# Agency for Health Care Administration

# Long Range Program Plan

Fiscal Years 2007-2008 through 2011-2012

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

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# AGENCY FOR HEALTH CARE ADMINISTRATION

# LONG-RANGE PROGRAM PLAN

## FOR

## FY 2007-2008 THROUGH FY 2011-2012

## SEPTEMBER 30, 2006

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# Agency for Health Care Administration's Management Team

| | |
|---|---|
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# Agency Mission

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**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 availability of transparent health care information and data on www.FloridaHealthStat.com, www.FloridaCompareCare.gov, and www.MyFloridaRx.com that consumers may use to make informed health care selection and purchasing decisions. | Administration and Support (Chief Medical Officer) |
| **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 communications with the general public, media, Agency stakeholders, and federal and state policy makers | Administration and Support (Chief of Staff) |

# Health Care Services

**(Division of Medicaid)**

Deputy Secretary for Medicaid ..... Tom Arnold (850) 488-3560

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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 eight percent per year for FY 2007-08 through FY 2011-12.

**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 2005-06 | FY 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-11 | FY 2011-12 |
|---|---|---|---|---|---|
| $597.15<br>Expenditures per-case-month at 8% increments | $644.92 | $696.52 | $752.24 | $812.42 | $877.41 |

**Objective 1. B:** To **maintain or** improve baseline performance on 100 percent of all outcome measures developed under performance-based budgeting by FY 2011-12

**Service Outcome Measure 1. B:** Percent maintained or improved 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 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-11 | FY 2011-12 |
|---|---|---|---|---|---|
| 58<br>Number of $PB^2$ outcome measures | 58 | 58 | 58 | 58 | 58 |
| 36<br>Number of outcome measures maintained or improved | 45 | 49 | 52 | 55 | 58 |

| Baseline/Year FY 2002-03 | FY 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-11 | FY 2011-12 |
|---|---|---|---|---|---|
| 62%<br><br>Percent of outcomes maintained or improved | 77.5% | 84.4% | 89.6% | 94.8% | 100% |

**Objective 1. C:** To slow the growth in long-term care expenditures to $543 million by converting a portion of the institutional care budget to community-based long-term care, by FY 2011-12.

**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<br><br>FY 2005-06 | FY 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-11 | FY 2011-12 |
|---|---|---|---|---|---|
| $2,677 Current LTC Projections | $3,299 | $3,662 | $4,065 | $4,512 | $5,008 |
| $2,534 Revised LTC Projections | $3,061 | $3,364 | $3,697 | $4,063 | $4,465 |
| $143 LTC Savings | $238 | $298 | $368 | $449 | $543 |

Table excludes Medicare nursing home crossover payments.

**Objective 1. D:** To increase beneficiaries reported satisfaction with access to specialty care services to 90 percent by FY 2011-12.

**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 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-11 | FY 2011-12 |
|---|---|---|---|---|---|
| 63%<br><br>Percent of MediPass patients that reported satisfaction with access to specialty care. | 70% | 75% | 80% | 85% | 90% |

**Objective 1. E:** To maintain the percentage of the Medicaid budget used for capitated services to 26 percent by FY 2011-12.

**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 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-11 | FY 2011-12 |
|---|---|---|---|---|---|
| 11.6%<br><br>Percent of the Medicaid budget paid through capitated payments | 18.5% | 21% | 23.5% | 26% | 26% |

**Objective 1. F:** To increase the extent of consumer directed care to five programs/services, to include development of alternative options to Medicaid by FY 2011-12.

**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 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-11 | FY 2011-12 |
|---|---|---|---|---|---|
| 1<br><br>Services/programs with consumer directed incentives | 3 | 4 | 4 | 5 | 5 |

**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 2011-12.

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

**Service Outcome Measure Projection Table 1. G:**

| Baseline/Year FY 2004-05 | FY 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-11 | FY 2011-12 |
|---|---|---|---|---|---|
| 8% | 33% | 42% | 50% | 60% | 60% |

## Linkage of Agency Goals and Programs to Governor's Priorities

| | Governor's Priorities and Goals | Agency Goals and/or Programs |
|---|---|---|
| 1. | Provide a Quality Education | |
| 2. | Growing the Economy | **Goal 1:** To be a prudent purchaser of quality health care services for low-income Floridians. |
| 3. | Strengthening Florida's Families | |
| 4. | Building Better Communities | |
| 5. | Improving Healthcare | **Goal 1:** To be a prudent purchaser of quality health care services for low-income Floridians. |
| 6. | Protecting the Environment | **Goal 1:** To be a prudent purchaser of quality health care services for low-income Floridians. |

## Trends and Conditions Statement

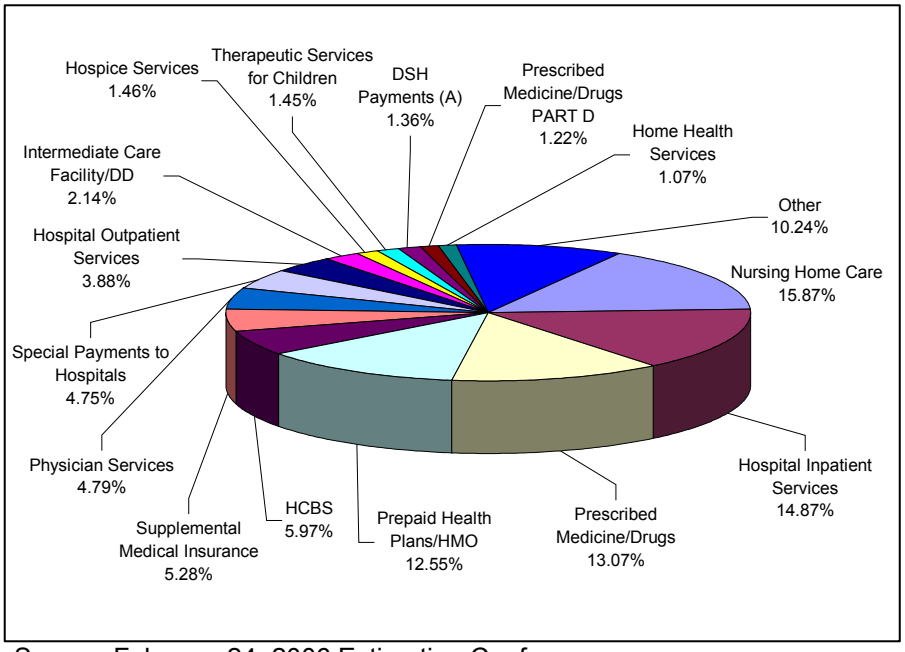
Authority for the Florida Medicaid Program is established in Chapter 409, F.S., (Social and Economic Assistance) and Chapter 59G (Medicaid) of the Florida Administrative Code. The statutes that mandate the management and administration of state and federal Medicaid programs, child health insurance programs, 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, 58.76 percent of the cost of most Medicaid services will be reimbursed with federal funds in FY 2006-07, while administrative costs are reimbursed 50 percent. Information technology projects and services such as family planning are reimbursed at higher levels.

In April 2005 Florida's population was estimated to be 17,789,864 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. Its growth rate is among the highest in the nation.

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 17.8 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.

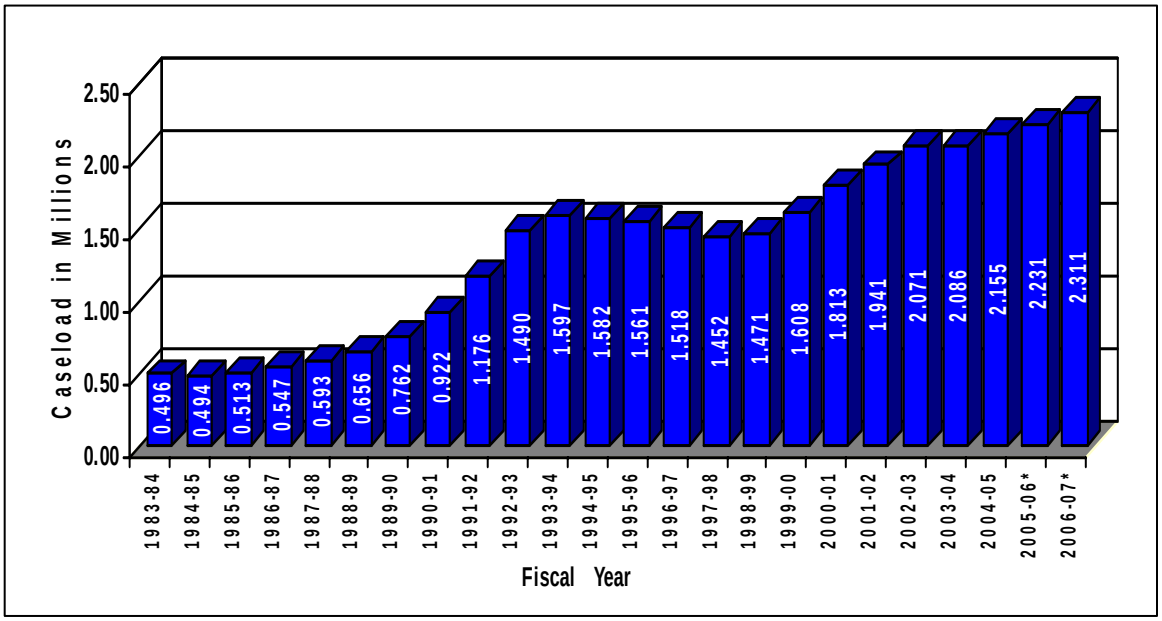
Medicaid caseloads dropped in the 1990s as a result of welfare reform and then rose sharply from CY 1999 through 2003, primarily due to population growth, economic downturns, and a higher percentage of the population being below the poverty line. However, since that time, caseloads have leveled off and the state experienced a budget surplus for FY 2005-06. See Table 1 for Estimated Percentage of Medicaid Spending for FY 2005-06, and Table 2 below for trends in average monthly caseloads.

**Table 1. Estimated Percentage of Medicaid Spending 2005-06**




Source: February 24, 2006 Estimating Conference

**Table 2. Growth in Average Medicaid Monthly Caseload**
**1983-84 to 2006-07**




Source: Medicaid Services Eligibility Subsystem Reports. * As of June 2006, Budgeted Caseload from FY 2006-07 GAA

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.

Medicaid accounted for 23.9 percent of the state's FY 2004-05 budget and 23.3 percent of the FY 2005-06 budget under current programs. These rates compare to only 15.7 percent of the state's budget in FY 1995-96. See Table 3. Children accounted for the largest caseload, while the blind and disabled had the largest expenditures. The second largest expenditure group was the elderly 65 plus population. See Table 4.

**Table 3. Medicaid General Revenue as a percentage of State General Revenue and Medicaid Expenditures as a percentage of the State Budget FY 2005-2006**

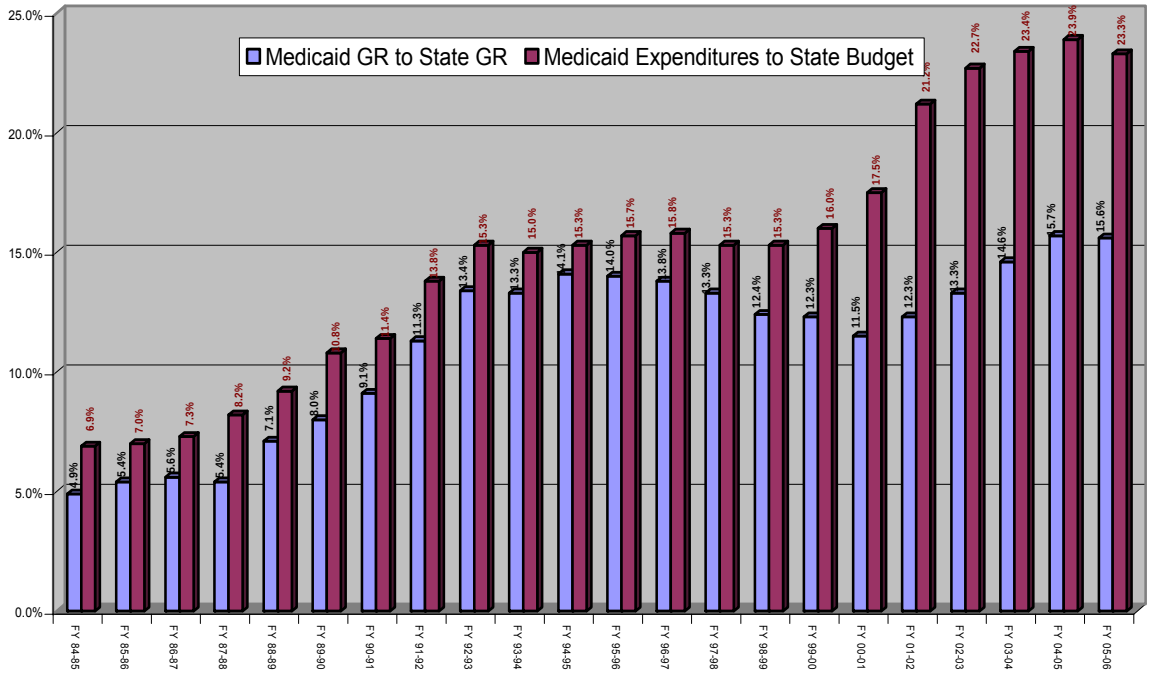
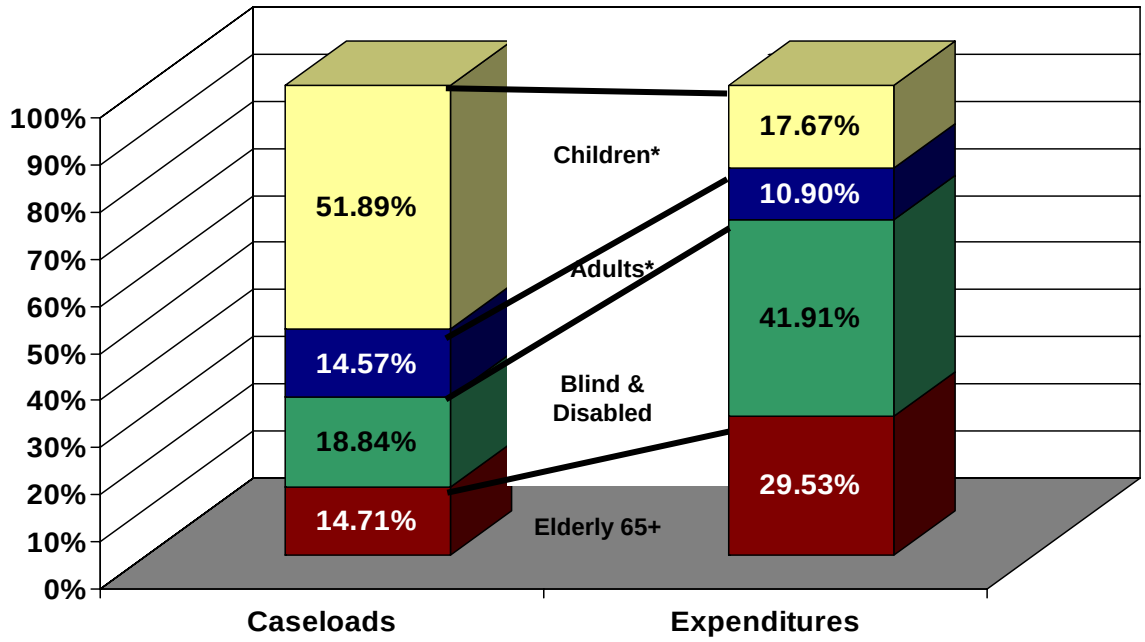



**Table 4. Medicaid Budget - How it is Spent FY 2005-2006**




* Adults and children refer to non-disabled adults and children.

**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.

Senate Bill (SB) 838 which passed in the 2005 Legislative session, and HB 3B, which was passed in a special session in December of 2005, authorized the Agency to seek and implement a demonstration project waiver (pursuant to s. 1115 of the Social Security Act) to create a statewide initiative for a more efficient and effective services delivery system that would enhance quality of care and client outcomes in the Florida Medicaid program. Medicaid Reform will transform the Medicaid program by empowering Medicaid recipients to take control of their health care, providing more choices for recipients, and enhancing their health status through increased health literacy and incentives to engage in healthy behaviors.

The major components of Medicaid Reform are:

- Choice Counseling;
- Customized Benefit Plans;
- Opt-Out;
- Risk-Adjusted Premiums; and
- Enhanced Benefits.

As specified by state legislation, Florida will initially implement Medicaid Reform in two counties: Broward and Duval. The state is conducting a phased-in approach to transition current recipients into reform plans. During the initial phase of implementation, TANF, TANF-related recipients and aged and disabled recipients are required to enroll in a reform program. Some recipients may voluntarily enroll in a reform plan.

The State implemented the program in Broward and Duval County on July 1, 2006 when the choice counseling telephone lines opened to respond to recipient questions. Recipients who are in the mandatory group are given choice counseling materials and 30-days to make a plan selection. If a recipient does not make a selection, the State will assign the recipient to a plan. The first date of enrollment is September 1, 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.

As the State expands the program statewide, the vast majority of Medicaid enrollees will be required to enroll in a reform plan. 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.

Through on-going coordination and reporting, the Centers for Medicare and Medicaid Services (CMS) will be notified in advance as additional phases proceed.

Updates on Medicaid reform may be found at:
http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml

**SCHIP/KidCare**

Although there has been open enrollment since June 2005, enrollment in Florida's State Children's Health Insurance Program (SCHIP), a component of Florida KidCare, has decreased following two years of closed enrollment, income documentation requirements and limited outreach funding. In July 2004, SCHIP enrollment was 331,281. In July 2006, SCHIP enrollment was 196,674. This 59% decrease represents 134,607 children.

In 2006, the Florida Legislature funded $1 million in matching grants for KidCare community outreach. The Legislature also provided SCHIP funding for a maximum of 228,159 children. This target enrollment ceiling allows for a growth of 31,485 children during FY 2006-07. Enrollment in the Title XXI programs will cease when enrollment reaches the GAA target enrollment ceiling.

The income documentation requirement continues, as well as the policy that requires families who have access to employer-sponsored family health insurance coverage to not be allowed to enroll their children if the cost of such coverage is less than five percent of their family income.

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.

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. No insurance for children has long-term implications for the state since inadequate health screenings and developmental assessments may result in lifelong health problems.

**Prescription Drug Program**

The Agency is utilizing 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 2011-12." The Agency started this initiative in FY 2003-04 with a contract with Gold Standard Multimedia (GSM), a Florida company, who in partnership with Embarq (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 beneficiary's pharmacy or a hard copy printing of the prescription so that errors due to handwriting are significantly 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 transition to a new fiscal agent contract effective March 1, 2008. The goal of re-engineering is to increase the system's ability to respond rapidly to change.

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 eight percent per year for FY 2007-08 through FY 2011-12."

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 and as a result pharmacy costs have grown less in the past few years compared to total costs.

