment Accuracy Study done in FY 2001-02 was used as a baseline. That study measured the accuracy rate of acute care, long-term care and prescribed medicine and determined an error rate of 6.25 percent. However, the Payment Accuracy Study performed in CY 2004 measured the accuracy rate of capitation payments, fee-for-service and changed the methodology of how the data was compiled. Due to these aforementioned differences, comparison of the results of these two studies is not possible. Therefore, we are changing our measurement rate to "Collections," using FY 2003-04 data as a baseline. Fiscal Year 2003-04 is the first year that consistent reporting of data began. The Office of the Inspector General is hoping to increase these collections by a minimum of seven percent annually.

Collections are identified in this table as monies received by the Agency and include recoveries resulting from liens on Medicaid payments to providers and recovering overpayments through claim adjustments and offsets posted directly to the claims processing system.

Linkage of Agency Goals and Programs to Governor's Priorities

	Governor's Priorities and Goals	Name of Agency Goals and/or Programs
1.	Improve education	
2.	Strengthen families	
3.	Promote economic diversity	
4.	Reduce violent crime and illegal drug use	
5.	Create a smaller, more effective, more efficient government	**Goal 4**: To combat fraud, waste and abuse in the Florida Medicaid Program
6.	Enhance Florida's environment and quality of life	**Goal 4**: To combat fraud, waste and abuse in the Florida Medicaid Program

Trends and Conditions Statement

Section 409.913, F.S., and Section 42, Code of Federal Regulations, mandates oversight of the Florida Medicaid program. The major cost of this oversight function is reflected in appropriations to the Bureau of Medicaid Program Integrity (MPI). The bureau's oversight responsibility includes identifying and discouraging fraud, waste, mismanagement and misconduct in the Medicaid program. The Agency has detected negligent and fraudulent behavior and wasteful billing practices by Medicaid providers that are willing to manipulate the Medicaid program for personal gain. Not all billing errors are due to deliberate or criminal activities, some are due to over utilization, procedure and billing errors. For these reasons, the Agency is committed to reviewing and investigating all suspicious practices in which Medicaid may be billed in error. Considerable efforts are made to identify and stop inappropriate billing practices, to educate providers and to prevent these incidents.

Medicaid Program Integrity spearheaded the promulgation of Rule 59G-0.70 that calls for sanctions to be imposed upon providers that cause the Florida Medicaid program to be billed erroneously. The Agency began to impose these sanctions on July 1, 2005, and will report on the effectiveness of this compliance tool in future reports.

Medicaid Program Integrity is also part of the procurement team for the Florida Medicaid Management Information System (FMMIS) contract that will commence in FY 2007-08. As part of this team, MPI has worked diligently to include valuable statistical information and complicated algorithms to be integrated into the new Decision Support System (DSS). The team will incorporate new detection tools and edits that will provide invaluable assistance in detecting and deterring possible fraud and abuse.

List of Potential Policy Changes Affecting Agency Budget Requests

Number	Potential Policy Changes	Reference LRPP Goals	The Legislative Budget Requests (LBR) Affected	Impact on Policy if LBR Request is not Approved
1	None			

List of Changes that Would Require Legislative Action

Number	Changes in Current Programs	Statutory Reference	Changes in Current Services	Changes in Current Activities	Substantive Legislative Action Required to Support Changes
1	None				

List of All Task Forces and Studies in Progress

Number	Bill Number	Legislative Language	Division
1	None		

Chief of Staff

Goals 5: To promote and advance the mission and objectives of the Agency through increased communications with the general public, media, Agency stakeholders, and federal and state policy makers.

Objectives 5. A: To increase by two percent annually, through FY 2010-11, the number of contacts made through the Agency's Chief of Staff Office with the general public, media, state and federal officials to educate and provide information about the Agency's issues and priorities, and Florida's health care delivery system**.**

Service Outcome Measure 5. A. (1): The number of external information requests received and processed in the Office of the Chief of Staff.

Service Outcome Measure Projection Table 5. A. (1) (a):

Baseline/Year FY 2002-03	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
5,710 Number of correspondence pieces tracked by the Agency's correspondence Unit	5,963	6,082	6,204	6,328	6,454
Annual percent of increase	2%	2%	2%	2%	2%

Please note that factors outside of Agency control strongly impact the number of correspondence pieces received and tracked by the Agency. This may result in significant increases and/or decreases over time that fall outside of the parameters of this projection.

Service Outcome Measure Projection Table 5. A. (1) (b):

Baseline/Year FY 2004-05	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
8,059 Number of Public Records Requests tracked through the Agency.	8,220	8,385	8,552	8,723	8898
Annual percent of increase	2%	2%	2%	2%	2%

In FY 2004-05, the reporting of these numbers by the Public Records office was updated to reflect the change in policy for the handling of the Third Party Liability (TPL) requests. Requests for the TPL office are now forwarded directly to their office for processing by a contractor working for TPL. Since these requests are being routed directly to TPL for handling we will no longer count them as a public records request that is being processed through the Public Records office. The new system of counting public records requests has reduced the base-line from 9,296 in FY 2002-03 to a new base-line of 8,059 in FY 2004-05. Please note that factors outside of Agency control strongly impact the number of public records requests received and tracked by the Agency. This may result in significant increases and/or decreases over time that fall outside of the parameters of this projection. Such factors may include changes in the law and the increasing electronic availability of Agency related information. The numbers above reflect such a decrease for FY 2004-05.

Service Outcome Measure Projection Table 5. A. (1) (c):

Baseline/Year FY 2003-04	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 20010-11
365 Number of Constituent and Legislative Inquiries handled by the Legislative Affairs Office.	423	431	440	448	457
Annual percent of increase	2%	2%	2%	2%	2%

Please note that factors outside of Agency control strongly impact the number of constituent and legislative inquiries received by the Agency. This may result in significant increases and/or decreases over time that fall outside of the parameters of this projection.

Service Outcome Measure Projection Table 5. A. (1) (d):

Baseline/Year FY 2002-03	FY 20006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
495 Number of Legislative Bills tracked & analyzed	306	312	318	324	330
Annual percent of increase	2%	2%	2%	2%	2%

Please note that factors outside of Agency control strongly impact the number of legislative bills tracked and analyzed by the Agency. This may result in significant increases and/or decreases over time that fall outside of the parameters of this projection. Such factors may include the number of days the legislature is in session, varying according to the number of special sessions called, as well as the number of bills filed each fiscal year. The numbers above reflect such a decrease for FY 2004-05.

Service Outcome Measure 5. A. (2): The number of individual phone contacts received by the Communications Office from media representatives.