To further offset the increases in drug costs, the FY 2005-06 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 Drug Administration guidelines;
- Require prior authorization of certain drugs, as well as beneficiary age-related prior authorization requirements as necessary for certain drugs;
- Coordinate the pharmacy lock-in program wherein beneficiaries who appear to be problem users are limited to one pharmacy. The physician lock-in program will augment the pharmacy program and limit beneficiaries to one physician or select group of physicians so that drug prescribing and use can be better monitored; and Continue using the wireless handheld clinical pharmacology drug information database along with the provision of a web-based real time prescription tracking and dispensing system. Electronic prescribing access has been added to the wireless handheld program and desktop access is being offered to prescribers who do not have wireless access.

**Disease Management/Other programs**

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 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.

In May 2006, Medicaid issued an Invitation to Negotiate as current disease management contracts were expiring. Through this ITN, the State is seeking to contract with a single disease management entity that will at a minimum provide services to individuals diagnosed with diabetes, asthma, hypertension and congestive heart failure statewide. The State is also working on contracting with two vendors selected to become specialty pharmacists 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.

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 Agency provides a financial incentive to providers in the plan that provides preventive services to 60 percent of the children enrolled with them.

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 Provider Sponsored Networks, Minority Physician Networks 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.

**Long Term Care**

Developing new models for long-term-care is critical. Significant reductions in the growth of the Medicaid budget will not be achieved without addressing the aged and disabled population.

Long-term care use is greatest in the population over age 85. The 85 plus population is expected to grow significantly by 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 individuals age 85 and older who are more likely to need nursing home assistance. For example, Florida ranks 42 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 converting a portion of the institutional care budget to community-based long-term care, by FY 2011-12."

**Developmental Disabilities**

The Agency has been particularly successful in serving individuals with developmental disabilities in the community. As of July 2005, 26,298 individuals were being served in community based options under two federal waivers 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 waivers have increased the number served, there is still a waiting list of 11,778. Funding was appropriated to offer waiver services to individuals identified in a crisis situation only for FY 2006-07. The waiting list includes 5,851 individuals (49.7 percent) who are receiving services on the Family and Supported Living Waiver but requested to remain on the wait list for services on the Developmental Disabilities Waiver when funds become available.

The Agency has federal approval to administer the Familial Dysautonomia (FD) Waiver for individuals diagnosed with FD. Familial dysautonomia is a genetic disorder that affects the development and survival of certain nerve cells. The disorder disturbs cells in the autonomic nervous system, which controls involuntary actions such as digestion, breathing, production of tears, and the regulation of blood pressure and body temperature. It also affects the sensory nervous system, which controls activities related to the senses, such as taste and the perception of pain, heat, and cold. Familial dysautonomia is also called hereditary sensory and autonomic neuropathy, type III.

The FD Waiver has an appropriation of $418,000 to serve 20 consumers statewide. The FD Waiver provides seven services, which are: support coordination; respite services; non-residential support services; consumable medical supplies; durable medical equipment; behavioral services; and dental services. Each FD Waiver beneficiary will have a maximum total annual cost plan of $20,900 each. Consumer and provider enrollment began July 2006.

## MMIS Development/Fiscal Agent Procurement

The Agency has selected a new fiscal agent and has begun the process of transferring from the old agent to the new. The effective date for operation of the new agent is set for March 1, 2008. To obtain more information on the fiscal agent, use the following website:
http://ahca.myflorida.com/Medicaid/Procurement/index.shtml

## 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 Potential Policy 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 Legislation | Division Assigned |
|---|---|---|---|
| 1. | **HB 947** Pages 3-4 Web Page | Long Term Care Partnership Program: The Agency for Health Care Administration, in consultation with the Office of Insurance Regulation and the Department of Children and Families, and in accordance with federal guidelines, shall create standards for long-term care partnership program information distributed to individuals through insurance companies offering approved long-term care partnership program policies. | Medicaid |
| 2. | **HB 947** Page 4 Web Page | Long Term Care Partnership Program: The Agency for Health Care Administration is authorized to amend the Medicaid state plan and adopt rules pursuant to ss. 120.536(1) F.S., and ss 120.54 F.S. to implement this section. | Medicaid |
| 3. | **HB 947** Page 3 Web Page | Long Term Care Partnership Program: The Agency for Health Care Administration, in consultation with the Office of Insurance Regulation and the Department of Children and Families, is directed to establish a qualified state Long-Term Care Insurance Partnership Program in Florida, in compliance with the requirements of s. 1917(b) of the Social Security Act, as amended. | Medicaid |
| 4. | **HB 1247** Page 3 Web Page | Riley Day waiver: Section 409.912(51), F.S., is amended to include adult recipients, as follows: The Agency for Health Care Administration shall work with the Agency for Persons with Disabilities to develop a model home and community-based waiver to serve children *and adults* 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. | Medicaid |

| Number | Bill Cite | Ongoing Task Forces and Studies Required by Legislation | Division Assigned |
|---|---|---|---|
| 5. | **CS/SB 1278** Pages 1-2 Web Page | Interagency Services Committee for Youth and Young Adults with Disabilities: The committee shall consist of heads, or their designees, of the following agencies and bureaus or divisions of agencies: the Department of Education and, in that department, the Bureau of Exceptional Education and Student Services, the Division of Vocational Rehabilitation, the Division of Blind Services, the Division of Community Colleges, workforce education, and the office of interagency programs; the Agency for Persons with Disabilities; the Agency for Health Care Administration; the Division of Children's Medical Services Network in the Department of Health; children's mental health in the Department of Children and Families; the Department of Juvenile Justice; the Department of Corrections; the Commission for the Transportation Disadvantaged; and the Florida Housing Finance Corporation. Agency representatives must be at least at the bureau chief level. | Medicaid |
| 6. | **CS/SB 1278** Page 3 Web Page | Interagency Services Committee for Youth and Young Adults with Disabilities: The committee shall present a report of its findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives by March 1, 2007, and a final report on its findings and recommendations by January 1, 2008. The committee is abolished on June 1, 2008. | Medicaid |

| Number | Bill Cite | Ongoing Task Forces and Studies Required by Legislation | Division Assigned |
|---|---|---|---|
| 7. | **SB 1850** Pages 10 Web Page | Workgroup: Services for Adults with Disabilities: The Department of Children and Families, the Agency for Persons with Disabilities, the Department of Health, the Agency for Health Care Administration, and the Department of Elder Affairs shall convene a workgroup for the purpose of developing and implementing a workable statewide system of ensuring that adults with disabilities are provided ready access to the programs most likely to meet their needs. The system shall avoid duplication of services and unnecessary delay in providing needed services. The participating agencies shall implement improvements that maximize access to the services provided under applicable state and federal laws, with an emphasis on developing strategies for overcoming barriers to the timely access to services. | Medicaid |
| 8. | **HB 5001** Page 56 Web Page | Center for Healthcare Racial Disparities: From the funds in Specific Appropriation 196, up to $200,000 in non-recurring funds from the Tobacco Settlement Trust Fund, subject to private matching funds, is provided to contract with the University of Florida Center for Medicaid and the Uninsured for the creation of the Center for Health Care Racial Disparities within the Center for Medicaid and the Uninsured. The Center for Health Care Racial Disparities shall focus its effort toward the study of racial disparities in access to health care. A portion of the funds will be used to support research conducted by students at Florida A & M University. At no time shall funds provided by the Agency exceed those funds that are raised from private sources. | Medicaid |

| Number | Bill Cite | Ongoing Task Forces and Studies Required by Legislation | Division Assigned |
|---|---|---|---|
| 9. | **HB 5001** Page 60 Web Page | Obstetrical Management Program: From the funds in Specific Appropriation 213, the Agency is authorized to test, on a pilot basis in one or more 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 |

| Number | Bill Cite | Ongoing Task Forces and Studies Required by Legislation | Division Assigned |
|---|---|---|---|
| 10. | **HB 5001** Page 80-81 Web Page | Personal Care Attendant Pilot: From the funds in Specific Appropriation 340, $400,000 from non-recurring general revenue funds is appropriated to provide a pilot personal care attendant program in Lake, Orange, Osceola, and Seminole counties. The Department of Children and Families, in partnership with the Florida Association of Centers for Independent Living, shall develop the pilot program to provide personal care attendants to persons who are eligible pursuant to the criteria below. The association may jointly develop memoranda of understanding with the Department of Health, Department of Revenue, the Florida Medicaid program in the Agency for Health Care Administration, the Division of Vocational Rehabilitation of the Department of Education, the Department of Children and Families, and the Florida Endowment Foundation for Vocational Rehabilitation. The Florida Association of Centers for Independent Living shall receive 15 percent of the $400,000 for administration of the program.<br><br>Persons eligible to participate in the Personal Care Attendant program must: reside in the pilot program area; be at least 18 years of age and be significantly physically or mentally disabled; require self-care assistance including, but not limited to, bathing, eating, bowel and bladder management, and transportation; require a personal care attendant to maintain substantial gainful employment; be able to hire and supervise a personal care attendant; and presently be employed or have an offer of employment but, because of a lack of a caregiver, will lose employment or the offer thereof.<br><br>The association, in cooperation with the Division of Vocational Rehabilitation of the Department of Education and the Florida Endowment Foundation for Vocational Rehabilitation, shall establish procedures for selecting persons eligible to participate in the program. | Medicaid |

| Number | Bill Cite | Ongoing Task Forces and Studies Required by Legislation | Division Assigned |
|---|---|---|---|
| 11. | **HB 5007** Page 15 Web Page | Hospitalist: Section 409.905(5) (d), F.S., is amended to read: (d) The Agency shall implement a hospitalist program in nonteaching hospitals, select counties, or statewide. The program shall require hospitalists to manage Medicaid recipients' hospital admissions and lengths of stay. Individuals who are dually eligible for Medicare and Medicaid are exempted from this requirement. Medicaid participating physicians and other practitioners with hospital admitting privileges shall coordinate and review admissions of Medicaid recipients with the hospitalist. The Agency may competitively bid a contract for selection of a single qualified organization to provide hospitalist services. The Agency may procure hospitalist services by individual county or may combine counties in a single procurement. The qualified organization shall contract with or employ board-eligible board certified physicians in Miami-Dade, Palm Beach, Hillsborough, Pasco, and Pinellas Counties. The Agency is authorized to seek federal waivers to implement this program. | Medicaid |
| 12. | **HB 5007** Page 51 Web Page | Pharmaceutical Expense Assistance: Section 409.9301(1), F.S., is created to read: (1) PROGRAM ESTABLISHED.--A program is established in the Agency for Health Care Administration to provide pharmaceutical expense assistance to individuals diagnosed with cancer or individuals who have received organ transplants who were medically needy recipients prior to January 1, 2006. | Medicaid |
| 13. | **HB 5007** Page 52 Web Page | Pharmaceutical Expense Assistance: Section 409.9301(4) (b), F.S., is created to read: (b) By January 1 of each year, the Agency shall report to the Legislature on the operation of the program. The report shall include information on the number of individuals served, use rates, and expenditures under the program. | Medicaid |

# Health Care Regulation

**(**Division of Health Quality Assurance**)**

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# Health Care Regulation

**(Division of Health Quality Assurance)**

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**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.

**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 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-11 | FY 2011-12 |
|---|---|---|---|---|---|
| 11,380<br><br>Average annual number of renewal applications | 569 | 1,707 | 3,414 | 4,552 | 5,690 |
| 0%<br><br>Percent applications received via Internet | 5% | 15% | 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. During the 2006 legislative session, the Agency secured passage of HB 7141 (Chapter 2006-192) the uniform licensure statute, which enables it to promulgate rules requiring electronic submission of documents. The Agency intends to use this rule authority to require electronic renewal applications via the Internet. 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 2011-12.

**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 records requests handled by AHCA Division of Health Quality Assurance.

**Service Outcome Measure Projection Table 2. B:**

| Baseline/Year FY 2003-04 | FY 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-11 | FY 2011-12 |
|---|---|---|---|---|---|
| 3,723<br><br>Number of public record requests handled by the Division of Health Quality Assurance | 2,978 | 2,606 | 2,234 | 1,862 | 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 two segments of a new automated document management system were implemented in the Long Term Care Unit and various other units of Health Quality Assurance during FY 2004-05 and FY 2005-06. The third will be implemented in all field offices and throughout the remainder of the division in 2006-07. However, the system is so new that significant results will not be experienced until FY 2007-08. At that point, we will be able to determine the impact of efficiency improvements on public records requests.

**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 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-2011 | FY 2011-2012 |
|---|---|---|---|---|---|
| 53.0%<br><br>Percentage of Medicaid HMOs that reach the statewide average on the reported HEDIS measures | 100% | Completed | Completed | Completed | Completed |

This objective will be re-evaluated at the end of FY 2006-07 for possible changes. In 2005, the Agency posted the average score across all Medicaid plans for each indicator on its Internet website. On three of the five measures, 50 percent or more of the plans exceeded the average score. However, they have not reached the desired 100% mark.

**Objective 2. D:** To increase the numbers of fully operational Health Flex plans to 20 by FY 2011-12.

**Service Outcome Measure 2. D:** The numbers of Health Flex plans that are fully operational at the end of FY 20011-12.

**Service Outcome Measure Projection Table 2. D:**

| Baseline/Year FY 2003-04 | FY 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-11 | FY 2011-12 |
|---|---|---|---|---|---|
| 4<br><br>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 anticipated working to approve additional plans over the next five years. As only one additional plan was approved during FY 2005-06, we extended the time frame to meet our goal of 20 plans to FY 2010-12.

As of August 2006, there were only five operational Health Flex plans. Provider and consumer interest in the establishment of these plans has been low. The only Health Flex plans that have

acceptable enrollment levels receive significant subsidies from the county and from other health care providers. Initial perceptions that these plans could be fully funded by member premiums proved incorrect. The Division proposes to give this objective an additional year to succeed or be eliminated in the next planning document.

# Linkage of Agency Goals and Programs to Governor's Priorities

| | Governor's Priorities and Goals | Agency Goals and/or Programs |
|---|---|---|
| 1. | Provide a Quality Education | |
| 2. | Growing the Economy | |
| 3. | Strengthening Florida's Families | **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. | Building Better Communities | |
| 5. | Improving Healthcare | **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. | Protecting the Environment | **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, 429, 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, Staffing, and Licensure Issues

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, 429 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, the Florida Hospital Association 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 2006-07, it appears that there are plenty of nursing jobs available and many qualified students wanting to pursue nursing careers, but the shortage of faculty in Florida's nursing schools is creating waiting lists for entry into nursing programs (Florida Trend, August 2005). At least one new nursing program was created in Florida in early 2006 at North Florida Community College and online nurse training programs are increasing. 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. Nurse staffing shortages in the regulatory arena remain, although they are not as significant as they were prior to the legislated pay increases in 2005. As of June 20, 2006, the field offices where the majority of health quality assurance nurses are employed, had a 12.6 percent vacancy rate for registered nurses as compared to a 9.5 percent vacancy rate for all other types of field office staff.

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 2005 was 87.87 percent, down by 0.25 percent since the prior year. As of March 1, 2006, there were 79,753 licensed and 824 approved community nursing home beds in Florida. This represents a decrease from the prior year of 407 beds—less than one percent of last year's total available beds. Medicaid occupancy for CY 2005 was 63.36 percent; six-month occupancy was 62.50 percent during the period July 2005 through December 2005. Both nursing home occupancy in total and Medicaid occupancy of nursing homes show a slight downward trend from the previous year, becoming more

significant in the latter half of 2005. For the latter half of CY 2005, the Medicaid occupancy reduction from the same time period in the prior year is greater than one percent.

Overall, Florida's facilities are still improving. For FY 2005-06, the most recent year for which complete information is available, conditional days in nursing homes declined to 3,672, down by nearly 69 percent from their high of 11,670 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 2005-2006 report, entitled "Nursing Home and Assisted Living Facility: Adverse Incidents & Notices of Intent Filed**,"** specifically notes the following:

July 1, 2005 to June 30, 2006

- 4,672 reported adverse incidents occurring with associated outcomes.

- 31 on-site visits to nursing homes and 31 on-site visits to assisted living facilities specifically in response to adverse incident requiring investigations. These surveys resulted in findings of Class I & II deficiencies in two assisted living facilities.

- 73 practitioner cases opened by the Department of Health in response to adverse incident reports with 47 license revocations or suspensions.

- 38 percent decrease in the number of nursing homes reporting receipt of notices of intent to litigate between the fiscal year 2001-2002 and fiscal year 2005-2006.

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.

## Certificates of Need

Activity in the CON program has generally trended down due to a moratorium on the approval of new community nursing home beds and the deregulation of most types of hospital bed additions. The five-year moratorium on new nursing homes began in 2001 and was extended for another five years in 2006. Beginning in July 2004, most types of hospital bed additions, which previously required full CON review, now require a simple notification to the Agency.

Between 2003 and 2006, the most common type of application reviewed by the Agency was for long term care hospitals. These specialized facilities, which mostly serve long-stay post-acute patients who are funded by Medicare, have submitted CON applications for many areas around the state.

The CON program also staffed a FY 2005-2006 technical advisory group on the development of licensure standards for hospital-based adult interventional cardiology programs. The group was charged with envisioning an outcome-oriented reporting system that would become a part of the regulation of all hospitals that wish to provide open heart surgery, angioplasty or other adult interventional cardiology services. The advisory group also provided clinical direction on the content of administrative rules regarding the licensure of adult interventional cardiology services. When the rules are final, there will be no more CON review of adult open heart surgery programs.

## Consumerism, Technology, Public Information and Document Management

Florida laws passed in 2005 expanded the notion of "transparency" to the costs and quality indicators for hospitals. When the Florida Center for Health Information and Policy Analysis implemented Florida Compare Care in 2005/06, it represented the first time such information had been required by law in any state.

Consumer complaints about health care facilities are trending upward, not necessarily because there are more problems in health care facilities, but often because consumers are more familiar with ways to obtain information and are more capable of using the Internet to obtain information than in the past. Complaints coming into the division for review and potential investigation have nearly doubled over the past six years, increasing from 3,984 to 7,280. The Division had nearly a seven percent increase in the number of consumer complaints just between FY 2004-05 and 2005-06. Increasing numbers of complaints place additional resource requirements upon the Agency in an age of consumer activism. Sources of complaints include not only individual consumers, but also other state agencies and the media.

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 2005-06, the Agency received 3,245 public information requests, 2,608 (80.4%) of which were 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, for which third year funding in the amount of $449,251 was obtained in FY 2006-07. By the time this project is completed in FY 2007-08, it will effectively place all of the records of the Division of Health Quality Assurance into an electronic format. The system 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 re-filing documents.

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 is still in the planning stages on this initiative.

## Disaster Preparedness

Florida's 2006 legislature passed a significant emergency management bill which became Chapter 2006-71, Laws of Florida. Among other things, the bill established a framework for emergency management and response that included requirements affecting home health agencies, nurse registries, home medical equipment providers and hospices. Although the requirements placed on the Agency are already operational, the statute formalized some of the details of Agency assistance with emergency response to nursing homes.

Hurricanes that devastated Florida in 2004 and 2005 led to the development of a new on-line tracking system for emergency situations. This system, called the Emergency Status System, or ESS, has been developed over a two-year period into an effective on-line tracking system for hospitals, nursing homes, assisted living facilities, end-stage renal disease facilities, intermediate care facilities for the developmentally disabled, crisis stabilization units and residential treatment facilities to enter their own status reports before, during and after an emergency situation. The system contains information on emergency contacts, status of facilities with respect to evacuation planning and implementation, electrical power, water systems, facility damage, facility accessibility, needs and available beds in non-evacuating facilities for those that must move their residents and patients.

## 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 2005, there were 37 licensed Health Maintenance Organizations (HMOs), up from 26 in 2004. Not all of these 37 HMOs were fully operational for the entire year of CY 2005. The following statistics are based on data available for 33 operational HMOs. Data show enrollment in Florida's HMOs declined from 4.5 million in CY 2001 to 3.8 million in CY 2005 (AHCA and OIR Data Reports). Aetna had the largest market share with 581,346 enrollees, followed by Humana with 460,862, and Medicaid Options, with 430,341 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 521,338, which would place WellCare second.

The decline in enrollment did not negatively affect the profitability of Florida's HMOs. In CY 2005, the HMO industry reported an overall net income of $699.9 million, down from $724.9 million in 2004, but up from $478.6 million in CY 2003. HMOs clearly recovered from the losses incurred in earlier years.

As of December 2005, 21 of the HMOs offered commercial managed care, 23 provided a Medicare product and 13 offered Medicaid plans. Seven HMOs offer all three product lines.

While the overall number of HMO enrollees declined 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. In June 2006, Medicaid enrollment had climbed to 764,995. HealthEase and Staywell, both product lines of WellCare, had the largest market share with 401,442 enrollees or 51 percent, followed by AMERIGROUP with 148,424, or 19 percent.

Medicaid HMOs showed overall operating income of $31.4 million in CY 2005 compared to $13.4 million in CY 2004 for the Medicaid product line only. The consolidated HMO operating income for the 11 HMOs over all product lines declined from $125 million in CY 2004 to $107.3 million in CY 2005.

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 that are rotated annually. Each year, the managed care plans are required to report data on five indicators selected by the Agency. In the past, the Agency’s published report card containing these indicators measured the size of an eligible population that had received specific types of care. In CY 2004, the Agency revised the published 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. However, the Agency posted the average score across all Medicaid plans for each indicator on its Internet website. On three out of the five measures, 50 percent of the plans exceeded the average score.

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 2005-06, this program reviewed more than 346 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.

To give providers an opportunity to dispute insurance claim payments, the Legislature established the Statewide Provider and Managed Care Organization Claim Dispute Program in CY 2001. This program is operated by 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 handled a total of 96 cases in CY 2003; 174 cases in CY 2004, and 175 cases in CY 2005.

## Hospital Emergency Care Issues

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. 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.

The Agency is currently involved in litigation regarding off site emergency departments. In the Agency's view, off site emergency departments are departments of an existing hospital that are not located on the main campus of the hospital. Other than their physician location, the Agency views off site emergency departments as equivalent to the onsite emergency department. The legislature recognized the existence of off premises emergency departments in 2004. In an effort to alleviate emergency room overcrowding problems, two hospitals requested and the Agency approved off-site emergency department locations. Subsection 395.003 (1) (b) 3, Florida Statutes, directed the Agency to submit a report by December 31, 2004, recommending whether it was it the best interest of the public to allow a hospital to license or operate an emergency department located off the premises of the hospital; to make recommendations regarding licensure criteria; and imposing a moratorium on additional emergency departments located off the premises of licensed hospitals until July 1, 2005. In 2005, the moratorium was extended through July 1, 2006. A copy of the report is available at the following website: http://www.fdhc.state.fl.us/freestanding/contents.shtml .

In 2005, the moratorium was extended through July 1, 2006 but the 2006 Legislature declined to further extend the moratorium. 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.

## Health Care Clinics

FY 2005-06 was the third 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 August 16, 2006, the Agency has licensed 2,491 clinics and provided exemption certificates to 4,952 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, 12 clinic licenses have been revoked, 58 licenses have been denied, and 21 clinics have licensure issues in litigation. Eight of the 12 revocations occurred in Dade County, two were in Broward County, and one each in Duval and Hillsborough Counties. The Division of Insurance Fraud in the Department of Financial Services indicated that, in FY 2005-06, 62 arrests were made involving a total of 21 health care clinics.

## Status of Regulatory Mandates

The major impact from the CY 2006 Legislative Session was on the Division of Medicaid. The Division of Health Quality Assurance received few additional mandates; however, the Division was successful in obtaining passage of a far-reaching uniform facility licensure bill. This legislation, Chapter 2006-192, created an “umbrella” licensure law for health care facilities, streamlining, solidifying and providing increased uniformity in such areas as duration of licensure, renewal timeframes, notices, definitions and imposition of administrative fines and other penalties across more than 35 types of health care providers regulated by the Agency.

The Division will work to implement the provisions of Chapter 2006-192 effective October 1, 2006. Additional legislation passed during the CY 2006 session requires the Division to:

- Implement additional survey checks to review for compliance of health care clinics for referral restrictions placed on medical or clinic directors for patients needing MRI, static radiographs, computed tomography or positron emission tomography; and placement of signage related to fraud reporting.

- Implement additional survey checks to ensure hospitals meet federal hospital nurse staffing requirements in operating rooms.

- Implement additional requirements to provide information on alternatives to nursing home care on the agency's website housing the Nursing Home Guide. Further, when nursing home information is listed on the website, the Agency must include any prior name by which a facility was known during the previous 24-month period and must list the most recent occupancy levels of a facility with the total number of beds in the facilities. Legislation specifies a date by which publication of the "Nursing Home Guide Watch List" must occur.

- Establish, with the Department of Elderly Affairs, outcome measures to determine quality and effectiveness of hospice care for hospices in the state. In conjunction with the Department of Elderly Affairs, implement national initiatives to set benchmarks for measuring quality of hospice care and develop an annual report on the information collected for hospices.

- Develop standards for active treatment in Intermediate Care Facilities for the Developmentally Disabled

- Distribute a lump sum of $25 million from Social Services Block Grant funds to the state's hospitals to fund relief for the hurricanes that occurred in CY 2005.

- Grant a nursing home's request to reduce its CON condition by 15% of the annual Medicaid patient days under certain circumstances.

- Add an exemption to the moratorium on nursing homes beds and extend the moratorium on nursing home CONs.

- Publish an emergency telephone number on the Internet that may be used by nursing homes and assisted living facilities to contact the Agency to report requests for assistance. Participate on the multi-agency special needs shelter discharge planning team and the Special Needs Shelter Interagency Committee.

- Establish standards for proof of financial ability to operate upon initial licensure and change of ownership licensure.

# 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 an online system for providers to submit renewal applications over the Internet | 2 | LBR planned for FY 2008-2009 legislative session | Inability to manage currently increasing application workload without additional staff |
| **2** | Establishment and continuing administration of an outcome reporting system for hospital-based interventional cardiology programs, oversight functions and consultation with medical experts as required by Section 408.0361, F.S. | 2 | LBR issue planned for FY 2007-08 | Inability to maintain effective quality oversight. |

# 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 Legislation | Division Assigned |
|---|---|---|---|
| 1. | SB 182<br>Page 8<br>Line 23<br>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.<br>*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<br>Page 40<br>Line 1160<br>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 |

| Number | Bill Cite | Ongoing Task Forces and Studies Required by Legislation | Division Assigned |
|---|---|---|---|
| *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 |

| Number | Bill Cite | Ongoing Task Forces and Studies Required by 2004 Legislation | Division Assigned |
|---|---|---|---|
| 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. |
| 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 | Health Quality Assurance |

| | | | |
|---|---|---|---|
| | | 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. | |

# Administration and Support

**(Executive Direction, and the Division of Administrative Services)**
www.fdhc.state.fl.us/

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Chief Medical Officer.....Vacant

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# Executive Direction

**Chief Medical Officer**

**Goal 3:** To increase the availability of transparent health care information and data on www.FloridaHealthStat.com, www.FloridaCompareCare.gov, and www.MyFloridaRx.com that consumers may use to make informed health care selection and purchasing decisions. (Florida Center for Health Information and Policy Analysis)

**Objective 3. A:** To reduce the length of time required to process facility patient data submissions (from receipt of patient data to the posting of related information on the Agency's website) from 485 days to a maximum of 62 days by FY 2011-12.

**Service Outcome Measure 3. A:** The average number of days before data is available on the Agency for Health Care Administration's web site www.FloridaHealthStat.com.

**Service Outcome Measure Projection Table 3. A:** Time from Data Receipt to Website Posting

| **Baseline/ Year FY 2005-06** | **FY 2007-08** | **FY 2008-09** | **FY 2009-10** | **FY 2010-11** | **FY 2011-12** |
|---|---|---|---|---|---|
| 485<br><br>Average number of days from data receipt to posting on website | 485 | 291 | 174 | 104 | 62 |
| Percent decrease in days to post on website | 0% | 40% | 40% | 40% | 40% |

**Objective 3. B:** By FY 2011-12, increase to 3,597 the average daily number of persons that visits www.FloridaCompareCare.gov.

**Service Outcome Measure 3. B:** The average daily number of persons that visits www.FloridaCompareCare.com annually. (This measure 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. B:**

| Baseline/Year FY 2005-06 | FY 2006-07 | FY 2007-08 | FY 2008-09 | FY 2009-10 | FY 2011-12 |
|---|---|---|---|---|---|
| 1,570<br><br>Average number of sessions on web site per day | 1,724 | 1,896 | 2,398 | 2,878 | 3,597 |
| Annual percent of increase in the number of sessions begun per day | 10% | 10% | 15% | 20% | 25% |

**Objective 3. C:** To increase by six percent annually through FY 2011-12 the number of persons who receive health care information from www.FloridaHealthStat.com.

**Service Outcome Measure 3. C:** 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. C:**

| Baseline/Year FY 2000-01 | FY 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-11 | FY 2011-12 |
|---|---|---|---|---|---|
| 1,250<br><br>Average number of sessions begun on the web site per day | 1,880 | 1,993 | 2,113 | 2,240 | 2,374 |
| Annual percent of increase in the number of sessions begun per day | 6% | 6% | 6% | 6% | 6% |

**Objective 3. D:** To increase at a non-linear rate percent annually, through FY 2011-12, the number of patient records accessed by practitioners through the Florida Health Information Network (FHIN).*

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

**Service Outcome Measure Projection Table 3. D (1):**

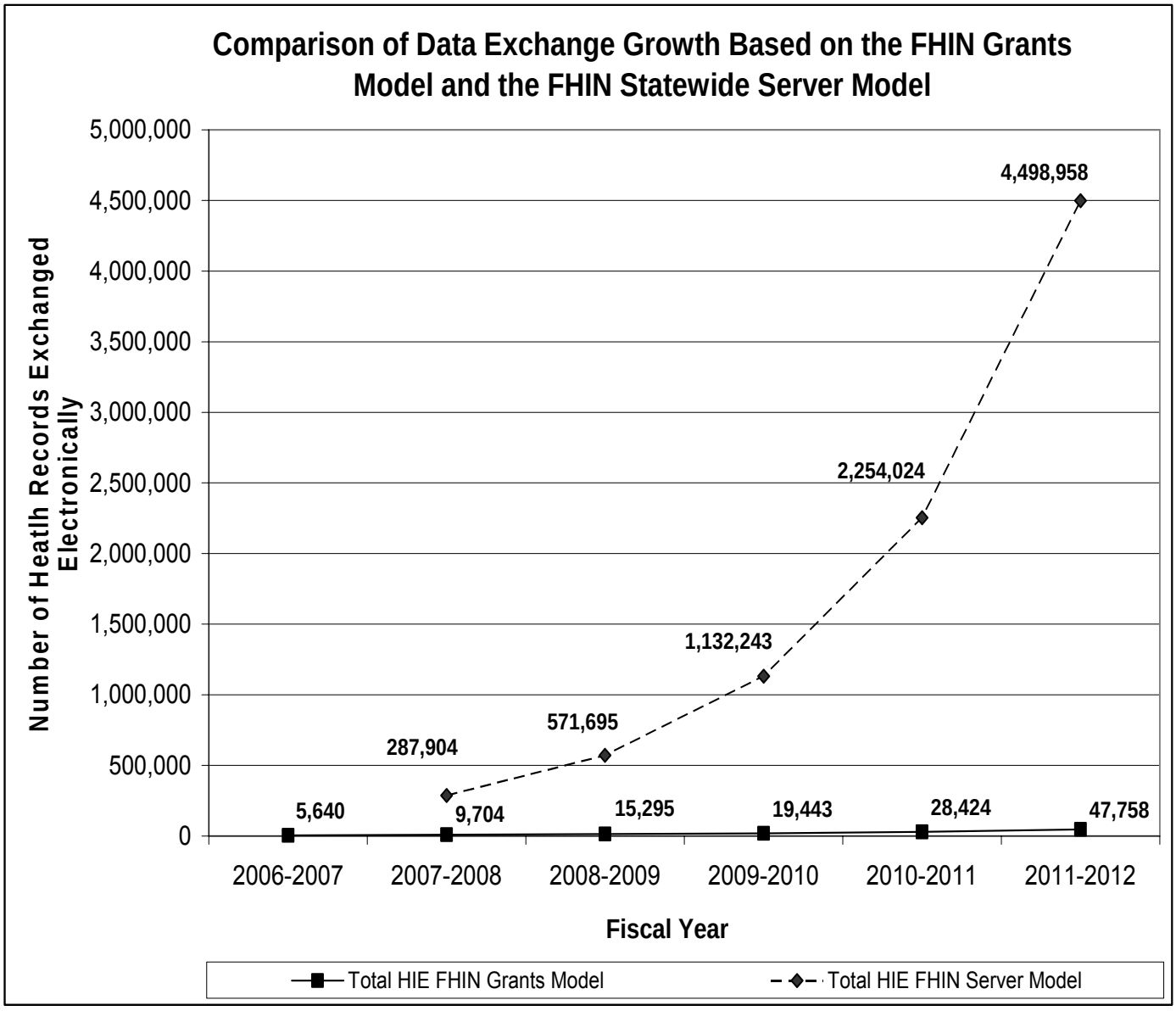
| Baseline/Year FY 2006-07 | FY 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-11 | FY 2011-12 |
|---|---|---|---|---|---|
| 5,640<br>Number of patient records accessed through the Florida Health Information Network based on FHIN Grants Model | 10,204 | 25,845 | 31,103 | 42,549 | 67,718 |
| Projected annual percent of increase in the number of records accessed (see table) | 72.1% | 57.6% | 27.1% | 46.2% | 68.0% |

**Service Outcome Measure Projection Table 3. D (2):**

| Baseline/Year FY 2007-2008 | FY 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-11 | FY 2011-12 |
|---|---|---|---|---|---|
| 287,904 Number of patient records accessed through the Florida Health Information Network based on FHIN Server Model | 287,904 | 571,695 | 1,132,243 | 2,254,024 | 4,498,958 |
| Projected annual percent of increase in the number of records accessed (see table) | | 98.6% | 98.1% | 99.1% | 99.6% |

*This objective has been changed from the FY 2006-07 – 2010-11 LRPP. The new objectives are based on utilization statistics received from FY 2005-2006 FHIN Grant recipients.

**Table 5: FHIN Data Exchange Estimates, for FY 2006-2007 through FY 2011-2012**



| Table 6: Comparison of Data Exchange Growth Based on the FHIN Grants to RHIOs Model | | | | | | |
|---|---|---|---|---|---|---|
| | **Baseline** | **10%** | **20%** | **40%** | **60%** | **80%** |
| **RHIOs** | **FY 2006-07** | **FY 2007-08** | **FY 2008-09** | **FY 2009-10** | **FY 2010-11** | **FY 2011-12** |
| PBCCHA | 1,290 | 1,419 | 1,703 | 2,384 | 3,814 | 6,866 |
| TB RHIO | 3,650 | 4,015 | 4,818 | 6,745 | 10,792 | 19,426 |
| BB RHIO | 700 | 770 | 924 | 1,294 | 2,070 | 3,726 |
| | | **Baseline** | **10%** | **20%** | **40%** | **60%** |
| SF HII | | 1,000 | 1,100 | 1,320 | 1,848 | 2,957 |
| ESSHIN | | 1,000 | 1,100 | 1,320 | 1,848 | 2,957 |
| CHIO | | 500 | 550 | 660 | 924 | 1,478 |
| JaxCare | | 1,000 | 1,100 | 1,320 | 1,848 | 2,957 |
| | | | **Baseline** | **10%** | **20%** | **40%** |
| Future RHIOs (4 Expected) | | | 4,000 | 4,400 | 5,280 | 7,392 |
| | 5,640 | 9,704 | 15,295 | | 28,424 | 47,758 |

| Table 7: FHIN Data Exchange Estimates, FY 2006-2012<br>FHIN Statewide Server Model<br>Total Health Information Exchange FHIN Grants Model | | | | | |
|---|---|---|---|---|---|
| | **Baseline** | **100%** | **100%** | **100%** | **100%** |
| Physicians on FHIN | 100 | 200 | 400 | 800 | 1,600 |
| Patient Queries | 278,200 | 556,400 | 1,112,800 | 2,225,600 | 4,451,200 |
| Total HIE FHIN Server Model | 287,904 | 571,695 | 1,132,243 | 2,254,024 | 4,498,958 |

**Objective 3. E:** To increase by 10 percent annually through FY 2011-12 the average monthly number of visitors to www.MyFloridaRx.com

**Service Outcome Measure 3. E:** The average monthly number of persons that visits the MyFloridaRx.com website

**Service Outcome Measure Projection Table 3. E:**

| Baseline/Year FY 2005-06 | FY 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-11 | FY 2011-12 |
|---|---|---|---|---|---|
| 14,632<br><br>The average annual monthly number of persons that visit MyFloridaRx.com | 16,095 | 17,704 | 19,474 | 21,421 | 23,563 |
| Annual monthly percent of increase | 10% | 10% | 10% | 10% | 10% |

**Objective 3. F:** To increase by 10 percent annually through FY 2011-12 the average daily number of persons that visits www.FloridaCompareCare.gov for Florida health plan** information.

**Service Outcome Measure 3. F:** The average daily number of sessions begun on the Florida health plan** website each year. (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. F:**

| Baseline/Year FY 2006-07 | FY 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-11 | FY 2011-12 |
|---|---|---|---|---|---|
| 0***<br><br>Average number of sessions begun on the web site per day | 2,000*** | 2,200 | 2,420 | 2,662 | 2,928 |
| Annual percent of increase in the number of sessions begun per day | 10% | 10% | 10% | 10% | 10% |

** This site is under development and will be released on October 1, 2006.
******* Targeted number of consumers to access each website beginning in FY 2007-2008

## Linkage of Agency Goals and Programs to Governor's Priorities

| | Governor's Priorities and Goals | Agency Goals and/or Programs |
|---|---|---|
| 1. | Provide a Quality Education | |
| 2. | Growing the Economy | |
| 3. | Strengthening Florida's Families | **Goal 3:** To increase the public's access to health care information |
| 4. | Building Better Communities | |
| 5. | Improving Healthcare | **Goal 3:** To increase the public's access to health care information |
| 6. | Protecting the Environment | |

**Trends and Conditions Statement:**

In recent years the need to create transparency in the healthcare delivery system 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 uses the Agency for Healthcare Research and Quality (AHRQ) quality indicators to guide public reporting, but also has considered using measures developed 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.