Service Outcome Measure Projection Table 5. A. (2):

Baseline/Year FY 2004-05	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
905 Number of phone contacts received by the Communication Office from Media Representatives	923	942	960	980	1,000
Annual percent of increase	2%	2%	2%	2%	2%

In FY 2004-05, the reporting of these numbers by the Communications Office was modified to better reflect the work the office does in supporting the Agency. The former method involved logging all calls received, regardless of their relevance to the Agency's mission of supporting the Governor's stated goals, or the extent to which the call involved formal contact with media. By updating the way in which calls are reported to reflect only those calls that are relevant to the Agency's mission, and omitting misdirected and erroneous calls from media, the baseline will more accurately reflect the activity of the office. Please note that this log is only one piece of a total communications picture, which also involves correspondence, community outreach, personal contact with media, opinion editorials and strategically coordinated media outreach by other agencies (e.g., Executive Office of the Governor, and the Department of Health). Further, media is necessarily issues-driven and unpredictable. Specific issue-based media activity (e.g., Medicaid reform) can cause spikes in media contact that cannot be accurately projected and may not be repeated in future years.

Service Outcome Measure 5. A. (3): The number of design and production projects completed by the Multimedia Unit.

Service Outcome Measure Projection Table 5. A. (3):

Baseline/Year FY 2002-03	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
1,776 Number of design and production jobs completed by Multimedia Unit	1,186	1,210	1,234	1,259	1,284
Annual percent of increase	2%	2%	2%	2%	2%

Although the number of design and production jobs completed by the Multimedia Unit is down, the volume of requirements associated with completion of each production request has increased significantly. In FY 2003-04 Multimedia had produced 2,409,464 impressions for the various 1,454 projects but that number increased to 2,943,639 impressions for the 1,163 projects in FY 2004-05. Projects in FY 2004-05 were on average three-to four percent larger in size, which required more time and resources to complete. Other factors that need to be considered are: hurricanes in Fiscal Year 2004-05 disrupted production during the summer, as our major clients the Medicaid Area Offices were closed and cancelled a large number of events. Please note that factors outside of Agency control strongly impact the number of design and production jobs completed by the Agency. This may result in significant increases and/or decreases over time that fall outside of the parameters of this projection. The numbers above reflect such decease for FY 2004-05.

Linkage of Agency Goals and Programs to Governor's Priorities

	Governor's Priorities and Goals	Name of Agency Goals and/or Programs
1.	Improve education	**Goal 5:** To promote and advance the mission and objectives of the Agency through increased communication with the general public, media, Agency stakeholders, and federal and state policy makers
2.	Strengthen families	
3.	Promote economic diversity	
4.	Reduce violent crime and illegal drug use	
5.	Create a smaller, more effective, more efficient government	
6.	Enhance Florida's environment and quality of life	**Goal 5:** To promote and advance the mission and objectives of the Agency through increased communication with the general public, media, Agency stakeholders, and federal and state policy makers

Trends and Conditions Statement

Health care for Americans will continue to be an ever evolving state and federal issues as more people age and the demands for more health care services and information increase. These increases will prompt the need for more contact between the Agency and the general public, the media, and state and federal legislators. These trends mandate that the Office of the Chief of Staff must play a larger role in the development of Agency policies, the analysis of health care issues and the communication of information to the general public, the media, stakeholders, and legislators.

Without the coordination of the Agency's activities and objectives, the federal and state policy makers would not have the information they need to make informed decisions relating to Florida's health care delivery system and the Governor's health care agenda. The Agency provides the state with a proactive program that includes legislative initiatives to advance and accomplish policy and procurement decisions that affect the state's health care system. The Agency's Legislative Affairs Offices in Tallahassee and Washington D.C. monitor hundreds of state and national task forces, studies, and legislative items that will affect the people of Florida and its health care system.

In addition to its traditional responsibilities to coordinate the development of the Agency's legislative initiatives and to articulate and advance the Governor's health care agenda during the legislative session, the Legislative Affairs Office has encountered an increased need to educate the new legislators about the Agency's statutory roles and responsibilities as a result of term-limits mandated upon Florida Legislators and the increase in the turnover of freshmen legislators.

Since health care issues are expected to remain top state and national priorities, the Agency must anticipate the increasing need to respond to inquiries from the general public, the media, stakeholders, and legislators on a variety of issues relating to Medicaid, the uninsured, health care facilities, and health maintenance organizations. The Agency must inform these groups about policy changes, new initiatives, and other state and national actions that will impact them as they interact with the Florida's health care delivery system. Consequently the Agency's legislative staff's commitment to promote health care initiatives that provide assistance to needy Floridians will remain a top priority. The increase in Florida's population has made it necessary to increase the amount and diversity of health education provided to citizens. The Agency will continue to host events, prepare outreach materials, and work with government and private organizations to promote health education issues and programs throughout the state.

In an effort to reach and educate Florida's disadvantaged populations, the Agency will continue to utilize its Multimedia Unit to produce brochures, posters, and other informational documents to explain through words and pictures the type of programs and initiatives the Agency provides to meet Floridians' health care needs. The Multimedia Unit will continue to produce health care reports and other documents for use by policy makers, Legislators and the Executive Office of the Governor in reviewing the effectiveness of Agency activities and new initiatives.

Most of the Agency's contacts with the general public, with members of the news media, and with legislators are conducted person-to-person. If there was a decline in the number of staff assigned to these coordination responsibilities, the Agency would have to refer inquirers to the Agency's web site as its primary source for information. Communications between the Agency and legislators cannot be effectively duplicated or replaced by technological means. Because

there are requirements to answer media and legislators' questions, and to respond to comments about the Agency, information exchange is best conducted person-to-person.

With this in mind, it is important to note that such person-to-person contact is not reflected in the service outcome measure descriptions of this document. Those legislative constituent inquiries are the direct calls received by the Agency, which are more easily captured by the Agency from a quantitative standpoint, yet that is not a truly accurate portrayal of the bulk of the interaction of the Legislative Affairs and Communication Offices. For instance, during a typical day of legislative session, the Agency Legislative Affairs Office interacts with numerous legislators, legislator's offices and legislative committee staff, and these interactions are not tracked, and it is not feasible, nor in the best interest of efficiency or time, to track. The number of these interactions is also dependent upon the number of days legislators are in session, the number of special sessions (if any), as well as other factors outside the Agency's control. Likewise for the Communications Office, as the Communications Office staff may interface with multiple reporters at press conferences, events or committee hearings, or work on media inquiries referred to them.

As described, person-to-person contact constitutes a significant portion of the core mission and the job duties for the offices under the Chief of Staff. This important point should be taken into consideration when viewing the service outcome measure descriptions of this document.