**Office of Data Collection and Quality Assurance**

To promote streamlined and enhanced data processing functions (collection, auditing, certification, database upload, maintenance and dissemination) within a climate of growing production demands and faster consumer accessibility to high quality health data information, the Agency must continue to take advantage of all available technologies to speed data

processing and public reporting. The Agency submitted a FY 2007-08 legislative budget request (LBR) for the resources necessary to support an extensive technical process analysis of the current system and further examine potential linkage and distribution for improved efficiencies.

Post analysis, the Agency will determine technology and process strategies that are best suited to achieve the desired goal and further develop a related LBR to appropriate resources for enhanced technology and the implementation of improved data processing.

The Agency websites, FloridaHealthStat.com (January 2000), and FloridaCompareCare.gov (October 2005), were developed by the Florida Center. These consumer oriented sites were developed in support of the Florida Center's mission to provide accurate and timely information to the public, and to promote well informed health care decisions and transparency in the health care delivery system. The website includes a detailed look at reported data for Hospital Inpatient, Ambulatory Surgery, Emergency Department and Surgical Infection Prevention measures.

With national trends heading toward a performance based reimbursement system versus the current fee for service, data collection systems must have the capacity to handle increased data volumes efficiently and allow dynamic data access. Facilities currently report discharge data quarterly, however a movement towards monthly reporting has been discussed. That functionality will approach a "real time" delivery of health data and information. Real time data access demands the employment of robust technologies to migrate toward measurably reduced turn around time and thereby greater transparency.

**Collection of Patient Data:**

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

The hospital inpatient database is the most widely used of the Florida Center's 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 de-identified 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.)

The number of hospital inpatient discharge records submitted increased from 2,232,553 records in 2000 to 2,490,713 records in 2004, for an increase of 11.6 percent during CY 2000-2004. The number of records received continues to increase. Inpatient services remain an important part of health care in Florida and this growing database will continue to provide a foundation for the information consumers, researchers, analysts and policymakers use to make well-informed health care decisions.

**Ambulatory patient data** collection is authorized under s. 408.061 (1) (e), F.S., and implemented under Chapter 59 -AGENCY FOR HEALTH CARE ADMINISTRATION, 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 trends in Florida's health care delivery system.

The number of ambulatory patient records submitted increased from 2,278,559 records in CY 2000 to 2,747,497 records in CY 2004, for an increase of 20.6 percent.

**Emergency Department data** collection is authorized in s. 408.061 (1), F.S., and is implemented under Chapter 59B-9, Florida Administrative Code. This significant change to the ambulatory patient data rule requires the reporting of hospital emergency department data beginning from January 1, 2005.

With emergency department data collection, the total volume of ambulatory data for CY 2005 has already increased by over 5,075,670 records YTD, representing 83 percent of the total expected records submission. Upon 100% completion of CY 2005 Emergency Department (ED) data collection, total volume increase attributed to ED data submissions may reach 6.5 - 7 million records.

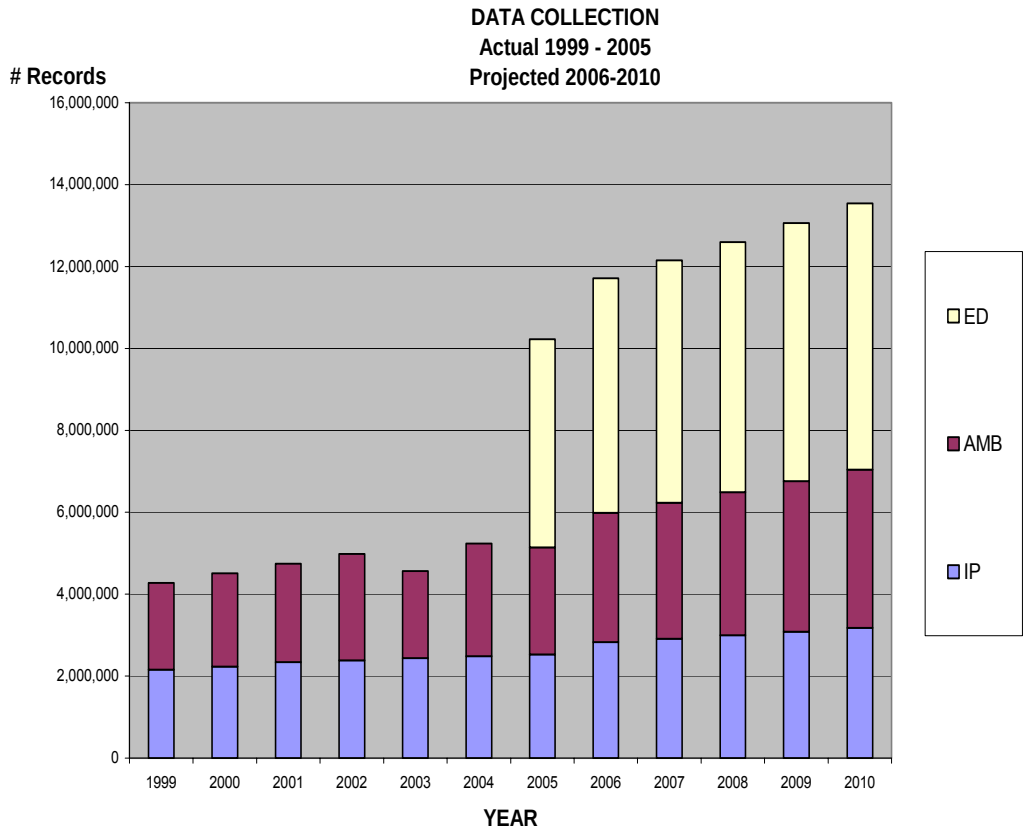
**Comprehensive inpatient rehabilitation** data collection is authorized under s. 408.061 (1) (e), F.S., and is implemented under Chapter 59E-7, Part II, Florida Administrative Code.

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 Florida's health care delivery system.

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 number of comprehensive inpatient rehabilitation discharge records submitted increased from 18,216 in CY 2000 to 22,731 in CY 2004, for an increase of 24.8 percent.

The following tables provide a visual comparison for the historic, current and projected volume of data collected:

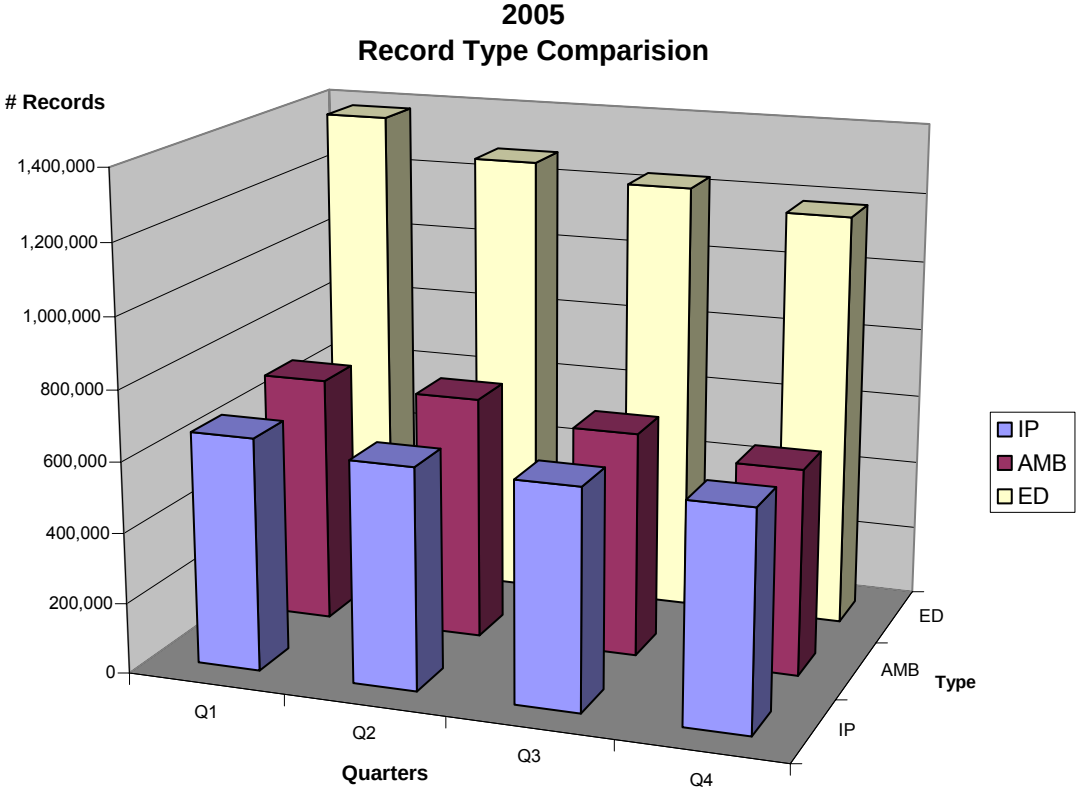



| |
|---|
| Emergency Department |
| Ambulatory Surgery |
| Hospital Inpatient |

| Actual # Records | | | | | | | |
|---|---|---|---|---|---|---|---|
| Year / Type | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 |
| IP | 2,155,123 | 2,232,533 | 2,343,136 | 2,385,417 | 2,443,926 | 2,490,713 | 2,527,699 |
| AMB | 2,118,515 | 2,278,559 | 2,399,859 | 2,594,629 | 2,118,515 | 2,747,497 | 2,618,503 |
| ED | | | | | | | 5,075,679 |
| Year TOTAL | 4,273,638 | 4,511,092 | 4,742,995 | 4,980,046 | 4,562,441 | 5,238,210 | 10,221,881 |

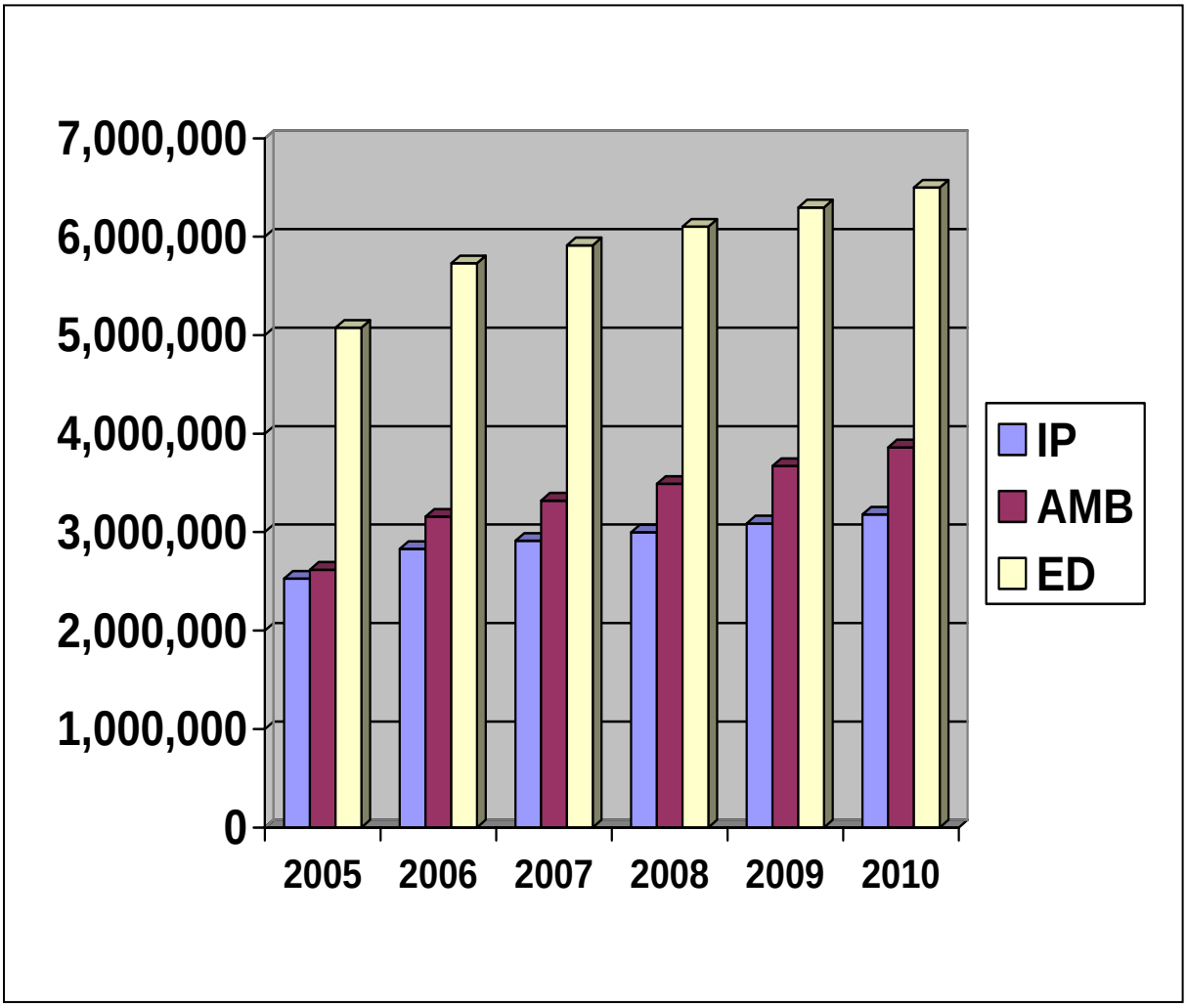
| Projected # Records | | | | | | |
|---|---|---|---|---|---|---|
| Year / Type | 2006 | 2007 | 2008 | 2009 | 2010 | Multi Year Total / Projected Collection |
| IP | 2,828,495 | 2,912,501 | 2,999,003 | 3,088,073 | 3,179,789 | 31,586,408 |
| AMB | 3,157,915 | 3,320,547 | 3,491,555 | 3,671,371 | 3,860,446 | 34,377,911 |
| ED | 5,730,442 | 5,913,816 | 6,103,058 | 6,298,356 | 6,499,903 | 35,621,254 |
| Year TOTAL | 11,716,852 | 12,146,864 | 12,593,616 | 13,057,800 | 13,540,138 | 101,585,573 |

**Table 9: Report Comparison**
**CY 2005 YTD**
**Total Records 10,221,881**




| Quarter / Data Type | Q1 | Q2 | Q3 | Q4 | Total Records |
|---|---|---|---|---|---|
| **ED Emergency Department** | 1,381,289 | 1,277,806 | 1,233,609 | 1,182,975 | 5,075,679 |
| **AMB Ambulatory Surgery** | 703,654 | 691,833 | 638,220 | 584,796 | 2,618,503 |
| **IP Hospital In Patient** | 660,160 | 627861 | 622,618 | 617,060 | 2,527,699 |

**Table 10: Data Collection**
**2005 Actual**
**Projected 2006 – 2010**




| Year / Record Type | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | Multi Year Total / Projected Collection |
|---|---|---|---|---|---|---|---|
| **IP** | 2,527,699 | 2,828,495 | 2,912,501 | 2,999,003 | 3,088,073 | 3,179,789 | **17,535,560** |
| **AMB** | 2,618,503 | 3,157,915 | 3,320,547 | 3,491,555 | 3,671,371 | 3,860,446 | **20,120,337** |
| **ED** | 5,075,679 | 5,730,442 | 5,913,816 | 6,103,058 | 6,298,356 | 6,499,903 | **35,621,254** |
| **Year Total** | 10,221,881 | 11,716,852 | 12,146,864 | 12,593,616 | 13,057,800 | 13,540,138 | **73,277,151** |

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

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.

In CY 2005, the rule for data collection, Ch. 59E-7.012, Florida Administrative Code, was changed to require as of January 1, 2006 for hospitals to send their data to the Florida Center via the Internet. The file format for the data was changed from a fixed-width text file to a file format using XML code, based on the Inpatient Data XML Schema published by the Agency. The use of XML coding allows patient records to be sent over the Internet directly to the Florida Center's computers, is decoded automatically, and is available at http://ahca.myflorida.com/SCHS/hpunit.shtml. This change to online reporting of data moves the Florida Center toward full Electronic Document Interchange (EDI), and will decrease the time required to process inpatient data.

Also in CY 2005, the Florida Center amended the rules governing hospital inpatient data collection, Ch. 59E-7.014, Florida Administrative Code, by expanding the number of fields reported quarterly by hospitals. The number of required diagnosis codes (International Classification of Diseases, 9th Revision, Clinical Modification, or ICD-9-CM) increased from ten to thirty. The number of procedure codes also increased from ten to thirty and the date of all procedures is required. ICD-10 codes are also now accepted, in anticipation of a future updating of the diagnostic coding system.

The rule change also required reporting on additional categories of charges made to the patient for services, and the reporting of an additional operating physician's identification number, if applicable beginning on January 1, 2006. A final change was for hospitals to report a "Present on Admission" indicator for each of the diagnostic codes reported; this measure indicates whether the patient entered the hospital with the condition, or if it developed after admission. This measure must be reported beginning on January 1, 2007.

In October 2004, the Comprehensive Health Information System Advisory Council (CHIS) recommended that hospitals in Florida also report Surgical Infection Prevention (SIP) measures to AHCA. The SIP measures address the appropriate use of antibiotics before and after surgery, and include three indicators: 1) Prophylactic antibiotic received within 1 hour prior to surgical incision; 2) Prophylactic antibiotic selection for surgical patients; 3) Prophylactic antibiotics discontinued within 24 hours after surgery end time.

The Florida Center initiated a new rule Ch. 59B-15, F.A.C to collect SIP data on the use of appropriate antibiotics for surgical patients. The rule went into effect in November, CY 2005. Hospitals began reporting SIP data on all eligible patients beginning the second quarter of CY 2005. Additional staff resources have been required to establish protocol and process the SIP data submissions. Data will be available on the website in CY 2006.

**Ambulatory Patient Data Collection**

Ambulatory patient data collection is authorized under s. 408.061(1) (e), F.S., and 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 are used in many reports including the Health Outcomes Series. The data are used for many special data requests within the Agency for Health Care Administration, the Florida Legislature, researchers and the general public. As with hospital inpatient data, a de-identified version of the ambulatory data (limited data set) is available for purchase.

Through CY 2004, the ambulatory patient database contains patient-level information on reported 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 may request to be exempted from reporting for a given quarter.

As with inpatient data, ambulatory discharged patient data includes 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 the Florida license numbers for the reported attending and operating physician(s). 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.

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.

The amended rule, Ch. 59B-9, Florida Administrative Code, effective on January 1, 2005, changed the mode of file transmissions for ambulatory surgery and emergency department data reports. Beginning January 1, 2006, acute care inpatient facilities were also required to submit data reports in "XML" format and transmit electronically via the secure Internet Data Submission System (IDSS) implemented by the Agency.