List of Potential Policy Changes Affecting Agency Budget Requests

Number	Potential Policy Change	Referenced LRPP Goals	The Legislative Budget Requests (LBR) Affected	Impact on Policy if LBR Request is not Approved
1	None			

List of Changes That Would Require Legislative Action

Number	Changes in Current Programs	Statutory Reference	Changes in Current Services	Changes in Current Activities	Substantive Legislative Action Required to Support Changes
1	None				

List of All Task Forces and Studies in Progress

Number	Bill Number	Proviso Language	Division
1	None		

Division of Administrative Services

Administrative Services

Deputy Secretary of Administrative Services ..... Christy Gregg (850) 488-2964

- Budget Office.....Tom Denmark (850) 922-8414
- Finance & Accounting .....Janet Parramore (850) 488-5869
- Human Resources.....James Haynes (850) 922-8435
- Support Services ..... Don McAlpin (850) 921-4406
- Information Technology ..... Frank Folmar (850) 922-5945

Exhibits:

Exhibit I: .....Agency Workforce Plan

Exhibit II: .....Performance Measures and Standards

Exhibit III: ..... Performance Measure Assessment

Exhibit IV:..... Performance Measure Validity and Reliability

Glossary of Terms and Acronyms:

Exhibit I

Agency Workforce Plan

LRPP Exhibit I
Agency Workforce Plan

Fiscal Years	Total FTE Reductions	Description of Reduction Issue	Positions per Issue	Impact of Reduction
FY 2006 -2007	0	No positions are proposed for reduction in FY 2006-2007.		
FY 2007-2008		No positions are proposed for reduction FY 2007-2008.		
Total*	**0**			

*to equal remainder of target

Exhibit II

Performance Measures and Standards

LRPP Exhibit II
Performance Measures and Standards

Department: AGENCY FOR HEALTH CARE ADMINISTRATION

68200000 Program: Administration and Support

Approved Performance Measures (Words)	Approved Prior Year Standards FY 2004-05 (Numbers)	Prior Year Actual FY 2004-05 (Numbers)	Approved Standards for FY 2005-06 (Numbers)	Requested FY 2006-07 Standard (Numbers)
Administrative costs as a percent of total agency costs	0.11%	0.09%	0.11%	0.11%
Administrative positions as a percent of total agency positions	11.45%	11.30%	11.45%	11.45%

68500000 Program: Health Care Services

68500100 Children's Special Health Care

Approved Performance Measures (Words)	Approved Prior Year Standards FY 2004-05 (Numbers)	Prior Year Actual FY 2004-05 (Numbers)	Approved Standards for FY 2005-06 (Numbers)	Requested FY 2006-07 Standard (Numbers)
Percent of hospitalizations for conditions preventable by good ambulatory care	7.7%	8.90%	7.7%	7.7%
Percent of eligible uninsured children receiving health benefits coverage	100%	87.90%	100%	100%
Percent of children enrolled with up-to-date immunizations	85%	76.00%	85%	85%
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	97%	90.00%	97%	97%
Percent of families satisfied with the care provided under the program	90%	81.30%	90%	90%
Total number of uninsured children enrolled in Kidcare	406,451	203,781	351,301	351,301

Number of uninsured children enrolled in Florida Healthy Kids	339,557	178,997	306,444	306,444
Number of uninsured children enrolled in Medikids	56,225	15,833	34,804	34,804
Number of uninsured children enrolled in Children's Medical Services Network	10,669	7,728	10,053	10,053

68500200 Executive Direction and Support Services

Approved Performance Measures (Words)	Approved Prior Year Standards FY 2004-05 (Numbers)	Prior Year Actual FY 2004-05 (Numbers)	Approved Standards for FY 2005-06 (Numbers)	Requested FY 2006-07 Standard (Numbers)
Program administrative costs as a percent of total program costs	1.44%	1.23%	1.44%	1.44%
Average number of days between receipt of clean Medicaid claim and payment	11	11	15	15
Number of Medicaid claims received	160,920,934	158,870,994	145,101,035	145,101,035

68501400 Medicaid Services to Individuals

Approved Performance Measures (Words)	Approved Prior Year Standards FY 2004-05 (Numbers)	Prior Year Actual FY 2004-05 (Numbers)	Approved Standards for FY 2005-06 (Numbers)	Requested FY 2006-07 Standard (Numbers)
Percent of hospitalizations that are preventable by good ambulatory care	10%	9.92%	11%	11%
Percent of women receiving adequate prenatal care	85%	85.90%	86%	86%
Neonatal mortality rate per 1000	4.7	6.00	4.7	4.7
Average number of months between pregnancies for those receiving family planning services	35	35	35	35
Percent of eligible children who received all required components of Child Health Check-up (CHCUP) screen	64%	56%	64%	64%

Number of children ages 1-20 enrolled in Medicaid	1,590,866	1,566,362	1,590,866	1,590,866
Number of children receiving Child Health Check-up (CHCUP) services	407,052	703,191	407,052	407,052
Number of hospital inpatient services provided to children	92,960	111,829	92,960	92,960
Number of physician services provided to children	6,457,900	7,223,407	6,457,900	6,457,900
Number of prescribed drugs provided to children	4,444,636	5,568,375	4,444,636	4,444,636
Number of hospital inpatient services provided to elders	81,919	119,484	100,808	100,808
Number of physician services provided to elders	1,436,160	1,065,997	1,436,160	1,436,160
Number of prescribed drugs provided to elders	15,214,293	15,541,346	15,214,293	15,214,293
Number of uninsured children enrolled in the Medicaid Expansion	1,635	1,223	3,529	3,529

68501500 Medicaid Long Term Care

Approved Performance Measures (Words)	Approved Prior Year Standards FY 2004-05 (Numbers)	Prior Year Actual FY 2004-05 (Numbers)	Approved Standards for FY 2005-06 (Numbers)	Requested FY 2006-07 Standard (Numbers)
Percent of hospitalizations for conditions preventable with good ambulatory care	12.60%	13.92%	12.60%	12.60%
Number of case months (home and community-based services)	550,436	470,143	550,436	550,436
Number of case months services purchased (Nursing Home)	619,387	575,724	619,387	619,387

68501600 Medicaid Prepaid Health Plan

Approved Performance Measures (Words)	Approved Prior Year Standards FY 2004-05 (Numbers)	Prior Year Actual FY 2004-05 (Numbers)	Approved Standards for FY 2005-06 (Numbers)	Requested FY 2006-07 Standard (Numbers)
Percent of hospitalizations for conditions preventable by good ambulatory care	13%	15.86%	13%	13%
Percent of women and child hospitalizations for conditions preventable with good ambulatory care	14.50%	16.40%	14.50%	14.50%
Number of case months services purchased (elderly and disabled)	1,877,040	1,778,676	1,877,040	1,877,040
Number of case months services purchased (families)	9,396,828	9,850,224	9,396,828	9,396,828

68700000 Program: Health Care Regulation
68700700 Health Care Regulation

Approved Performance Measures (Words)	Approved Prior Year Standards FY 2004-05 (Numbers)	Prior Year Actual FY 2004-05 (Numbers)	Approved Standards for FY 2005-06 (Numbers)	Requested FY 2006-07 Standard (Numbers)
Percent of nursing home facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0%	2.50%	0%	0%
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	4%	0%	4%	4%
Percent of Priority I consumer complaints about licensed facilities and programs that are investigated within 48 hours	100%	97.9	100%	100%
Percent of accredited hospitals and ambulatory surgical centers cited for not complying with life safety, licensure, or emergency access standards	25%	26.4	25%	25%
Percent of validation surveys that are consistent with findings noted during the accreditation survey	98%	100%	98%	98%
Percent of assisted living facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0%	1.50%	0%	0%

Percent of home health facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0%	0%	0%	0%
Percent of clinical laboratories with deficiencies that pose a serious threat for not complying with life safety, licensure, or emergency access standards	0%	0%	0%	0%
Percent of ambulatory surgical centers with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0%	0.30%	0%	0%
Percent of hospitals with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0%	3.20%	0%	0%
Percent of hospitals that fail to report serious incidents (agency identified)	6%	6.20%	6%	6%
Percent of new Medicaid recipients voluntarily selecting managed care plan	50%	50%	50%	50%
Percent of complaints of HMO patient dumping received that are investigated	100%	100%	100%	100%
Percent of facility patient dumping complaints confirmed	0%	17.20%	0%	0%
Number of complaints of facility patient dumping received that are investigated	10	278	10	10
Number of inquiries to the call center regarding practitioner licensure and disciplinary information	30,000	12,724	30,000	30,000
Total number of full facility quality-of-care surveys conducted	7,550	7,572	7,550	7,550
Average processing time (in days) for Subscriber Assistance Program cases.	53	37	53	53
Number of construction reviews performed (plans and construction)	4,500	5,282	4,500	4,500
Number of new enrollees provided with choice counseling	520,000	528,893	520,000	520,000

Exhibit III

Performance Measure Assessment

LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Children's Special Health Care/68500100
Measure: Percent of hospitalizations for conditions preventable with good ambulatory care

Action:
☒ Performance Assessment of Outcome Measure
☐ Performance Assessment of Output Measure
☐ Adjustment of GAA Performance Standards
☐ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
7.7%	9.4%	1.7%	22.08%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☒ Other (Identify)
☐ Staff Capacity
☐ Level of Training
Explanation: Disease management initiatives are ongoing, and should yield better results in the future.

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
☐ Technological Problems
☐ Natural Disaster
☒ Other (Identify)
Explanation:

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☒ Other (Identify)
Recommendations: The Agency will examine DM findings in greater detail to evaluate their effectiveness.

Office of Policy and Budget – July 2005

LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Children's Special Health Care/68500100
Measure: Percent of eligible uninsured children who receive health care benefits

Action:
☒ Performance Assessment of Outcome Measure
☐ Performance Assessment of Output Measure
☐ Adjustment of GAA Performance Standards
☐ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
100%	87.9%	(12.1%)	(12.1%)

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☐ Other (Identify)
☐ Staff Capacity
☐ Level of Training
Explanation:

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☒ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
☐ Technological Problems
☐ Natural Disaster
☐ Other (Identify)
Explanation:

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☒ Other (Identify)
Recommendations: N/A

Office of Policy and Budget – July 2005

LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Children's Special Health Care/68500100
Measure: Percent of children enrolled with up-to-date immunizations

Action:
☒ Performance Assessment of Outcome Measure
☐ Performance Assessment of Output Measure
☐ Adjustment of GAA Performance Standards
☐ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
85%	76.0%	9.0%	10.6%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☒ Other (Identify)
☐ Staff Capacity
☐ Level of Training
Explanation: Compliance with a new immunization (pneomococcal) continues to be low.

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
☐ Technological Problems
☐ Natural Disaster
☒ Other (Identify)
Explanation: Collection of this data is subject to error since it is self-reported by parents.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☒ Other (Identify)
Recommendations: The Agency will work with DOH and the Florida Academy of Pediatricians to increase immunizations.

Office of Policy and Budget – July 2005

LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Children's Special Health Care/68500100
Measure: Total number of uninsured children enrolled in Kidcare

Action:
☒ Performance Assessment of Outcome Measure
☐ Performance Assessment of Output Measure
☐ Adjustment of GAA Performance Standards
☐ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
406,451	288,201	(118,250)	(29.09%)

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☐ Other (Identify)
☐ Staff Capacity
☐ Level of Training
Explanation:

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
☐ Technological Problems
☐ Natural Disaster
☒ Other (Identify)
Explanation: Actual figures are totaled as of the date of the report. All totals available 12/31/05.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☐ Other (Identify)
Recommendations:

Office of Policy and Budget – July 2005

LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Children's Special Health Care/68500100
Measure: Number of uninsured children enrolled in Florida Healthy Kids

Action:
☒ Performance Assessment of Outcome Measure
☐ Performance Assessment of Output Measure
☐ Adjustment of GAA Performance Standards
☐ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
339,557	255,156	(84,401)	(24.9%)

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☐ Other (Identify)
☐ Staff Capacity
☐ Level of Training
Explanation:

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
☐ Technological Problems
☐ Natural Disaster
☒ Other (Identify)
Explanation: Actual figures are totaled as of the date of the report. All totals available 12/31/05.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☐ Other (Identify)
Recommendations:

Office of Policy and Budget – July 2005

LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Children's Special Health Care/68500100
Measure: Number of uninsured children enrolled in Medikids

Action:
☒ Performance Assessment of Outcome Measure
☐ Performance Assessment of Output Measure
☐ Adjustment of GAA Performance Standards
☐ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
56,225	34,267	(21,958)	(39.05%)

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☐ Other (Identify)
☐ Staff Capacity
☐ Level of Training
Explanation:

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
☐ Technological Problems
☐ Natural Disaster
☒ Other (Identify)
Explanation: Actual figures are totaled as of the date of the report. All totals available 12/31/05.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☐ Other (Identify)
Recommendations:

Office of Policy and Budget – July 2005

LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Children's Special Health Care/68500100
Measure: Number of uninsured children enrolled in Children's Medical Services Network

Action:
☒ Performance Assessment of Outcome Measure
☐ Performance Assessment of Output Measure
☐ Adjustment of GAA Performance Standards
☐ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
10,669	8,778	(1,891)	(17.7%)

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☐ Other (Identify)
☐ Staff Capacity
☐ Level of Training
Explanation:

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
☐ Technological Problems
☐ Natural Disaster
☒ Other (Identify)
Explanation: Actual figures are totaled as of the date of the report. All totals available 12/31/05.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☐ Other (Identify)
Recommendations:

Office of Policy and Budget – July 2005

LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure: Percent of hospitalizations for conditions preventable by good ambulatory care

Action:
☒ Performance Assessment of Outcome Measure
☐ Performance Assessment of Output Measure
☐ Adjustment of GAA Performance Standards
☐ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
10%	12.5%	2.5%	20%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☐ Other (Identify)
☐ Staff Capacity
☐ Level of Training
Explanation:

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
☐ Technological Problems
☐ Natural Disaster
☐ Other (Identify)
Explanation:

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☒ Other (Identify)
Recommendations: The Agency should continue to monitor performance with Medicaid delivery systems (FFS/Medipass/HMOs) and continue to work on more preventable care issues.