**Emergency Department Data Collection**

Emergency Department data collection is authorized in s. 408.061(1), F.S., and is implemented under Chapter 59B-9, Florida Administrative Code. This significant change to the ambulatory patient data rule requires the reporting of 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 includes, but are not limited to, the hour of arrival, patient's chief complaint, evaluation and management code, 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 required file format is the same XML as used for reporting of ambulatory patient surgery (Chapter 59B-9, Florida Administrative Code). The data collected will be analyzed for a mandated study of emergency department utilization and the implications for hospital costs.

It is important to note, in addition to the aforementioned launch of new format (XML) and transmission method IDSS, there is a significant increase in volume of data collected. The addition of ED data significantly increases the operational demands placed upon Florida Center staff and effects the overall time required to completely process all data submissions.

**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 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 continues to grow.

**Office of Research Analysis and Development**

**MyFloridaRx.com**

Many Florida residents, especially individuals on a fixed income, have to make a choice between purchasing life saving medication or paying their rent or buying their groceries. Policy makers of Florida thought it essential to give consumers a tool for shopping for the best price for prescription drugs.

With the release of the prescription drug website, www.MyFloridaRx.com, mandated by the landmark 2004 Affordable Health Care legislation HB 1629, consumers are provided with the retail prices of the top 100-prescribed drugs by pharmacy across Florida. The website was developed and is maintained through coordination between AHCA and the Office of the Florida Attorney General. Thee website helps consumers shop for the lowest price for their prescription drugs. More information about understanding prescription drug prices is also available on www.FloridaHealthStat.com.

The purpose of Objective 3.C. is to increase consumers' use of the MyFloridaRx.com web site. Mandated in HB 1629, the site was developed and is maintained by the Office of the Attorney General and the Agency for Health Care Administration. The Agency extracts the usual and customary prices (retail) charged by pharmacy and publish information for the top 100 name brand prescription drugs, along with their generic alternatives and varieties of dosages. The MyFloridaRx.com website went live on June 1, 2005. Although the Office of the Attorney General hosts and maintains the site the pharmacy data used is derived from the Agency for Health Care Administration's Medicaid resources. The site supports the Agency's mandate to implement health care transparency and to provide information that consumers may use to make informed health care selection and purchasing decisions.

**Florida Health Plan Website**

The purpose of Objective 3.D. is to increase the number of consumers that visits www.FloridaCompareCare.gov to acquire plan customer satisfaction data, financial indicators, quality of care and transparent performance information about health plans. Consumers will be able to search all licensed health plans offered in Florida. These plans will be searchable by geographic location and pay type. Information presented in the website is based upon recommendations from the State Consumer Health Information and Policy Advisory Council and

its Health Plan Technical Workgroup. The release date for the www.FloridaCompareCare.gov health plan website component is October 1, 2006. This site supports the Agency's mandate to implement health care transparency and to provide information that consumers may use to make health care selection and purchasing decisions.

**Physician Website**

Another health care consumer's resource in development is the Physician Website. This website will be located on www.FloridaCompareCare.gov and is scheduled to be released in June 2007. It will contain physician level data on the number of surgical procedures performed, patient satisfaction survey information and specific quality measures that consumers may use to make informed health care selection and purchasing decisions.

The FloridaCompareCare.gov website is having positive influences on Florida's provider communities. Hospital and outpatient facilities are improving their organizational profiles, become more attentive to quality of care, and adjusting cost of care to make them more competitive.

**Consumer Information Campaign**

The purpose of Objective 3.F. is to use outreach programs and activities to promote consumers awareness and use of the Agency's and Florida Center's websites, FloridaHealthStat.com, FloridaCompareCare.gov, and MyFloridaRx.com to obtain information that may be used to make informed health care selection and purchasing decisions. In cooperation with the State Consumer Health Information and Policy Advisory Council and its Public Relations Workgroup the Florida Center developed a communications plan that describes how community outreach activities are to be conducted. These include transparency and conference participations, making presentations, public service announcements, distribution of information brochures, writing newspaper and magazine articles, and working with stakeholder groups about ways we can help them to inform their membership about the information on the Agency's websites.

Although Florida leads the nation in the use of putting transparent health care information on its website there is a need to be more aggressive about our efforts to keep the public informed. The Florida Center for Health Information and Policy Analysis, and the State Consumer Health Information and Policy Advisory Council are working hard to promote and encourage Floridians to use the Agency's websites. Both traditional and non-traditional marketing efforts are being explored to maximize the use of outreach opportunities.

**Office of Data Dissemination**

In recent years the need to create transparency in the healthcare delivery system 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, health care purchasing decisions by consumers and organizations, and quality/cost improvement efforts within the health care sector. The Agency for Health Care Administration uses the Agency for Healthcare Research and Quality (AHRQ) quality indicators to guide public reporting, but also has considered using measures developed by employer and health care 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 House Bill 1629 (Web Page | PDF) and CY 2006 House Bill 7073 (Web Page | PDF) the legislature demonstrated its sensitivity and need to address the gap between the current state of health care 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. AHCA was mandated by House Bill 1629 to report on a wide range of data in health care facilities. They include patient charges, volume, length of stay, and performance outcome measures collected from health care facilities for specific conditions and procedures.
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 and help them make informed health care purchasing and selection decisions. The Agency's website, www.FloridaHealthStat.com, was developed by the Florida Center for Health Information and Policy Analysis and became operational in January 2000. This website, specifically designed for consumers, was developed to help meet the Bureau's mission of providing accurate and timely information to help the public in making well informed health care decisions. The site provides a list of licensed health care facilities and providers; information on patient data from hospitals and ambulatory surgery centers; information on insurance programs; prescription drug programs; seniors and family health care information; consumer publications; statistical reports and much more.

In November 2005, as part of this continuing effort to create a transparent health care delivery system as legislatively mandated in CY 2004, www.FloridaCompareCare.gov was launched. This consumer-focused website provides a clear, transparent view of performance data for selected medical conditions and procedures in Florida's short-term acute care hospitals and ambulatory surgery (outpatient) centers. This search tool assists consumers, health care professionals, and researchers in comparing hospitals and ambulatory surgery centers, including information on quality of care, pricing and performance. This information can help consumers in choosing a health care facility that best serves their needs, and it helps researchers that are studying the status of health care in Florida.

Since its initial release in November 2005, the FloridaCompareCare.gov website has received a total of 204,566 visitors with an average of 746 visitors per day. An April to July 2005 survey taken of FloridaCompareCare.gov website users revealed that the respondents used the site to help them make personal health care decisions and the majority of them would recommend this website to family and friends.

The results from a second survey of users revealed that the majority of the respondents were able to find what they were looking for, thought the site was relatively easy to navigate, and found the information provided was helpful. Many respondents were referred to the site by newspaper articles. In addition, the FloridaCompareCare.gov website has received national attention from such organizations as the National Association of Health Data Organizations (NAHDO), the Agency for Healthcare Research and Quality (AHRQ), and the Centers for Disease Control and Prevention and others.

Florida's consumer centric health care data reporting system is leading the nation in health care transparency and technology. Florida was the first state in the nation to publicly report infection rates, mortality rates, and pediatric indicators by facility. Florida's efforts directly address the goal to improve health care and reduce skyrocketing costs by providing Florida's consumers with more user-friendly and comparative health care information. To maintain this level of

success in its consumer centric reporting system, the Legislature must continue to appropriate funds to AHCA.

On August 22, 2006, President W. Bush issued Executive Order: Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs. The Executive Order Directs Federal Agencies That Administer Or Sponsor Federal Health Insurance Programs to:

1. **Increase Transparency in Pricing.** The Executive Order directs Federal agencies to share with beneficiaries information about prices paid to health care providers for procedures.

2. **Increase Transparency in Quality.** The Executive Order directs Federal agencies to share with beneficiaries information on the quality of services provided by doctors, hospitals, and other health care providers.

3. **Encourage Adoption of Health Information Technology (IT) Standards.** The Executive Order directs Federal agencies to use improved health IT systems to facilitate the rapid exchange of health information.

4. **Provide Options that Promote Quality and Efficiency in Health Care.** The Executive Order directs Federal agencies to develop and identify approaches that facilitate high quality and efficient care.

Florida is proud to join the President in this initiative to facilitate access and provide consumers with the tools they need to make informed health care decisions. Fortunately however, Florida has already achieved much success as the National Leader in accomplishing what is outlined in the Executive Order. The President's program will permit the Agency to continue its success and implement more transparency programs that will make Floridians the most informed health care consumers in the nation.

Through the FloridaCompareCare.gov website, AHCA has increased transparency in pricing by providing Floridians with health care charge information, by procedure and condition, for services received at inpatient and outpatient facilities. In addition, AHCA has increased transparency in quality by providing quality of care facility data information on FloridaCompareCare.gov that includes quality of care facility data by reporting information on volume, length of stay, risk adjusted readmission, mortality, infection, and complication rate data for select conditions and procedures. Information to be provided in the future will include physician and health plan data.

As statutorily mandated, AHCA is working with the State Consumer Health Information and Policy Advisory Council, (Formally the Comprehensive Health Care Advisory Council) to review and discuss public reporting issues and future enhancements to improve the transparency of health care data and information. The Advisory Council is made up of stakeholders including consumers, purchasers, hospitals, physicians, and health plans to review and discuss public reporting and transparency implementation activities.

Public reporting of health care data will definitely enhance the health care system's progress towards preventive and quality care. Future data transparency reports and research studies should focus attention on areas Florida has made progress and where it needs more attention. For example, within the next five years, consumers will benefit greatly from the following accomplishments:

1. Implementation of Electronic Medical Record Systems – allows for research and understanding of continuum of care

2. Favorable market changes for health insurance companies- will allow for more efficient and effective health care system for Floridians

3. Continued growth in consumer health education and awareness- consumers will remain cognizant and attentive to personal health care needs; and preventive health care measures should increase after further education through access AHCA's websites

4. Improved health care access and delivery systems – In the future the state should be able to assist the health care industry in achieving economies of scale and provide motivation and rewards for programs that work; the costs of the delivery system should start to taper and therefore consumers costs should began to stabilize and retard.

Accomplishments in developing a transparent health care system will provide benefits in overcoming the following challenges:

1. Uninsured population – increase partnerships with state, corporate America and foundations to offer grants and funding for areas of greatest need

2. Health care access for children in poverty- continue programs such as Healthy Kids, and MediKids

3. Health disparities among ethnic groups and genders- continue to provide consumer information on websites and host education workshops and seminars in high risk geographic areas

4. Ability to attract more skilled medical professionals and facilities – greatly needed due to population projections;

5. Ability to provide quality end of life care for seniors- continue inspections and audits of nursing home facilities, etc; provide feedback tool such as a survey for families with aging adults who utilize health services

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 of Representatives, 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 Number 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.

Florida is leading the nation in healthcare transparency and healthcare technology in creating a consumer centric delivery system for the 21st Century. Through the leadership of Governor Bush, AHCA's Secretary Christa Calamas, and the Florida Center for Health Information and Policy Analysis, Florida will continue to meet the requirements in the Florida Legislature's 2004 landmark legislation that mandated public reporting of transparent health care information.

**Office of Health Information and Technology**

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 network that includes the use of electronic health records by individual health care providers and the secure electronic transfer of clinical data between multiple providers.

There is a general consensus among policy leaders and stakeholders that that the current health information infrastructure must be modernized to enable fast and accurate transmission of medical records among health care practitioners treating patients. A system that supports communication among clinicians will improve coordination of patient care, reduce medical errors, control fraud, and eliminate duplicate testing.

Information technologies exist that can improve the system and the delivery of services. However, stakeholders must cooperate in new ways and policies need to be developed that can support system change.

1. **Governor's Health Information Infrastructure Advisory Board**
   On May 4, 2004, by Executive Order No. 04-93, Governor Jeb Bush established the Governor's Health Information Infrastructure Advisory Board (the "Board") and he charged the Board with the following four tasks to be completed no later than June 30, 2007:

   A. Advising and supporting the Agency for Health Care Administration (the "Agency") as it develops a strategy for the adoption and use of electronic health records (EHR) and as it creates a plan to promote the development and implementation of a Florida health information infrastructure, including measures to promote greater adoption of EHR information systems among the state's healthcare providers;

   B. Identifying obstacles to the implementation of an effective health information infrastructure in the state and providing the Agency with policy recommendations to remove or minimize those obstacles;

   C. Advising the Executive and Legislative branches on issues related to the development and implementation of the Florida health information infrastructure; and

   D. Assisting the Agency in ensuring that the strategy and plan preserve the privacy and security of health information as required by law.

The Board and Agency have made substantial progress in the promotion of electronic health information exchange since the Board's creation. These activities and accomplishments are listed below:

A. The Board has been instrumental in the establishment and early success of the Florida Health Information Network (FHIN) grants program. Through the grants program, the Agency provides seed money to develop local health information exchange projects and to encourage practitioner participation as users of electronic health records. The Board had provided guidance to the Agency regarding FHIN Grant Program requirements, criteria for evaluation of proposals, and the selection of awardees.

B. Three local pilot projects for health information exchange were implemented in 2006. These projects were funded, in part, by the FHIN Grants Program established under the auspices of the Agency and Board. These projects received matching funding from stakeholders through their Regional Health Information Organization (RHIO). Operational health information exchange projects are located in Broward, Hillsborough and Leon Counties, and health information exchange projects are proposed in Escambia, Jacksonville, and Miami-Dade to be implemented by their respective RHIO in 2007.

C. Board members have contributed significant technical expertise in the development of a white paper describing architectural considerations for a state health information infrastructure. The FHIN White Paper describes the critical functions of the state level server and the technical requirements for building a system that is secure and in compliance with federal and state laws regarding the privacy and security protections for health information. The FHIN will provide the coordinating infrastructure to ensure interoperability of health information exchange across the state.

D. A bill (HB 1409) to create a public private partnership that would govern the Florida Health Information Network was introduced in the 2006 Legislative Session consistent with the recommendations of the Board.

E. The Agency and Board were successful in securing the passage of legislation (HB 7073) that mandates the development of a statewide health information network, authorizes the FHIN grants program, and provides for the integration of State databases participating in the network.

F. The Agency and the Board hosted several conferences and workshops in 2004, 2005 and 2006 that allowed the Board and the Agency to gather information and advice from national experts and a number of Florida stakeholders, including providers, consumers, payors and purchasers of electronic health information systems. These experts offered several possible approaches to planning, implementing and operating an effective and secure health information infrastructure in Florida. Board members have also reviewed much of the abundant, high quality academic, industry and policy literature that is being published on integrated health information networks and related topics.

Through the efforts of the Board, Florida's health information infrastructure initiative has achieved a scope of stakeholder involvement that includes the leadership of hospitals, medical groups, laboratories, payors, employers, community health centers, and other stakeholders. These stakeholders represent a significant market presence in Florida. Other active participants, academic institutions, technology firms, professional associations, county health departments, and other state agencies are also active participants in the initiative.

**Florida Health Information Network**

In 2004, the Florida Legislature directed the Agency to begin a planning process to develop a strategy for implementing a Florida health information infrastructure to encourage the use of electronic health records (EHRs) by individual health care providers and the secure electronic transfer of clinical data between multiple providers. Under the provisions of s. 408.062 (5), Florida Statutes, the Agency was directed to develop and implement a strategy for the adoption and use of EHRs and to develop rules to facilitate the functionality and protect the confidentiality of electronic health records.

Following the Executive Order creating the Governor's Health Information Infrastructure Advisory Board, the Board held numerous workshops at which national experts and stakeholders spoke about national health information exchange initiatives and trends in the use of electronic health records.

The Board published an *Interim Report* in February 2005 which articulated the vision of the Florida Health Information Network (FHIN):

> The Florida Health Information Network (FHIN) will connect the state's healthcare stakeholders through an integrated information system. It will be a secure network that will make available to authorized parties the medical information they need to make sound decisions about healthcare, regardless of where that information is stored, and where or when it is needed.

Two strategies to build the FHIN were proposed in the Interim Report: 1) to foster the adoption of effective electronic health record systems among Florida providers and 2) to build out the FHIN infrastructure by starting with well-planned, strategically selected pilot projects that would pursue a "launch and learn" approach.

In November, 2005, the board brought together a group of information technology experts from both private and public arenas to strategize about the development of a state-wide server to support health information exchange in Florida. One outcome of the meeting was a proposal to draft a technical White Paper that would specify the architecture of the state server as a key component of the FHIN and to propose specifications and standards to ensure interoperability among the RHIOs and the FHIN.

The *Florida Health Information Network Architectural Considerations for State Infrastructure - Draft White Paper* was written over the following months as a collaborative effort among eight primary contributors and fifteen reviewers. A first draft of the document was completed in March, 2006, and released for wider review. Two White Paper workgroups were formed in April, 2006, to specifically address issues of network security and a minimal clinical data set of records to be stored on the RHIO server. The workgroups have worked through the relevant concerns and have issued recommendations to the Board for inclusion into the White Paper in its final draft. The White Paper has become the road map for developing of statewide health information exchange in Florida, and already has received positive acclaim from reviewers across the country.

The White Paper specifies that the FHIN will ensure access to secure, accurate medical records across Florida by providing a technical infrastructure which allows authorized health care workers to obtain health care information on patients from all of the RHIOs connected to the FHIN. The FHIN will ensure the data are applicable to the individual being treated, the transit is secure and efficient, and that the receiving provider is authorized to obtain the information. Additionally, the FHIN will provide access to health care data held in state databases.

The FHIN is envisioned as a statewide health information infrastructure that will enable health care professionals to access a patient's medical records from any provider database connected to the network over a secure Internet connection. The FHIN represents a collaborative effort between the public and private sectors, state and local governments, RHIOs and health information exchanges, providers, employers, consumers, health plans and payors. The FHIN proposes to interconnect health care providers across Florida to facilitate the sharing of health care data without regard to where in the state the consumer resides or where the health care was delivered. The FHIN infrastructure will allow local RHIOs the greatest amount of flexibility in implementing their plans to integrate health care data in their communities.

As Florida's top-tier HIT resource, the FHIN will manage communications, process data requests and responses, maintain an Enterprise Master Patient Index and Record Locator Service to locate health care records, provide accessibility to independent health care databases and other health information networks outside of the state, and establish technical standards that ensure interoperability among all state sub-networks. The FHIN will work closely with the Office of the National Coordinator for Health Information Technology to model its network architecture on the standards established for the National Health Information Network.

The FHIN infrastructure will be built around a central server that will maintain connectivity among RHIOs or other health information networks in the state. It will be responsible for querying clinical datasets held by providers within the local RHIOs connected to the FHIN. It will take the lead in establishing and maintaining technical standards among the RHIOs to ensure interoperable connection to the FHIN. It will integrate state agency health care datasets and make them available to authorized users, maintaining levels of security, confidentiality and certification of users that match the high levels of security required for all patient records. The FHIN server could also connect to databases maintained by payors that cover provider-generated claims records for Florida patients. Building a standardized interface will enhance the portability and scalability of the FHIN, and of the RHIOs around the state.

By making medical records available to providers, the FHIN will offer physicians relevant information on patients that covers diagnoses, procedures, operations and frequency of hospitalizations, among other information. The FHIN should serve as the technical model to drive the diffusion of electronic medical records and the integration of electronic health records to physicians across Florida.