Office of Policy and Budget – July 2005

LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure: Neonatal mortality rate per 1,000

Action:
☒ Performance Assessment of Outcome Measure
☐ Performance Assessment of Output Measure
☐ Adjustment of GAA Performance Standards
☐ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
4.7	6	1.3	27.7%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☐ Other (Identify)
☐ Staff Capacity
☐ Level of Training
Explanation:

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
☐ Technological Problems
☐ Natural Disaster
☒ Other (Identify)
Explanation: Awaiting data from Department of Health

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☒ Other (Identify)
Recommendations: The Agency will continue to review each death to determine causes.

Office of Policy and Budget – July 2005

LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure: Percent of eligible children who received all required components of EPSTD screen

Action:
☒ Performance Assessment of Outcome Measure ☐ Revision of Measure
☐ Performance Assessment of Output Measure ☐ Deletion of Measure
☐ Adjustment of GAA Performance Standards

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
64%	56%	(8%)	(12.5%)

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect
☒ Other (Identify)
Explanation: The actual performance result was lower than the approved standard due to lower utilization rates than estimated.

External Factors (check all that apply):
☒ Resources Unavailable ☐ Technological Problems
☐ Legal/Legislative Change ☐ Natural Disaster
☐ Target Population Change ☐ Other (Identify)
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
Explanation: The actual performance result is provided through a federal report based on the last federal fiscal year. The most current data available at this time is for the FFY Oct. 1, 2003 to Sept. 30, 2004.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☐ Other (Identify)
Recommendations:

Office of Policy and Budget – July 2005

LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals
Measure: Number of children ages 1-20 enrolled in Medicaid/68501400

Action:
☒ Performance Assessment of Outcome Measure
☐ Performance Assessment of Output Measure
☐ Adjustment of GAA Performance Standards
☐ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
1,590,866	1,566,362	(24,504)	(1.54%)

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☐ Other (Identify)
☐ Staff Capacity
☐ Level of Training
Explanation:

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
☐ Technological Problems
☐ Natural Disaster
☒ Other (Identify)
Explanation: Actual figures are totaled as of the date of the report. All totals available 12/31/05.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☐ Other (Identify)
Recommendations:

Office of Policy and Budget – July 2005

LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid services to individuals
Measure: Number of children receiving EPSDT services/68501400

Action:
☒ Performance Assessment of Outcome Measure
☐ Performance Assessment of Output Measure
☐ Adjustment of GAA Performance Standards
☐ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
407,052	383,591	(23,461)	(5.76%)

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☐ Other (Identify)
☐ Staff Capacity
☐ Level of Training
Explanation:

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
☐ Technological Problems
☐ Natural Disaster
☐ Other (Identify)
Explanation:

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☐ Other (Identify)
Recommendations:

Office of Policy and Budget – July 2005

LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure: Number of physician services provided to elders

Action:
☒ Performance Assessment of Outcome Measure
☐ Performance Assessment of Output Measure
☐ Adjustment of GAA Performance Standards
☐ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
1,436,160	1,065,997	(370,163)	(25.77%)

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☒ Previous Estimate Incorrect
☐ Other (Identify)
☐ Staff Capacity
☐ Level of Training
Explanation: The actual performance result was lower than the approved standard due to lower enrollment rates than estimated.

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
☐ Technological Problems
☐ Natural Disaster
☐ Other (Identify)
Explanation:

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☐ Other (Identify)
Recommendations:

Office of Policy and Budget – July 2005

LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure: Number of uninsured children enrolled in the Medicaid Expansion

Action:
☒ Performance Assessment of Outcome Measure
☐ Performance Assessment of Output Measure
☐ Adjustment of GAA Performance Standards
☐ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
1,635	1,223	(412)	(25.2%)

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☐ Other (Identify)
☐ Staff Capacity
☐ Level of Training
Explanation:

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
☐ Technological Problems
☐ Natural Disaster
☒ Other (Identify)
Explanation: Actual figures are totaled as of the date of the report. All totals available 12/31/05.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☐ Other (Identify)
Recommendations:

Office of Policy and Budget – July 2005

LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Long Term Care/68501500
Measure: Percent of hospitalizations for conditions preventable by good ambulatory care

Action:
☒ Performance Assessment of Outcome Measure
☐ Performance Assessment of Output Measure
☐ Adjustment of GAA Performance Standards
☐ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
12.6%	17.5%	4.9%	38.9%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☒ Other (Identify)
☐ Staff Capacity
☐ Level of Training
Explanation: The approved GAA standard of 12.6% has never been met. However, it is still a reasonable target for this measure.

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
☐ Technological Problems
☐ Natural Disaster
☒ Other (Identify)
Explanation: Long-term care data for the non-Medicaid population was not available.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☒ Other (Identify)
Recommendations: The Agency continues to improve and refine its disease management program.

Office of Policy and Budget – July 2005

LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Long-Term Care/68501500
Measure: Number of case months (home & community-based services)

Action:
☒ Performance Assessment of Outcome Measure
☐ Performance Assessment of Output Measure
☐ Adjustment of GAA Performance Standards
☐ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
550,436	470,143	(80,293)	(14.59%)

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☐ Other (Identify)
☐ Staff Capacity
☐ Level of Training
Explanation:

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
☐ Technological Problems
☐ Natural Disaster
☒ Other (Identify)
Explanation: The actual performance result was lower than the standard due to lower enrollment rates than estimated.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☐ Other (Identify)
Recommendations:

Office of Policy and Budget – July 2005

LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Long Term Care/68501500
Measure: Number of case months services purchased (Nursing home)

Action:
☒ Performance Assessment of Outcome Measure
☐ Performance Assessment of Output Measure
☐ Adjustment of GAA Performance Standards
☐ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
619,387	575,724	(43,663)	(7.05%)

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☐ Other (Identify)
☐ Staff Capacity
☐ Level of Training
Explanation:

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
☐ Technological Problems
☐ Natural Disaster
☒ Other (Identify)
Explanation: The actual performance result was lower than the approved standard due to lower enrollment rates than estimated.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☐ Other (Identify)
Recommendations:

Office of Policy and Budget – July 2005

LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Prepaid Health Plans/68501600
Measure: Percent of hospitalizations for conditions preventable with good ambulatory care

Action:
☒ Performance Assessment of Outcome Measure
☐ Performance Assessment of Output Measure
☐ Adjustment of GAA Performance Standards
☐ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
13%	18.1%	5.1%	39.2%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☐ Other (Identify)
☐ Staff Capacity
☐ Level of Training
Explanation:
External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
☐ Technological Problems
☐ Natural Disaster
☐ Other (Identify)
Explanation:
Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☒ Other (Identify)
Recommendations: The Agency continues to monitor HMO performance and improve its disease management program. Specifically, the Agency is reviewing these hospitalizations to determine if there is any trend related to the location, disease state, or prepaid health plan. Further, the Agency will consider including performance measures as part of the contract requirements for the prepaid health plans.

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LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Prepaid Health Plans/68501600
Measure: Percent of women and children hospitalizations for conditions preventable by good ambulatory care

Action:
☒ Performance Assessment of Outcome Measure
☐ Performance Assessment of Output Measure
☐ Adjustment of GAA Performance Standards
☐ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
14.5%	17.6%	3.1%	21.4%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☐ Other (Identify)
☐ Staff Capacity
☐ Level of Training
Explanation:
External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
☐ Technological Problems
☐ Natural Disaster
☐ Other (Identify)
Explanation:
Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☒ Other (Identify)
Recommendations: The Agency continues to monitor HMO performance and improve its disease management program. Specifically, the Agency is reviewing these hospitalizations to determine if there is any trend related to the location, disease state, or prepaid health plan. Further, the Agency will consider including performance measures as part of the contract requirements for the prepaid health plans.

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LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Prepaid Health Plan/68501600
Measure: Number of case months services purchased (elderly & disabled)

Action:
☒ Performance Assessment of Outcome Measure
☐ Performance Assessment of Output Measure
☐ Adjustment of GAA Performance Standards
☐ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
1,877,040	1,778,676	(98,364)	(5.24%)

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☐ Other (Identify)
☐ Staff Capacity
☐ Level of Training
Explanation:

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
☐ Technological Problems
☐ Natural Disaster
☒ Other (Identify)
Explanation: The actual performance result was lower than the approved standard due to lower enrollment rates than estimated.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☐ Other (Identify)
Recommendations:

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LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure: Percent of nursing home facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public.

Action:
☐ Performance Assessment of Outcome Measure
☐ Performance Assessment of Output Measure
☒ Adjustment of GAA Performance Standards
☐ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0%	2.5%	2.5%	2.5%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☒ Other (Identify)
☐ Staff Capacity
☐ Level of Training

Explanation: Although 0% is a laudable goal, it is not a reasonable expectation or standard, nor is it a standard over which the Agency has control. What is important is that the Agency is able to find and require corrective action for deficiencies when such problems do exist. As regulators, discovery and correction of problems is the area over which we exercise control. We anticipate that less than 5% of nursing homes will, each year, have deficiencies that pose a serious threat to the health, safety, or welfare of the public.

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
☐ Technological Problems
☐ Natural Disaster
☐ Other (Identify)

Explanation:

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☐ Other (Identify)

Recommendations:

Office of Policy and Budget – July 2005

LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
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**

Action:
☒ Performance Assessment of Outcome Measure
☐ Performance Assessment of Output Measure
☐ Adjustment of GAA Performance Standards
☐ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
4%	0%	4%	4%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☒ Other (Identify)
☐ Staff Capacity
☐ Level of Training

Explanation: The Agency is committed to protecting its customers through the investigation of all reports of unlicensed activity followed by facility closure or facility compliance with applicable standards. As these facilities are closed or brought into compliance, there will be fewer instances of repeat unlicensed activities. A decrease in this measure demonstrates the Agency's commitment to ensuring quality of care and services through compliance with minimum standards.

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
☐ Technological Problems
☐ Natural Disaster
☐ Other (Identify)

Explanation:

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☐ Other (Identify)

Recommendations:

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LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure: Percent of Priority I consumer complaints about licensed facilities and programs that are investigated within 2 working days from receipt of information.

Action:
☒ Performance Assessment of Outcome Measure
☐ Performance Assessment of Output Measure
☐ Adjustment of GAA Performance Standards
☐ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
100%	97.9%	(2.1%)	(2.1%)

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☒ Other (Identify)
☐ Staff Capacity
☐ Level of Training
Explanation: Should standardize language to that required by CMS for certified facilities. Monitoring of compliance with time frames, personnel changes, and area office accountability resulted in nearly 100% compliance with this measure.

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
☐ Technological Problems
☐ Natural Disaster
☐ Other (Identify)
Explanation:

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☐ Other (Identify)
Recommendations:

Office of Policy and Budget – July 2005

LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure: Percent of accredited hospitals and ambulatory surgical centers cited for not complying with life safety, licensure, or emergency access standards.

Action:
☒ Performance Assessment of Outcome Measure
☐ Performance Assessment of Output Measure
☐ Adjustment of GAA Performance Standards
☐ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
25%	26.4%	1.4%	5.6%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☒ Other (Identify)
☐ Staff Capacity
☐ Level of Training

Explanation: While the number of accredited hospitals and ambulatory surgical centers remains fairly constant, the number of times these facilities were inspected is not a fixed number. Deficiencies cited during these inspections may run the gamut from minor to severe. The Agency can find and require correction of deficiencies, but cannot prevent those deficiencies from occurring.

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
☐ Technological Problems
☐ Natural Disaster
☐ Other (Identify)

Explanation:

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☐ Other (Identify)

Recommendations:

Office of Policy and Budget – July 2005

LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure: Percent of validation surveys that are consistent with findings noted during the accreditation survey.

Action:
☒ Performance Assessment of Outcome Measure
☐ Performance Assessment of Output Measure
☐ Adjustment of GAA Performance Standards
☐ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
98%	100%	2%	2%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☒ Other (Identify)
☐ Staff Capacity
☐ Level of Training
Explanation: This standard reflects improvement on the part of the accreditation programs to complete accurate surveys during the review period.

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
☐ Technological Problems
☐ Natural Disaster
☐ Other (Identify)
Explanation:

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☐ Other (Identify)
Recommendations:

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LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure: Percent of assisted living facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public.

Action:
☐ Performance Assessment of Outcome Measure
☐ Performance Assessment of Output Measure
☒ Adjustment of GAA Performance Standards
☐ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0%	1.5%	1.5%	1.5%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☒ Other (Identify)
☐ Staff Capacity
☐ Level of Training

Explanation: Please note that it is unreasonable to expect that these facilities will never be cited for deficiencies that pose a serious threat to the health, safety or welfare of the public. Senate Bill 1202 amended s. 400.407, F.S., and increased the frequency of Agency monitoring visits for assisted living facilities licensed to provide extended congregate care services from 2 times per year to quarterly and assisted living facilities licensed to provide limited nursing services from once a year to twice a year. However, the same problem exists with ALFs as with nursing homes. Although 0% is an admirable goal, it is not a reasonable standard.

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
☐ Technological Problems
☐ Natural Disaster
☐ Other (Identify)

Explanation:

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☐ Other (Identify)

Recommendations:

Office of Policy and Budget – July 2005

LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure: Percent of ambulatory surgical centers with deficiencies that pose a serious threat to the health, safety, or welfare of the public.

Action:
☐ Performance Assessment of Outcome Measure
☐ Performance Assessment of Output Measure
☒ Adjustment of GAA Performance Standards
☐ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0%	0.3%	0.3%	0.3%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☒ Other (Identify)
☐ Staff Capacity
☐ Level of Training

Explanation: Although 0% is a laudable goal, it is not a reasonable expectation or standard, nor is it a standard over which the Agency has control. What is important is that the Agency is able to find and require corrective action for deficiencies when such problems do exist.

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
☐ Technological Problems
☐ Natural Disaster
☐ Other (Identify)

Explanation:

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☐ Other (Identify)

Recommendations:

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LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure: Percent of hospitals with deficiencies that pose a serious threat to the health, safety, or welfare of the public.