During the 2006 legislative session, the Legislature endorsed the concept of the Florida Health Information Network in HB 7073, by requiring the Agency to develop and implement a strategy for the "development of an electronic health information network for the sharing of electronic health records among health care facilities, health care providers, and health insurers" (s 408.05 (5) F.S.). The Legislature further charged the Agency with initiating the "integration of health care data from each state agency that collects, stores, and reports on health care issues and make that data available to any health care practitioner through a state health information network" (s. 408.05 (4) 9 (c) F.S.). From this legislation, it seems clear that there is support for the development of the FHIN from the highest level of leadership in Florida.

**Regional Health Information Organizations**

Regional health information organizations (RHIOs) play an important role both as community "umbrella" organizations that bring health care stakeholders together and as network intermediaries between the providers in the local community and the FHIN. RHIOs take on the responsibility of bringing providers together for the purpose of sharing health care data and integrating their disparate computer systems into a health care data network that can pass

medical records among all participants. The function of the RHIO is to work in the local community as a governing body, developing common policies, common security and privacy infrastructures and a sustainable business model for health information exchange.

In Florida, the development of RHIOs accelerated in CY 2005, with four not-for-profit corporations organizing as RHIOs, all of them working with a core of health care professionals. An issue of critical importance for RHIOs is the location, accessibility and integration of medical records. Most providers maintain their own patient records but an orientation toward data-sharing must be fostered by each RHIO. Each RHIO will provide access to patient records held by providers in other RHIOs via the overarching connection of the FHIN infrastructure. The FHIN will provide statewide connectivity, but the RHIOs are responsible for working at the local level with providers, laboratories, radiology labs, clinics and administrators at all levels. The RHIOs will work with the FHIN to create a seamless health care information network across the state that is accessible to every provider and benefits all

During the CY 2005 legislative session, the Legislature provided $1.5 million to AHCA for developing a funding mechanism to support pilot projects in health information exchange. The Florida Center for Health Information and Policy Analysis (Florida Center) developed a grants program designed to foster the formation of RHIOs across Florida. The FHIN Grants Program provides matching support to eligible organizations that endeavor to advance Florida's health information infrastructure consistent with program objectives as authorized by Chapter ch_2005-070.pdf, Laws of Florida and the Legislative Budget Commission, subject to the availability of funds.

The program provides grants to health-related institutions and organizations that seek assistance to plan, deploy, and evaluate interoperable health information exchange projects in clinical settings. The goal of the program is to implement a health information exchange that crosses the organizational boundaries of multiple providers. Funded projects must include health information exchange among two or more competing provider organizations and demonstrate the sharing of health information for purposes of patient care and public health. A second objective of the FHIN grants program is to increase the number of practitioners who use electronic health records systems and who participate in health information exchange. The program thus provides grants to organizations that wish to implement outreach and technical assistance activities to encourage the rapid adoption of electronic health records by physicians and other practitioners.

The FHIN Grants Program supports three types of grant categories: assessment and planning, operations and evaluation and training grants.

The planning grants support activities that underlie RHIO development by requiring grantees to engage appropriate health care stakeholders, analyze problems that the health exchange project will address, assess the resources required to maintain the health information exchange and an approach for sustaining the new information environment, gain support from the appropriate leaders in key stakeholder organizations who will be responsible for implementing the plan and develop a work plan listing steps that will lead from the current state to the desired information environment.

Operations grants support the implementation and evaluation of health information exchange projects. Applicants must submit a comprehensive plan for implementing a health information exchange, similar to the final report that would result from a planning grant. The grantees are required to implement and operate a health information exchange that passes health care records between at least two competing facilities before the end of the grant period. The training grants support practitioner training and technical assistance activities designed to increase

physician use of electronic health record systems in primary care, office-based settings. It supports continuing medical education programs offered by professional medical associations on the application of health information technology in patient care and public health.

The FHIN Grants program was announced in September, 2005, and resulted in fifteen projects that submitted proposals for planning, implementation or training grants. After reviewing the proposals and listening to presentations, the Board recommended nine of the projects for funding. These included five planning projects, three implementation grants and one training grant. The three operational health information exchange projects funded by the FHIN Grants Program were representative of a broad range of stakeholders and geographic location. The operational grantees included:

1. The Big Bend Regional Healthcare Information Organization facilitated the exchange of patient data across multiple health care providers in the Florida Big Bend area by implementing and operating a regional health information network. Project participants currently utilize sophisticated electronic medical record systems. Project partners included Capital Health Plan, Capital Regional Medical Center, KWB Pathology Associates, Radiology Associates of Tallahassee, Tallahassee Memorial Healthcare, Southern Medical Group, Tallahassee Ear Nose and Throat, and Vascular Surgery Associates.

2. The Tampa Bay RHIO created new technical and clinical pathways to improve the quality and availability of health information targeting persons with three specific diseases – adult diabetes, pediatric asthma, and prostate cancer. The project conducted formal electronic clinical data exchange among Tampa General Hospital, All Children's Hospital, H. Lee Moffitt Cancer Research Hospital, participating Medicaid physicians, and other providers. The formation of the Tampa Bay Regional Health Information Organization (Tampa Bay RHIO) is the result of a year long planning effort of the Tampa Bay Partnership Regional Research and Education Foundation, Inc., in collaboration with The University of South Florida Health Colleges of Medicine, Public Health, and Nursing, and more than a dozen public and private health care, government and private business organizations.

3. The Palm Beach County Community Health Alliance and the Health Care District of Palm Beach County implemented and evaluated a shared electronic health record model for record sharing among a core group of safety net providers in Palm Beach County. The Alliance is composed of a total of 33 public and private entities, including Glades General Hospital, C.L. Brumback Federally Qualified Health Center, and other safety net health and mental health providers. The first phase of the project developed an All-Care interface for Glades General Hospital and C.L. Brumback physicians to exchange and view data from both locations.

   During the CY 2006 legislative session, the Legislature appropriated $2 million for the FHIN Grants Program for FY 2006-2007. Upon announcing the grant, the Agency received 20 proposals, worth $6 million. Again, after reviewing the proposals and presentations, the Board was faced with a very difficult funding decision. Seven Operations and Evaluation proposals were offered funding, including projects in Pensacola, Tallahassee, Jacksonville, Amelia Island, Tampa, Palm Beach and Miami.

   The Legislature also passed HB 7073, which gave the Agency the authority to “administer, manage, and monitor grants to not-for-profit organizations, regional health information organizations, public health departments, or state agencies that submit proposals for planning, implementation, or training projects to advance the development of a health information network” (s. 408.05 (4) 9 (b) F.S.). Through this action, the Legislature endorsed

the FHIN Grants Program, and created an institution that will play a pivotal role in the development of a statewide health information network

Through the efforts of Governor Bush, the Legislature and the Board, Florida's health information infrastructure initiative has achieved a scope of stakeholder involvement that includes hospitals, physician groups, clinics, laboratories, payors, community health centers, county health departments and other stakeholders. All of these health care organizations will be integrated into the statewide network through the efforts of the local RHIOs and by the development of the Florida Health Information Network.

**Privacy and Security Project**

In May 2006, Florida became one of over 30 states and territories to join a national collaborative effort to examine current privacy and security policies, regulations and business practices related to health information exchange. The Privacy and Security Project is a partnership with the Office of the National Coordinator for Health Information Technology, the Agency for Healthcare Research and Quality, RTI International, the National Governors Association, and individual states. It will provide a foundation to guide State policy and enable Florida's participation in the national agenda for the creation of a Nationwide Health Information Network.

The Agency has identified highly skilled, knowledgeable, and experienced health care stakeholders, community leaders, and advocates from the private and public sector to participate in the project as work group members. Members include individuals that have been selected based on their involvement in the health information technology initiatives at the state, regional, and national level.

The Privacy and Security Project will conclude in March 2007, and the end product will be presented to a state and national audience. Two reports will be issued. The Final Assessment and Analysis Report will contain as assessment of current conditions and propose a range of workable solutions to address privacy and security concerns. The Final State Implementation Plan Report will make recommendations for methods to advance health information exchange in a privacy-protected and secure manner and for ongoing governance.

The Governor's Health Information Infrastructure Advisory Board leads the project in Florida as the Steering Committee. The National Conference of Commissions of Uniform State Laws in monitoring the project in Florida as part of its national assessment of variations in law across the states.

# 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 |
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| 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 | Describe Substantive Legislative Action Required to Support Changes |
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| 1 | Expansion of Technical Assistance | 408.05 (4), F.S. | The Florida Center 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. |
| 2 | Establish Florida Health Information Network (FHIN) Corporation | Create new Section 408.064 F.S. | The Agency shall implement plan for a statewide health information network. | The Agency shall contract with FHIN Corporation to implement plan. | Statutorily create FHIN Corporation, the composition of its Board of Directors, and its purpose and duties. |

# List of All Task Forces and Studies in Progress

| Number | Bill Cite | Ongoing Task Forces and Studies Required by Legislation | Division Assigned |
|---|---|---|---|
| 1. | N/A | The Agency is participating as a State subcontractor in a national study to develop recommendation for ensuring the privacy and security of electronic health records. | Chief Medical Officer |
| 2. | 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 Medical Officer |
| 3. | 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, | Chief Medical Officer |

| Number | Bill Cite | Ongoing Task Forces and Studies Required by Legislation | Division Assigned |
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| | | 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. | |
| 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 January 1, 2006, for the reporting of infection rates. | Chief Medical Officer |
| 5. | 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 Medical Officer |

| Number | Bill Cite | Ongoing Task Forces and Studies Required by Legislation | Division Assigned |
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| 6. | HB-1629 Web Page | The Agency shall adopt nationally recognized risk adjustment methodologies or software consistent with the standards of the Agency for Healthcare Research and Quality and as selected by the Agency for all data submitted as required by this section. | Chief Medical Officer |
| 7. | HB-1629 Web Page | Mandates the collection of a statistically valid sample of data on retail prices charged by pharmacies for the 50 most frequently prescribed medicines as a special study authorized by the Legislature to be performed by the Agency quarterly. The Agency shall make available on its Internet website for each pharmacy, no later than October 1, 2005, drug prices for a 30-day supply at a standard dose. | Chief Medical Officer |
| 8. | HB-1629 Web Page | Mandates monitoring and assessment of the use of emergency department services by patient acuity level and the implication of increasing hospital cost by providing non-urgent care in emergency departments. The Agency shall submit an annual report based on this monitoring and assessment to the Governor, the Speaker of the House of Representatives, the President of the Senate, and the substantive legislative committees with the first report due January 1, 2006. | Chief Medical Officer |
| 9. | HB-1629 Web Page | Directs the Agency to develop and implement a strategy for the adoption and use of electronic health records. Authorizes the Agency to develop rules to facilitate the functionality and protect the confidentiality of electronic health records. Requires the Agency to report to the Governor, the Speaker of the House of Representatives, and the President of the Senate on legislative recommendations to protect the confidentiality of electronic health records. | Chief Medical Officer |
| 10. | HB-1629 Web Page | Requires the State Center for Health Statistics in conjunction with the State Comprehensive Health Information System Advisory Council, to develop | Chief Medical Officer |

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| | | and implement a long-range plan for making available performance outcome and financial data that will allow consumers to compare health care services. The Agency must submit the initial plan to the Governor and the Legislature by March 1, 2005, followed by an update annually. The Agency shall make the plan and status report available to the public on its Internet website. The specified performance outcomes and patient charge data shall be released no later than March 1, 2005. *Further detail: Language outlines various mandated inclusions in the plan and describes elements which may be included and/or considered in the determination of which performance outcomes to be disclosed.* | |
| 11. | HB-1629 Web Page | Requires the Agency to publish performance measures, benefit design, and health plan premium cost data for all insurers licensed pursuant to chapter 627 and 641, Florida Statutes. Other data that may be collected includes membership satisfaction, quality of care, coverage areas, accreditation status, co-pays and deductibles. The council must provide input into all decisions regarding the publication of this data. The data must be released no later than March 1, 2006. | Chief Medical Officer |
| 12. | HB-1629 Web Page | Amends 408.062 to add coordination with OIR in the study of the availability and affordability of health insurance for small businesses. | Chief Medical Officer |
| 13. | HB-1629 Web Page | Statutory language amended to read as follows: "may" changed to "shall". (a) Data submitted by health care facilities, including the facilities as defined in chapter 395, SHALL include, but are not limited to: case-mix data, patient admission discharge data, hospital emergency department data which shall include the number of patients treated in the emergency department of a licensed hospital reported by patient acuity level, data on hospital-acquired infections as specified by rule, data on complications as specified by rule, data on readmissions as specified by rule. | Chief Medical Officer |
| 14. | HB-1629 Web Page | Statutory language amended to change "may" to "shall": The agency SHALL conduct data-based studies and evaluations and make recommendations to the Legislature and the Governor concerning exemptions, the effectiveness of limitations of referrals, restrictions on investment interests and compensation arrangements, and the effectiveness of public disclosure. Such analysis SHALL include, but need not be limited to, utilization of services, cost of care, quality of care, and access to care. The agency may require the | Chief Medical Officer |

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| | | submission of data necessary to carry out this duty, which may include, but need not be limited to, data concerning ownership, Medicare and Medicaid, charity care, types of services offered to patients, revenues and expenses, patient-encounter data, and other data reasonably necessary to study utilization patterns and the impact of health care provider ownership interests in healthcare- related entities on the cost, quality, and accessibility of health care. | |
| 15. | HB-7073<br>Web Page<br>Lines 47-55 | S. 408.05 F.S., Florida Center for Health Information and Policy Analysis -The agency shall establish a Florida Center for Health Information and Policy Analysis. The center shall establish a comprehensive health information system to provide for the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of both purposefully collected and extant health-related data and statistics | Chief Medical Officer |
| 16. | HB-7073<br>Web Page<br>Lines 60-91 | The comprehensive health information system operated by the Florida Center<br>for Health Information and Policy Analysis shall identify the best available data sources and coordinate the compilation of extant health-related data and statistics and purposefully collect data on:<br>(a) The extent and nature of illness and disability of the state population, including life expectancy, the incidence of various acute and chronic illnesses, and infant and maternal morbidity and mortality.<br>(b) The impact of illness and disability of the state population on the state economy and on other aspects of the well-being of the people in this state.<br>(c) Environmental, social, and other health hazards.<br>(d) Health knowledge and practices of the people in this state and determinants of health and nutritional practices and status.<br>(e) Health resources, including physicians, dentists, nurses, and other health professionals, by specialty and type of practice and acute, long-term care and other institutional care facility supplies and specific services provided by hospitals, nursing homes, home health agencies, and other health care facilities.<br>(f) Utilization of health care by type of provider.<br>(g) Health care costs and financing, including trends in health care prices and costs, the | Chief Medical Officer |

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| | | sources of payment for health care services, and federal, state, and local expenditures for health care.<br>(h) Family formation, growth, and dissolution.<br>(i) The extent of public and private health insurance coverage in this state.<br>(j) The quality of care provided by various health care providers. | |

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| 17. | HB-7073<br>Web Page<br>Line 92-157 | In order to produce comparable and uniform health information and statistics for the development of policy recommendations, the agency shall perform the following functions:<br>(a) Coordinate the activities of state agencies involved in the design and implementation of the comprehensive health information system.<br>(b) Undertake research, development, and evaluation respecting the comprehensive health information system.<br>(c) Review the statistical activities of state agencies to ensure that they are consistent with the comprehensive health information system.<br>(d) Develop written agreements with local, state, and federal agencies for the sharing of health-care-related data or using the facilities and services of such agencies. State agencies, local health councils, and other agencies under state in obtaining, compiling, and transferring health-care-related data maintained by state and local agencies. Written agreements must specify the types, methods, and periodicity of data exchanges and specify the types of data that will be transferred collected, compiled, processed, used, or shared. Decisions regarding center data sets should be made based on consultation with the State Consumer Health Information and Policy Advisory Council and other public and private users regarding the types of data which should be collected and their uses.<br>(e)The center shall establish standardized means for collecting health information and statistics under laws and rules administered by the agency.<br>(f) Establish minimum health-care-related data sets which are necessary on a continuing basis to fulfill the collection requirements of the center and which shall be used by state agencies in collecting and compiling health-care-related data. The agency shall periodically review ongoing health care data collections of the Department of Health and other state agencies to determine if the collections are being conducted in accordance with the established minimum sets of data.<br>(g) Establish advisory standards to ensure the quality of health statistical and epidemiological data collection, processing, and analysis by local, state, and private organizations.<br>(h) Prescribe standards for the publication of health- care-related data reported pursuant to this section which ensure the reporting of accurate, | Chief Medical Officer |

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| | | valid, reliable, complete, and comparable data. Such standards should include advisory warnings to users of the data regarding the status and quality of any data reported by or available from the center.<br>(i) Prescribe standards for the maintenance and preservation of the center's data. This should include methods for archiving data, retrieval of archived data, and data editing maintained for the dissemination of data through publications,<br>(k) Develop, in conjunction with the State Consumer Council, and implement a long-range plan for making available data that will allow consumers to compare health care services. 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. | |
| 18. | HB-7073 Web Page Lines 239-290 | (4) TECHNICAL ASSISTANCE.-- (a) The center shall provide technical assistance to persons or organizations engaged in health planning activities in the effective use of statistics collected and compiled by the center. The center shall also provide the following additional technical assistance services:<br>1. Establish procedures identifying the circumstances under which, the places at which, the persons from whom, and the methods by which a person may secure data from the center, including procedures governing requests, the ordering of requests, timeframes for handling requests, and other procedures necessary to facilitate the use of the center's data. To the extent possible, the center should provide current data timely in response to requests from public or private agencies, statistical interpretation, and data access to promote improved health-care-related data sets.<br>3. Identify health care data gaps and provide technical private organizations for meeting documented health care data needs.<br>4. Assist other organizations in developing statistical abstracts of their data sets that could be used by the center.<br>5. Provide statistical support to state agencies with regard to the use of databases maintained by the center.<br><br>6. To the extent possible, respond to multiple requests for information not currently collected by | Chief Medical Officer |

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| | | the center or available from other sources by initiating data collection.<br>7. Maintain detailed information on data maintained by other local, state, federal, and private agencies in order to which are requested but which are not available from the center.<br>8. Respond to requests for data which are not available in published form by initiating special computer runs on data sets available to the center.<br>9. Monitor innovations in health information technology, informatics, and the exchange of health information and maintain a repository of technical resources to support the development<br>of a health information network.<br>information organizations, public health departments, or state agencies that submit proposals for planning, implementation, or ensure the effective outcome of the health information project.<br>(c) The agency shall initiate, oversee, manage, and evaluate the integration of health care data from each state agency that collects, stores, and reports on health care issues<br>and make that data available to any health care practitioner through a state health information network. | |
| 19. | HB-7073<br>Web Page<br>Lines 291-328 | 5) PUBLICATIONS; REPORTS; SPECIAL STUDIES.--The center shall provide for the widespread dissemination of data which it collects and analyzes. The center shall have the following publication, reporting, and special study functions:<br>(a) The center shall publish and make available periodically to agencies and individuals health statistics publications of general interest, including health plan consumer reports and health maintenance organization member satisfaction provide health status profiles of the people in this state; and other topical health statistics publications.<br>(b) The center shall publish, make available, and disseminate, promptly and as widely as practicable, the results of special health surveys, health care research, and health care evaluations conducted or supported under this section. Any publication by the center must include a statement of the limitations on the quality, accuracy, and completeness of the data.<br>(c) The center shall provide indexing, abstracting, translation, publication, and other services leading to a more effective and timely dissemination of | Chief Medical Officer |

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| | | health care statistics.<br>(d) The center shall be responsible for publishing and disseminating an annual report on the center's activities.<br>(e) The center shall be responsible, to the extent studies and surveys to expand the health care information and statistics available for health policy analyses, particularly for the review of public policy issues. The center shall develop a process by which users of the center's data are periodically surveyed regarding critical data needs and the results of the survey considered in determining which special surveys or studies will be conducted. The center shall select problems in health care for research, policy analyses, or special data collections on the basis of their local, regional, or state importance; the unique potential for definitive research on the problem; and opportunities for application of the study findings. | |
| 20. | HB-7073 Web Page Lines 361-372 | (8) STATE CONSUMER HEALTH INFORMATION ANDPOLICY ADVISORY COUNCIL.--<br>(a) There is established in the agency the State Consumer Council to assist the center in reviewing the comprehensive health information system, including the identification, collection, standardization, sharing, and coordination of health-related data, fraud and abuse data, and professional and facility licensing data among federal, state, local, and private entities and to recommend improvements for purposes of public health, policy analysis, and transparency of consumer health care information | Chief Medical Officer |
| 21. | HB-7073 Web Page Lines 478-524 | 408.062 Research, analyses, studies, and reports.--<br>(1) The agency shall conduct research, analyses, and studies relating to health care costs and access to and quality of health care services as access and quality are affected by changes in health care costs. Such research, analyses, and studies shall include, but not be limited to:<br>(h) The collection of a statistically valid sample of data on the retail prices charged by pharmacies for the 100 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 | Chief Medical Officer |

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| | | is the equivalent shall be reported. The agency shall make available on its Internet website for each pharmacy, no later than October 1, 2006, 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 and updated quarterly.<br>(j) The making available on its Internet website beginning no later than October 1, 2004, and in a hard-copy format upon request, of patient charge, volumes, length of stay, and performance indicators collected from health care facilities pursuant to s. 408.061(1)(a) for specific medical conditions, surgeries, and procedures provided in inpatient and outpatient facilities as determined by the agency. In making the determination of specific medical conditions, surgeries, and procedures to include, the agency shall consider such factors as volume, severity of the illness, urgency of admission, individual and societal costs, and whether the condition is acute or chronic. Performance outcome indicators shall be risk adjusted or severity adjusted, as applicable, using nationally recognized risk adjustment methodologies or software consistent with the standards of the Agency for Healthcare Research and Quality and as selected by the agency. The website shall also provide an interactive search that allows consumers to view and compare the information for specific facilities, a map that allows consumers to select a county or region, definitions of all of the data, descriptions of each procedure, and an explanation about why the data may differ from facility to facility. Such public data shall be updated quarterly. The agency shall submit an annual status report on the collection of data and publication of health care quality measures to the Governor, the Speaker of the House of Representatives, the President of the Senate, and the substantive legislative committees with the first status report due January 1, 2005. | |
| 22. | HB-7073 Web Page Lines 441-451 | (5) The agency shall develop and implement a strategy for the adoption and use of electronic health records, including the development of an electronic health information network for the sharing of electronic health records among health care facilities, health care providers, and health insurers. The agency may develop rules to facilitate the functionality and protect the confidentiality of electronic health records. The agency shall report to the Governor, the Speaker of | Chief Medical Officer |

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| | | the House of Representatives, and the President of the Senate on legislative recommendations to protect the confidentiality of electronic health records. | |

## 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 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-11 | FY 2011-12 |
|---|---|---|---|---|---|
| $16,674,293 Actual Collections | $21,857,422 | $23,387,442 | $25,024,562 | $26,776,282 | $28,650,622 |
| Percent of Projection Increase | 7% | 7% | 7% | 7% | 7% |

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. The Office of the Inspector General is hoping to increase these collections by a minimum of seven percent annually.

## Linkage of Agency Goals and Programs to Governor's Priorities

| | Governor's Priorities and Goals | Name of Agency Goals and/or Programs |
|---|---|---|
| 1. | Provide a Quality Education | |
| 2. | Growing the Economy | |
| 3. | Strengthening Florida's Families | |
| 4. | Building Better Communities | |
| 5. | Improving Healthcare | **Goal 4**: To combat fraud, waste and abuse in the Florida Medicaid Program |
| 6. | Protecting the Environment | **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." Additionally, the federal government implemented more oversight of the Medicaid Integrity Program (MIP) with the passing of the Deficit Reduction Act of 2005 with funding that will rise from $5 million in 2007 to $75 million in fiscal year 2009 and each year thereafter. The new MIP, as instituted by the Centers for Medicare and Medicaid Services (CMS), will be based on four key principles: 1) National leadership in the Medicaid program integrity; 2) Accountability for the program's own activities and those of its contractors and the states; 3) Collaboration with internal and external partners and stakeholders; and, 4) Flexibility to address the ever-changing nature of Medicaid fraud.

# 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 2011-12, 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 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-11 | FY 2011-12 |
|---|---|---|---|---|---|
| 6234<br><br>Number of correspondence pieces tracked by the Agency's correspondence Unit | 6358 | 6485 | 6615 | 6747 | 6881 |
| 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 2006-07 | FY 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-11 | FY 2011-12 |
|---|---|---|---|---|---|
| 3215<br><br>Number of Public Records Requests tracked through the Agency. | 3279 | 3344 | 3411 | 3480 | 3549 |
| Annual percent of increase | 2% | 2% | 2% | 2% | 2% |

Fiscal Year 2005-2006 reflected the complete fade out of Third Party Liability assignments. There were 4710 TPL assignments for FY 04-05 and 227 for FY 05-06. The Public Records office also changed the policy for tracking facility complaints which do not actually request documents. They are now forwarded directly to the Health and Quality Assurance office for handling. As always, factors outside of the Agency's control strongly impact the number of requests received by the Agency. This may have contributed to the decrease in requests tracked this fiscal year. Such factors may include changes in law or the increasing amount of information available electronically.

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

| Baseline/Year FY 2003-04 | FY 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-11 | FY 20011-12 |
|---|---|---|---|---|---|
| 489<br><br>Number of Constituent and Legislative Inquiries handled by the Legislative Affairs Office. | 498 | 508 | 518 | 529 | 539 |
| 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 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-11 | FY 2011-12 |
|---|---|---|---|---|---|
| 394<br><br>Number of Legislative Bills tracked & analyzed | 401 | 409 | 418 | 426 | 435 |
| 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.

**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 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-11 | FY 2011-12 |
|---|---|---|---|---|---|
| 941<br><br>Number of phone contacts received by the Communication Office from Media Representatives | 959 | 979 | 998 | 1018 | 1038 |
| Annual percent of increase | 2% | 2% | 2% | 2% | 2% |

Please note that factors outside of Agency control strongly impact the number of media contacts 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 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 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-11 | FY 2011-12 |
|---|---|---|---|---|---|
| 1,178<br><br>Number of design and production jobs completed by Multimedia Unit | 1,201 | 1,225 | 1,250 | 1,275 | 1,300 |
| Annual percent of increase | 2% | 2% | 2% | 2% | 2% |

Please note that factors outside of Agency control strongly impact the number of design and production jobs 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.

# Linkage of Agency Goals and Programs to Governor's Priorities

| | Governor's Priorities and Goals | Name of Agency Goals and/or Programs |
|---|---|---|
| 1. | Provide a Quality 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. | Growing the Economy | |
| 3. | Strengthening Florida's Families | |
| 4. | Building Better Communities | |
| 5. | Improving Healthcare | |
| 6. | Protecting the Environment | **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 issue 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:** .....**Page**

# LRPP Exhibit I: Agency Workforce Plan

| Fiscal Years | Total FTE Reductions | Description of Reduction Issue | Positions per Issue | Impact of Reduction |
|---|---|---|---|---|
| FY 2007 -2008 | | N/A | | |
| | | | | |
| | | | | |
| | | | | |
| FY 2008-2009 | | N/A | | |
| | | | | |
| | | | | |
| | | | | |
| **Total*** | **0** | | | |

*to equal remainder of target

## 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 2005-06 (Numbers) | Prior Year Actual FY 2005-06 (Numbers) | Approved Standards for FY 2006-07 (Numbers) | Requested FY 2007-08 Standard (Numbers) |
|---|---|---|---|---|
| Administrative costs as a percent of total agency costs | 0.11% | 0.11% | 0.11% | 0.11% |
| Administrative positions as a percent of total agency positions | 11.45% | 11.29% | 11.45% | 11.45% |

68500000 Program: Health Care Services

68500100 Children's Special Health Care

| Approved Performance Measures (Words) | Approved Prior Year Standards FY 2005-06 (Numbers) | Prior Year Actual FY 2005-06 (Numbers) | Approved Standards for FY 2006-07 (Numbers) | Requested FY 2007-08 Standard (Numbers) |
|---|---|---|---|---|
| Percent of hospitalizations for conditions preventable by good ambulatory care | 7.7% | 8.3% | 7.7% | 7.7% |
| Percent of eligible uninsured children receiving health benefits coverage | 100% | 87.9%[1] | 100% | 100% |
| Percent of children enrolled with up-to-date immunizations | 85% | 80% | 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% | 83% | 97% | 97% |

[1] Reporting FY 2004-05 as more current information is not yet available

| | | | | |
|---|---|---|---|---|
| Percent of families satisfied with the care provided under the program | 90% | 84% | 95% | 90% |
| Total number of uninsured children enrolled in Kidcare | 351,301 | 190,493 | | |
| Total number of Title XXI-eligible children enrolled in Kidcare | | | 228,159 | 230,439 |
| Number of uninsured children enrolled in Florida Healthy Kids | 306,444 | 163,991 | | |
| Number of Title XXI-eligible children enrolled in Florida Healthy Kids | | | 195,867 | 197,825 |
| Number of uninsured children enrolled in Medikids | 34,804 | 16,653 | | |
| Number of Title XXI-eligible children enrolled in Medikids | | | 21,000 | 21,210 |
| Number of uninsured children enrolled in Children's Medical Services Network | 10,053 | 8,616 | | |
| Number of Title XXI-eligible children enrolled in Children's Medical Services Network | | | 11,292 | 11,404 |

| |
|---|
| 68500200 Executive Direction and Support Services |

| Approved Performance Measures (Words) | Approved Prior Year Standards FY 2005-06 (Numbers) | Prior Year Actual FY 2005-06 (Numbers) | Approved Standards for FY 2006-07 (Numbers) | Requested FY 2007-08 Standard (Numbers) |
|---|---|---|---|---|
| Program administrative costs as a percent of total program costs | 1.44% | 1.38% | 1.44% | 1.44% |
| Average number of days between receipt of clean Medicaid claim and payment | 15 | 6.8 | 15 | 15 |
| Number of Medicaid claims received | 145,101,035 | 143,742,532 | 145,101,035 | 145,101,035 |

| |
|---|
| 68501400 Medicaid Services to Individuals |

| Approved Performance Measures (Words) | Approved Prior Year Standards FY 2005-06 (Numbers) | Prior Year Actual FY 2005-06 (Numbers) | Approved Standards for FY 2006-07 (Numbers) | Requested FY 2007-08 Standard (Numbers) |
|---|---|---|---|---|
| Percent of hospitalizations that are preventable by good ambulatory care | 11% | 10.8% | 11% | 11% |
| Percent of women receiving adequate prenatal care | 86% | 83.4% | 86% | 86% |
| Neonatal mortality rate per 1000 | 4.7 | 5.4 | 4.7 | 4.7 |
| Average number of months between pregnancies for those receiving family planning services | 35 | 36.5 | 35 | 35 |
| Percent of eligible children who received all required components of EPSDT screen | 64% | 59% | 64% | 64% |
| Number of children ages 1-20 enrolled in Medicaid | 1,590,866 | 1,333,705 | 1,249,276 | 1,467,076 |
| Number of children receiving EPSDT services | 407,052 | 367,762 | 407,052 | 404,538 |
| Number of hospital inpatient services provided to children | 92,960 | 108,908 | 92,960 | 119,799 |
| Number of physician services provided to children | 6,457,900 | 7,243,494 | 6,457,900 | 7,967,843 |
| Number of prescribed drugs provided to children | 4,444,636 | 5,287,741 | 4,444,636 | 5,816,515 |
| Number of hospital inpatient services provided to elders | 100,808 | 111,362 | 100,808 | 122,498 |
| Number of physician services provided to elders | 1,436,160 | 793,731 | 1,436,160 | 873,140 |
| Number of prescribed drugs provided to elders | 15,214,293 | 8,530,951 | 15,214,293 | 1,595,668 |
| Number of uninsured children enrolled in the Medicaid Expansion | 3,529 | 1,234 | 1,227 | 1,357 |

| |
|---|
| 68501500 Medicaid Long Term Care |

| Approved Performance Measures (Words) | Approved Prior Year Standards FY 2005-06 (Numbers) | Prior Year Actual FY 2005-06 (Numbers) | Approved Standards for FY 2006-07 (Numbers) | Requested FY 2007-08 Standard (Numbers) |
|---|---|---|---|---|
| Percent of hospitalizations for conditions preventable with good ambulatory care | 12.60% | 10.10% | 12.60% | 12.60% |
| Number of case months (home and community-based services) | 550,436 | 571,710 | 550,436 | 628,881 |
| Number of case months services purchased (Nursing Home) | 619,387 | 565,140 | 619,387 | 595,816 |

| |
|---|
| 68501600 Medicaid Prepaid Health Plan |

| Approved Performance Measures (Words) | Approved Prior Year Standards FY 2005-06 (Numbers) | Prior Year Actual FY 2005-06 (Numbers) | Approved Standards for FY 2006-07 (Numbers) | Requested FY 2007-08 Standard (Numbers) |
|---|---|---|---|---|
| Percent of hospitalizations for conditions preventable by good ambulatory care | 13% | 11.23% | 16% | 13% |
| Percent of women and child hospitalizations for conditions preventable with good ambulatory care | 14.50% | 14.62% | 16.00% | 16.00% |
| Number of case months services purchased (elderly and disabled) | 1,877,040 | 1,446,160 | 1,877,040 | 1,590,776 |
| Number of case months services purchased (families) | 9,396,828 | 7,782,608 | 9,850,224 | 8,560,869 |

| 68700000 Program: Health Care Regulation |
|---|
| 68700700 Health Care Regulation |

| Approved Performance Measures (Words) | Approved Prior Year Standards FY 2005-06 (Numbers) | Prior Year Actual FY 2005-06 (Numbers) | Approved Standards for FY 2006-07 (Numbers) | Requested FY 2007-08 Standard (Numbers) |
|---|---|---|---|---|
| Percent of nursing home facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public | 0% | 2.38% | 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% | 98.55% | 100% | 100% |
| Percent of accredited hospitals and ambulatory surgical centers cited for not complying with life safety, licensure, or emergency access standards | 25% | 24.67% | 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% | 1.06% | 0% | 0% |
| Percent of home health facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public | 0% | 0.13% | 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% | 0.55% | 0% | 0% |
| Percent of hospitals with deficiencies that pose a serious threat to the health, safety, or welfare of the public | 0% | 2.16% | 0% | 0% |
| Percent of hospitals that fail to report serious incidents (agency identified) | 6% | 4.69% | 6% | 6% |

| | | | | |
|---|---|---|---|---|
| *Percent of new Medicaid beneficiaries voluntarily selecting managed care plan | 50% | 47.84% | 50% | 50% |
| Percent of complaints of HMO patient dumping received that are investigated | 100% | 100% | 100% | 100% |
| Percent of complaints of facility patient dumping received that are investigated | 100% | 100% | 100% | 100% |
| Number of inquiries to the call center regarding practitioner licensure and disciplinary information | 30,000 | 17,593 | 30,000 | 30,000 |
| Total number of full facility quality-of-care surveys conducted | 7,550 | 7,512 | 7,550 | 7,550 |
| Average processing time (in days) for Subscriber Assistance Program cases. | 53 | 31 | 53 | 53 |
| Number of construction reviews performed (plans and construction) | 4,500 | 4,535 | 4,500 | 4,500 |
| *Number of new enrollees provided with choice counseling | 520,000 | 487,089 | 520,000 | 520,000 |

*The ACT7150 segment of program component 1205.02.00.00 will be transferred from the Division of Quality Assurance to the Medicaid Program Office in FY 07-08.

## 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 ☐ 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 |
|---|---|---|---|
| 7.7% | 8.3% | 0.6% | 7.79% |

**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:** Performance has improved from the previous fiscal year, and initiatives are underway to contract new disease management services to further reduce physical and racial/ethnic/cultural barriers that impact access to primary care. These new initiatives are not yet in place or have not had time to fully develop to realize their full effectiveness.

**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:** Findings for FY 2005-06 are based on data from FY 2003-04. Florida was impacted by several hurricanes during this time frame that may have limited access to necessary primary care services, or have exacerbated conditions due to increased health hazards that may not, under normal circumstances, have required hospitalization.

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

**Recommendations:** The Agency will continue to develop new disease management initiatives to overcome barriers to care, and will continue to emphasize the program enhancements that will be derived from reform and increased emphasis on consumer-driven care.

*Office of Policy and Budget – July 2006*

# 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 ☐ 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 |
|---|---|---|---|
| 100% | 87.9%[1] | (12.1%) | (12.1%) |

**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:** This is the reported result from the previous fiscal year since current information is not yet available. This measure is based on estimates with large margins for error, so changes in the methodology have been requested.

**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:** KidCare endured many recent changes which have presented challenges to enrollment and outreach efforts.

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

**Recommendations:** Outreach efforts have been improved due to legislative change.

*Office of Policy and Budget – July 2006*

[1] Reporting FY 2004-05 as more current information is not yet available

# 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 ☐ 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 |
|---|---|---|---|
| 85% | 80% | (5%) | (5.9%) |

**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 Agency works closely with the Department of Health (DOH) and other professional associations/agencies on improving outreach to parents and guardians of children. Further, all appropriate Medicaid providers are made aware of the immunization standards.

**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:** Performance results are based on self-reported surveys from parents/ guardians of children. It is difficult for parents/guardians to accurately remember whether all shots are up to date. Further, DOH records show that over 94% of all children are compliant with guidelines at the time they enter kindergarten, despite the low percentages reported by parents. A vast majority of parents are compliant with common immunizations, such as the tetanus booster which had a compliance rate of 99%.

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

**Recommendations:** The Agency will continue to work with the Department of Health and the Florida Academy of Pediatricians to increase immunizations, including the collaboration on outreach efforts. Increased emphasis should be placed on the timely receipt of recommended immunizations since the majority of parents make sure their children are compliant when

mandated for school. In addition, Medicaid will continue to foster the environment of consumer driven care which will lead to a better understanding of the importance associated with up-to-date immunizations.