Action:
☐ Performance Assessment of Outcome Measure
☐ Performance Assessment of Output Measure
☒ Adjustment of GAA Performance Standards
☐ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0%	3.2%	3.2%	3.2%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☒ Other (Identify)
☐ Staff Capacity
☐ Level of Training
Explanation: Although 0% is a laudable goal, it is not a reasonable expectation or standard, nor is it a standard over which the Agency has control. What is important is that the Agency is able to find and require corrective action for deficiencies when such problems do exist.

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
☐ Technological Problems
☐ Natural Disaster
☐ Other (Identify)
Explanation:

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☐ Other (Identify)
Recommendations:

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LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure: Number of complaints of facility patient dumping received that are investigated.

Action:
☐ Performance Assessment of Outcome Measure ☐ Revision of Measure
☐ Performance Assessment of Output Measure ☒ Deletion of Measure
☐ Adjustment of GAA Performance Standards

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
10	N/A	N/A	N/A

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect
☒ Other (Identify)
Explanation: Eliminate. A better performance standard which is measurable and controlled by the Agency is "Percent of complaints of HMO patient dumping received that are investigated".

External Factors (check all that apply):
☐ Resources Unavailable ☐ Technological Problems
☐ Legal/Legislative Change ☐ Natural Disaster
☐ Target Population Change ☐ Other (Identify)
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
Explanation:

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☐ Other (Identify)
Recommendations:

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LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure: Total number of full facility quality-of-care surveys conducted.

Action:
☐ Performance Assessment of Outcome Measure
☒ Performance Assessment of Output Measure
☐ Adjustment of GAA Performance Standards
☐ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
7,550	7,572	22	.29%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☒ Other (Identify)
☐ Staff Capacity
☐ Level of Training

Explanation: The Agency has no control over the numbers of facilities that either desire licensure or that no longer wished to be licensed and discontinue operations. The total number of surveys conducted each year will fluctuate with the total number of licensed facilities.

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
☐ Technological Problems
☐ Natural Disaster
☐ Other (Identify)

Explanation:

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☐ Other (Identify)

Recommendations:

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LRPP Exhibit III
PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure: Average processing time (in days) for Subscriber Assistance Program cases.

Action:
☐ Performance Assessment of Outcome Measure
☐ Performance Assessment of Output Measure
☐ Adjustment of GAA Performance Standards
☒ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
53	37	16	30.19%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☒ Other (Identify)
☐ Staff Capacity
☐ Level of Training
Explanation: Name changed by the Legislature.

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
☐ Technological Problems
☐ Natural Disaster
☐ Other (Identify)
Explanation:

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☐ Other (Identify)
Recommendations:

Office of Policy and Budget – July 2005

Exhibit IV

Performance Measure Validity and Reliability

LRPP EXHIBIT IV
Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Executive Direction and Support Services/68500200
Measure: Fiscal Agent Contract

Action (check one):

☒ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☐ Backup for performance measure nor previously approved or for which validity, reliability and/or methodology information has not been provided.

Data Sources and Methodology:
The data is derived from the monthly yearly Operational Performance Summary report (FLMN0300-R001) generated from Medicaid Claims record of the Florida Medicaid Management Information System.

The measure is calculated using the total number of days from the claim entry date to the claim payment date divided by the total number of adjudicated claims paid. The date of receipt for a claim is the date the claim form enters the mailroom or is electronically received**.**

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. The level of efficiency in processing claims can influence a Medicaid provider's continued participation in the program.

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 Stage staff and annual Electronic Data Processing (EDP) auditing. Fields within the claim form contain the date a claim is received by the fiscal agent, its disposition determination, and the date its' respective payment is made.

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LRPP EXHIBIT IV
Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Executive Direction and Support Services/68500200
Measure: Number of Medicaid claims received

Action (check one):

☒ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☐ Backup for performance measure nor previously approved or for which validity, reliability and/or methodology information has not been provided.

Data Sources and Methodology:
The data is presented on the monthly/yearly Operational Performance Summary report (FLMM0300-R001) generated from the Medicaid Claims record of the Florida Medicaid Management Information System (FMMIS).

This measure indicates the total number of claims submitted to the fiscal agent by providers for Medicaid reimbursement. The "claims received" does not include gross adjustments.

Validity:
"Number of claims receive" (entry date) is used as the denominator in fractions to statistically measure and compare the percentage of claims that pay vs. The percentage of claims that deny in the FMMIS processing cycles and how quickly adjudication any payment occurs, also measured against the date of service. These percentages are compared to historical adjudication standards as another measure of how efficiently claims are being processed. The Medicaid Program relies on enrolled providers to meet the needs of Florida's Medicaid beneficiaries. The level of efficiency in processing claims can influence a Medicaid provider's continued participation in the program.

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, subject to regular monitoring by State staff and annual Electronic Data Processing (EDP) auditing.

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LRPP EXHIBIT IV
Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure: Percent of Priority 1 consumer complaints about licensed facilities and programs that are investigated within two working days (revised to meet federal standards)

Action (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure nor previously approved or for which validity, reliability and/or methodology information has not been provided.

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 two working days 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 two 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 two working days. Working days of receipt to match the federal requirement

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

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Glossary of Terms and Acronyms:

Adverse Incident Reports (For Nursing Homes and Assisted Living Facilities): Notifications required to be provided to the Agency within 1 to 15 days by nursing homes and assisted living facilities when an event occurs over which facility personnel could exercise control and which is associated in whole or in part with the facility's intervention, rather than the condition for which intervention. To meet reporting requirements, the event must have resulted in one of the following outcomes:

- Death;
- Brain or spinal damage;
- Permanent disfigurement;
- Fracture or dislocation of bones or joints;
- A limitation of neurological, physical or sensory function;
- Any condition that required medical attention to which the resident did not give informed consent, including failure to honor advanced directives;
- Any condition that required the transfer of the resident within or outside of the facility to a unit providing more acute care due to the adverse incident rather than to the resident's condition prior to the incident;
- Abuse, neglect or exploitation as defined in s. 415.102, F.S.;
- Abuse, neglect and harm as defined in s. 39.01, F.S.;
- Resident elopement;
- An event that is reported to law enforcement.

AHCA: Agency for Health Care Administration

Assisted Living Facilities (ALF): Facilities or portions of facilities, private homes, boarding homes, homes for the aged or other residential facilities, which undertake to provide housing, meals, and one or more personal services for a period exceeding 24 hours to adults who are not relatives of the owner or administrator.

Centers for Medicare and Medicaid Services (CMS) (formerly known as the Health Care Financing Administration, HCFA): A branch of the federal Department of Health and Human Services.

Certificate of Need (CON): A document that authorizes health care providers to add beds or provide services regulated by the CON program.

Chronic illness: A slowly progressive illness for which there is no cure. Treatment may slow progression or avoid complications. Examples of chronic illnesses are diabetes, arthritis, hemophilia and emphysema.

Class I deficiencies: Serious conditions or occurrences in a nursing home or assisted living facility that the agency determines have caused, or are likely to cause serious injury, imminent danger, emotional or physical harm, impairment, or death to a resident receiving care in the facility.

Class II deficiencies: Serious conditions or occurrence in a nursing home or assisted living facility that have compromised the resident's ability to maintain or reach his/her highest practical level of physical, mental, or psychosocial well-being. These violations threaten the physical or emotional health, safety or security of the residents.

Class III deficiencies: Conditions that are expected to result in no more than minimal physical, mental, or psychosocial discomfort to the resident or have the potential to compromise the resident's ability to maintain or reach his/her highest practical level of physical, mental, or psychosocial well-being. These violations pose an indirect or potential threat to the physical or emotional health, safety, or security of facility residents.

CMS: Centers for Medicare and Medicaid Services

Current Population Survey (CPS): A survey of the U.S. population conducted in March of each year by the U.S. Census Bureau that among other information provides data by state including an estimate of the percent insured by type of insurance and the percent uninsured.

Developmentally Disabled: Persons with an intelligence quotient below normal range and/or with a primary disability of either autism, cerebral palsy, spina bifida, or Prader-Willi syndrome, or these conditions in combination with other handicapping functional limitations.

EPO: Exclusive Provider Organization

Florida's Child Health Insurance Program (SCHIP): A program authorized under Title XXI of the Social Security Act to provide health insurance to low-income children not eligible for Medicaid.

Florida KidCare Program: The Florida Kidcare Program is a health insurance program for children between the ages of birth through 18 who are not currently covered by health insurance and whose parents may both be working.

FRAES: The Florida Regulatory Administration and Enforcement System initiated by the Agency for Health Care Administration in November 1996. The system incorporates the licensing, enforcement and inspection of all health care facilities into one system.

Frail Elder Program: A Medicaid waiver program in which a capitated payment is made monthly for each enrollee to provide long-term care services to individuals who meet functional and income requirements for nursing home placement.

Frail Elderly: Individuals who meet functional requirements for nursing home placement.

Gold Standard Multi-Media project: A project to provide physicians with hand held wireless devices that initially will provide information about the efficacy of the proposed prescription in terms of latest scientific evidence and Florida Medicaid guidelines for the product. Eventually physicians will be able to use the devices to write prescriptions.

Health Flex: A pilot program passed by the Legislature in 2002, to expand the availability of health options for low-income uninsured state residents by encouraging health insurers, health maintenance organizations, health care provider sponsored organizations, local governments, health care districts or other public or private community-sponsored organizations to develop

alternative approaches to traditional health insurance emphasizing coverage for basic and preventive health care services.

Health Maintenance Organization (HMO): A legal corporation that offers health insurance and medical care. HMOs provide a wide range of comprehensive health care services for a specified group at a fixed periodic rate. The government, medical schools, hospitals, employers, labor unions, consumer groups, and insurance companies can sponsor HMOs and hospital-medical plans.

Health Plan Employer Data and Information Set (HEDIS): A set of standard measures developed by the National Committee for Quality Assurance (NCQA) which allows the performance and quality of care provided by HMOs to be compared.

Hospital: An institution that is primarily engaged in providing, by or under the supervision of physicians, to inpatients 1) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons; or 2) rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

HIPAA: Health Insurance Portability and Accountability Act of 1996

HMO: Health Maintenance Organization

Investigations: Agency personnel conduct investigations when a complaint is determined legally sufficient as defined by statute or concerns quality of care by a facility. Sources of complaints include: consumers, Code 15 Reports (reports of serious incidents), Peer Review Discipline, the HEALTH QUALITY ASSURANCE Consumer Hotline, or direct contact with the Agency area offices. Complaints of Medicare and Medicaid fraud are referred to the appropriate Medicare or Medicaid investigative unit.

Kaiser Family Foundation: The Henry J. Kaiser Family Foundation is an independent philanthropy focusing on the major health care issues facing the nation. The Foundation is an independent voice and source of facts and analysis for policymakers, the media, the health care community, and the general public.

KidCare Program: The KidCare Program provides health care insurance for children between the ages of birth through 18 through either Medicaid (if eligibility requirements are met) or Florida's Child Health Insurance Program for those under 200 percent of poverty not eligible for Medicaid if they are not currently covered by health insurance and parents pay the premium of $20 per family.

Long-Term Care (LTC): LTC is the provision of services, including health care, personal care, social services, and economic assistance delivered over a sustained period of time in a variety of settings, ranging from a person's own home to institutional settings, to ensure quality of life for all persons, regardless of age.

Long Term Care Facility Minimum Data Set (MDS): A federally required form that must be completed by all Medicare and Medicaid certified nursing homes for each nursing home resident. The form serves as the basis for assessment of level of care needed, care plan development and ongoing success of treatment plans to achieve the highest practicable functional and psychosocial levels of well being for the individual.

LRPP: Long Range Program Plan

Managed Care Plans: Health Maintenance Organizations or other types of health care plans regulated jointly by the Agency and the Department of Financial Services under Chapter 641, F.S., in which health care is paid for on a monthly capitated or premium basis and is managed to control cost and quality of care.

Medicaid: The health program that purchases medical care for pregnant women, families, and aged, blind and disabled individuals who could not otherwise afford to pay for their care. The program is funded 45 percent by state general revenues and 55 percent by federal Title XIX money.

Medicare: The 100 percent federally funded national health insurance program for individuals that are aged 65 and over.

MediPass: The Medicaid Provider Access System is Florida Medicaid's primary care case management program.

OPPAGA: Office of Program Policy and Government Accountability

PB$^{2:}$ Performance-Based Budgeting

Personal Injury Protection Clinic: A term of art that has been chosen to identify clinics that specialize in or are established for the purpose of treating those insured under Florida's Personal Injury Protection requirements of the standard no fault automobile insurance policy. Medical coverage under such policies runs to a maximum of $10,000 per accident.

PHI: Protected Health Information (sometime referred to as IIHI – Individually Identifiable Health Information)

PPO: Preferred Provider Organization

Provider: Any party, which provides care for patients awaiting, receiving, or recuperating from treatment by intervening practitioners – i.e., hospitals, skilled, nursing facilities, etc.

Regulations: Requirements or standards established by state, federal, or local agencies pursuant to law and having the effect of law.

Silver Saver Program: A program that provides low-income elderly with assistance in purchasing prescriptions.

Subscriber Assistance Panel: The Statewide Provider and Subscriber Assistance Panel (SPSAP) serves as Florida's external review organization for grievances against Medicaid and Commercial managed care plans when the grievances have not been resolved to the satisfaction of the health plan subscribers.

State Children's Health Insurance Program (SCHIP): A program funded by federal and state governments through Title XXI of the Social Security Act specifically for the benefit of children under age 19 in families with incomes below 200 percent of the federal poverty level. The program encourages combinations of payment sources, including government payments and personal out of pocket premiums.

TANF: Temporary Assistance for Needy Families