*Office of Policy and Budget – July 2006*

# 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 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.**

**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 |
|---|---|---|---|
| 97% | 83% | (14%) | (14%) |

**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:** Historically this percentage has been around 85%, due to factors largely outside the Agency's control (such as caregiver not having time to take off work unless the child is sick). The approved standard does not reflect historical information for this measure.

**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:** Compliance with well-checkup guidelines are largely the parent/guardian's responsibility. The given performance percentage is based on self-reported survey results from questionnaires directed to parents and guardians. Evidence suggests that a large percentage of parents do not realize they should have well-child visits. However, of those that do, more than 98% reported a qualifying checkup in the previous year.

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

**Recommendations:** The Agency should continue to focus on patient education and consumer directed care to underscore the importance of well-child visits. Many of the Reform proposals also will increase the incentives for plans/providers to advocate compliance as well as improve the compliance in recipients.

*Office of Policy and Budget – July 2006*

# 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 families satisfied with the care provided under the program**

**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 |
|---|---|---|---|
| 90% | 84% | (6%) | (6.6%) |

**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:**

**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:** According to the national CAHPS chart book, 90% of respondents regarding child healthcare rated their health plan as a 7 or better on a scale of 1 to 10, with 10 being best. The standard set for Florida requires that the State meet the standard of 90% for respondents rating the plan an 8 or higher and is therefore much more stringent than the national results. The 84% performance rating is actually consistent with other states on a national scale. In addition, these results may not reflect actual program performance as they are largely based on perceptions which include factors such as getting services, regardless of the medical necessity.

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

**Recommendations:** The Agency will continue its efforts in patient education and consumer directed care. As consumers take a greater part in their health care and health care decisions, overall satisfaction should increase.

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# 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 ☐ 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 |
|---|---|---|---|
| 351,301 | 190,493 | (160,808) | (45.7%) |

**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:**

**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:** Target enrollment decreased as a result of information presented at the Social Services Estimating Conference. Enrollment decreased over the last two years due to limited KidCare Outreach funding, income documentation requirements and employer-sponsored health insurance requirements.

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

**Recommendations:** $1 million allocated for a KidCare community-based marketing and outreach program.

*Office of Policy and Budget – July 2006*

## 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 ☐ 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 |
|---|---|---|---|
| 306,444 | 163,991 | (142,453) | (46.4%) |

**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:**

**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:** Target enrollment decreased as a result of information presented at the Social Services Estimating Conference. Enrollment decreased over the last two years due to limited KidCare Outreach funding, income documentation requirements and employer-sponsored health insurance requirements.

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

**Recommendations:** $1 million allocated for a KidCare community-based marketing and outreach program.

*Office of Policy and Budget – July 2006*

# 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 ☐ 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 |
|---|---|---|---|
| 34,804 | 16,653 | (18,151) | (52.1%) |

**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:**

**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:** Target enrollment decreased as a result of information presented at the Social Services Estimating Conference. Enrollment decreased over the last two years due to limited KidCare Outreach funding, income documentation requirements and employer-sponsored health insurance requirements.

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

**Recommendations:** $1 million allocated for a KidCare community-based marketing and outreach program.

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# 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 ☐ 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 |
|---|---|---|---|
| 10,053 | 8,616 | (1,437) | (14.3%) |

**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:**

**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:** Target enrollment decreased as a result of information presented at the Social Services Estimating Conference. Enrollment decreased over the last two years due to limited KidCare Outreach funding, income documentation requirements and employer-sponsored health insurance requirements.

**Management Efforts to Address Differences/Problems** (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
**Recommendations:** $1 million allocated for a KidCare community-based marketing and outreach program.

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# 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 women receiving adequate prenatal care**

**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 |
|---|---|---|---|
| 86% | 83.4% | (2.6%) | (3%) |

**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:**

**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:** Medicaid paid for more than 51% of all births in Florida in 2004. This is up from just under 44% in 2000. This increase in Medicaid births is coupled with an increase in the number of women entering Medicaid late in their pregnancies (i.e., with less than 180 days Medicaid coverage prior to giving birth). Finally, the Family Planning Waiver allowed women to enroll in Medicaid for pre-delivery care. Enrollment has been changed from a passive enrollment to active enrollment, which could potentially delay a woman's access to Medicaid services. Medicaid paid for more than 73% of all births to African-American women, who collectively have had poorer access to prenatal care and poorer birth outcomes.

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

**Recommendations:** Outreach needs to continue to stress the importance of prenatal care including provider visits. In addition, the Agency needs to explore racial and ethnic disparities in health care and develop tools to address those disparities.

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# 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 ☐ 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 |
|---|---|---|---|
| 4.7 | 5.4 | .7 | 14.9% |

**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:**

**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 rise in neo-natal mortality mirrors a national trend, but can also be directly linked to inadequacy of prenatal care and environmental factors, such as smoking during pregnancy and poor nutrition.

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

**Recommendations:** Outreach regarding the importance of prenatal care and the availability of public programs such as Medicaid and its Family Planning Waiver needs to be given emphasis.

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# 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 Child Health Check-up screen (EPSDT – federal)**

**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% | 59% | (5%) | (7.81%) |

**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:**

**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 was lower than the approved standard due to lower utilization rates than estimated.

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

**Recommendations:** Outreach needs to stress the importance of well-child care including screening and regular check-ups. In addition, the Agency should continue to explore avenues that reduce the barriers to patient compliance, either through enhanced education or through greater access to primary care services. Underlying causes of non-compliance should be explored to identify areas to target Agency objectives.

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# 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 children ages 1-20 enrolled in Medicaid**

**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 |
|---|---|---|---|
| 1,590,866 | 1,333,705 | (257,161) | (16%) |

**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:**

**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:** Actual figures are totaled as of the date of the report. All totals available 12/31/06.

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

**Recommendations:** More outreach is needed.

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# 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 children receiving Child Health Check-up services – (EPSDT - federal)

**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 |
|---|---|---|---|
| 407,052 | 367,762 | (39,290) | (9.6%) |

**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:**

**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 was lower than the approved standard due to lower utilization rates than estimated.

**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 Services**
**Service/Budget Entity:** **Medicaid Services to Individuals/68501400**
**Measure:** **Number of physician services provided to elders**

**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 |
|---|---|---|---|
| 1,436,160 | 793,731 | (642,429) | (44%) |

**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 decreased utilization of physician services.

**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:** There may be more home and community based programs being utilized.

**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 Services**
**Service/Budget Entity:** **Medicaid Services to Individuals/68501400**
**Measure:** **Number of prescribed drugs provided to elders**

**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 |
|---|---|---|---|
| 15,214,293 | 8,530,951 | (6,683,342) | (44%) |

**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:**

**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:** Reduction due in part to initiation of Medicare Part D.

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

**Recommendations:**

*Office of Policy and Budget – July 2006*

# 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 ☐ 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 |
|---|---|---|---|
| 3,529 | 1,234 | (2,295) | (65%) |

**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:**

**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 Medicaid Expansion group of infants under one year of age is processed as Medicaid applicants. This group is not subject to enrollment limitations. However, KidCare applications which are referred to Title XIX Medicaid decreased in FY 2004-05 resulting in less children becoming eligible for Medicaid.

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

**Recommendations:** The Agency will work with its partners to ensure enrollment is proceeding as authorized by the Legislature.

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# 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 ☐ 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 |
|---|---|---|---|
| 619,387 | 565,140 | (54,247) | (8.7%) |

**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:**

**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 Legislature has increased funding for diversion into the Home and Community-based waiver program, and provided additional staff to CARES.

**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 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% | 14.62% | (.12%) | (.83%) |

**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 is 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 ☐ 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 |
|---|---|---|---|
| 1,877,040 | 1,446,160 | (430,880) | (23%) |

**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:**

**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 was lower than the approved standard due to lower enrollment rates than estimated.

**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 Services**
**Service/Budget Entity:** **Medicaid Prepaid Health Plans/68501600**
**Measure:** **Number of case months services purchased (families)**

**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 |
|---|---|---|---|
| 9,396,828 | 7,782,608 | (1,614,220) | (17%) |

**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:**

**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 was lower than the approved standard due to lower enrollment rates than estimated.

**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 Quality Assurance**
**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 ☐ 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 |
|---|---|---|---|
| 0% | 2.38% | 2.38% | 2.38% |

**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:** 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 ☐ 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 Quality Assurance**
**Service/Budget Entity:** **Health Care Regulation/68700700**
**Measure:** **Percent of Priority I consumer complaints about licensed facilities and programs that are investigated within 48 hours.**

**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 |
|---|---|---|---|
| 100% | 98.55% | 1.45% | 1.45% |

**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:** Monitoring of compliance with time frames and area office accountability resulted in nearly 100% compliance with this measure. However, personnel changes and turnover had a small negative impact.

**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 Quality Assurance**
**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 ☐ 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 |
|---|---|---|---|
| 0% | 1.06% | 1.06% | 1.06% |

**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:** Amendments to s. 400.407, F.S. 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 expectation.

**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 Quality Assurance**
**Service/Budget Entity:** **Health Care Regulation/68700700**
**Measure:** **Percent of home health facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public.**

☒ 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 |
|---|---|---|---|
| 0% | 0.13% | 0.13% | 0.13% |

**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: 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 Agency cannot control the number of deficiencies in external organizations that pose a serious threat to the health safety and welfare of the public. It can only find and require correction of those deficiencies, which it has done.

**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 Quality Assurance**
**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 ☐ 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 |
|---|---|---|---|
| 0% | 0.55% | 0.55% | 0.55% |

**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:** 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 ☐ 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 Quality Assurance**
**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% | 2.16% | 2.16% | 2.16% |

**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 Quality Assurance
**Service/Budget Entity:** Health Care Regulation/68700700
**Measure:** Percent of new Medicaid beneficiaries voluntarily selecting managed care plan

**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 |
|---|---|---|---|
| 50% | 47.84% | (2.16%) | 4.32% |

**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:**

**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 Legislature shortened the time frame for voluntarily choosing a plan from 90 to 30 days. This resulted in a higher than expected call volume during the 30 days leading to higher call abandonment rates. As a result a higher percentage of beneficiaries are mandatorily assigned. This issue cannot be addressed without increasing the staff and funding level of the current call center.

**Management Efforts to Address Differences/Problems** (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
**Recommendations:** Medicaid beneficiaries have 90 days to change plans after they have been mandatorily assigned. The negative effect of the reduction in the voluntary enrollment rate is minimal. In addition, another choice counseling has been established to handle calls for the two Medicaid reform counties (Duval and Broward) which should reduce the number of calls to be handled by the existing program for the non-reform areas and reduce the number of abandoned calls.

*The 2007-08 Legislative Budget Request has a technical issue in it transferring this program to Medicaid. This measure will be transferred also.

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# LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

**Department:** **Agency for Health Care Administration**
**Program:** **Health Quality Assurance**
**Service/Budget Entity:** **Health Care Regulation/68700700**
**Measure:** **Number of inquiries to the call center regarding practitioner licensure and disciplinary information.**

**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 |
|---|---|---|---|
| 30,000 | 17,593 | (12,407) | 41% less |

**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 number of calls received fell short of the expected total.

**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 Agency has no control over the number of calls that come into the call center.

**Management Efforts to Address Differences/Problems** (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☐ Other (Identify)
**Recommendations:** The difference in the approved estimate and actual is not perceived as a problem. The number of complaints the public submits against physicians cannot be anticipated. The difference is not attributable to any problem with taking the complaints, but rather is totally determined by circumstances of the complainants. There is no need to correct collection systems.

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# LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

**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 |
|---|---|---|---|
| 7,550 | 7,512 | 38 | 0.5% |

**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 Agency has no control over the numbers of facilities that either desire licensure or that no longer wish 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 ☐ 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 Quality Assurance**
**Service/Budget Entity: Health Care Regulation/68700700**
**Measure: Number of new enrollees provided with Choice Counseling**

**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 |
|---|---|---|---|
| 520,000 | 487,089 | 32,911 | 6.3% |

**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:**

**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:**
This measure is a composite measure of the number of enrollees and plan change requests. This number is largely driven by Medicaid beneficiaries and cannot be affected by the Agency.

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

**Recommendations:** No change in standard

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## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Health Care Administration**
**Program:** **Administration and Support**
**Service/Budget Entity:** **Administration and Support/68200000**
**Measure:** **Administrative costs as a percent of total Agency costs**

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

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

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

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## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Health Care Administration**
**Program:** **Administration and Support**
**Service/Budget Entity:** **Administration and Support/68200000**
**Measure:** **Administrative positions as a percent of total Agency positions**

**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 Agency's position data is maintained in the People First System. The Agency's administrative positions are first identified and then segregated from the Agency's total positions. The administrative positions are divided by the entire Agency's positions to arrive at the measurement.

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

**Reliability:**
Only authorized personnel can access the People First System data. The data is reconciled on a regular basis, ensuring accuracy and reliability.

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## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

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

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

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

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# LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Health Care Administration**
**Program:** **Health Care Services**
**Service/Budget Entity:** **Children's Special Health Care (KidCare)/68500100**
**Measure:** **Percentage of eligible uninsured children receiving health benefits coverage**

**Action** (check one):

☒ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☐ Backup for performance measure.

**Proposed Change to Measure:** Percent of children renewing KidCare coverage or maintaining health care coverage out of all KidCare enrollees eligible for renewal.

**Data Sources and Methodology:**
Florida KidCare enrollment and re-enrollment is tracked by the Florida Healthy Kids Corporation (FHKC) and results on re-enrollment are reported in the annual KidCare evaluation report prepared by the Institute for Child Health Policy at the University of Florida.

**Validity:**
The stated intent of the measure in its current form is to illustrate the number of previously uninsured children covered under KidCare. However, the actual methodology is ambiguous and there are several difficulties in identifying the population numbers to calculate the actual rate. The eligibility of children who apply but do not enroll in KidCare is often impossible to calculate since paperwork is often not complete to make a determination regarding eligibility. Eligibility of those who do not apply is impossible to determine with any degree of accuracy. Further, the *percentage* of uninsured children in Florida was calculated for the 2004 Florida Health Insurance Study (FHIS) conducted by the University of Florida using advanced statistical techniques. The actual *number* of uninsured children is accurate to the tens of thousands at best, and becomes less accurate the further the current year becomes from the base year of the FHIS.

Under the proposed change to the measure, the data would illustrate how successful KidCare is at maintaining health care coverage for eligible, enrolled children. This would in effect measure how successful the KidCare program is at educating current enrollees and maintaining health insurance for its eligible population. It also captures to an extent the level of administrative burden placed on the enrollees under the renewal process. The validity would be very high since the actual data used by the proposed measure are collected by FHKC and involves no estimates or approximations.

**Reliability:**
The data are highly reliable and are collected and reported annually based on readily available administrative data.

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# LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

**Data Sources and Methodology:**
Data for this measure comes from a telephone survey of a random sample of caregivers of established enrollees from each component of KidCare who enter KidCare through a simplified eligibility form, and does not include those who receive Medicaid through the traditional welfare system. In that survey parents are asked to report on their child's immunization. Seventy percent reported using the child's actual immunization record. The remainder use recall. Data are compared to standards for those recommended by the American Academy of Pediatrics for the child's age. From that, the percent with up-to-date immunization is reported. The percent reported is for the lowest rate for any of the following shots, DPT, Polio, MMR, and Hepatitis B. The Child Health Policy Institute conducted the surveys on established enrollees. An established beneficiary had been enrolled in the program for six months.

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

**Reliability:**
Given the extensive testing of the measures, they are quite reliable within normal statistical limitations. Because some parents use recall instead of actual immunization records to answer the survey questions, there may be some margin of error. For instance, since Florida school children are required to present proof that they are compliant with AAP guidelines, there is a chance that a child could be up-to-date with his/her immunizations but a parent might not report this during the survey.

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## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Health Care Administration**
**Program:** **Health Care Services**
**Service/Budget Entity:** **Children's Special Health Care (KidCare)/68500100**
**Measure** **Percent of compliance with the standards established in the Guidelines for Health Supervision of Children and Youth as developed by the American Academy of Pediatrics for children eligible under the program**

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

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

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

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

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## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Health Care Administration**
**Program:** **Health Care Services**
**Service/Budget Entity:** **Children's Special Health Care (KidCare)/68500100**
**Measure** **Percent of families satisfied with the care provided under the program**

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

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

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Health Care Administration**
**Program:** **Health Care Services**
**Service/Budget Entity:** **Children's Special Health Care (KidCare)/68500100**
**Measure** **Total number of Title XXI-eligible children enrolled in KidCare**

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

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

A component of Florida Kidcare is the expansion of Medicaid eligibility to infants to age one whose family income is above 185 percent but no more than 200 percent of the federal poverty level.

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

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

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

The data sources used are the Medicaid Recipient Subsystem (eligibility file) of the Florida Medicaid Management Information System (FMMIS), the data system maintained and operated

by the Florida Healthy Kids Corporation's third party administrator, and the data system maintained by the Children's Medical Services Network.

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

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

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

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

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

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

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Health Care Administration**
**Program:** **Health Care Services**
**Service/Budget Entity:** **Children's Special Health Care (KidCare)/68500100**
**Measure** **Total number of Title XXI-eligible children enrolled in Medikids**

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

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

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

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

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

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

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

*Office of Policy and Budget – July, 2006*

# LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** Agency for Health Care Administration
**Program:** Health Care Services
**Service/Budget Entity:** Children's Special Health Care (KidCare)/68500100
**Measure** Total number of Title XXI-eligible children enrolled in Children's Medical Services Network

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

**Data Sources and Methodology:**

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

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

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

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

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Health Care Administration**
**Program:** **Health Care Services**
**Service/Budget Entity:** **Executive Direction and Support Services/68500200**
**Measure** **Program administrative costs as a percent of total program costs**

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

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

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

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

*Office of Policy and Budget – July, 2006*

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

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

**Data Sources and Methodology:**
The data is derived from the monthly/yearly Operational Performance Summary report (FLMM0300-R001) generated from the 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 state 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.

*Office of Policy and Budget – July, 2006*

## 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.

**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 received" (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 of 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 FMMIS, subject to regular monitoring by state staff and annual Electronic Data Processing (EDP) auditing.

*Office of Policy and Budget – July, 2006*

# LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Healthcare 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** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

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

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

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

*Office of Policy and Budget – July, 2006*

# LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Healthcare Administration**
**Program:** **Health Care Services**
**Service/Budget Entity:** **Medicaid Services to Individuals/68501400**
**Measure:** **Percent of women receiving adequate prenatal care**

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

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

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

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

**Reliability:**
Reliability of the measure is high. The measure is only as accurate as the birth certificate and eligibility files. The Department of Health is responsible for maintaining the birth certificate file. Inaccuracies have been documented particularly in the prenatal care and gestational age data. Inaccuracies are not serious enough to jeopardize comparisons between programs or over time.

Eligibility files are the responsibility of the Department of Children and Families. Early in the development of the eligibility system, some inaccuracies were found. The system is now considered accurate. It forms the basis on which claims for Medicaid services are paid.

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

*Office of Policy and Budget – July, 2006*

# LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

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

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

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

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

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

*Office of Policy and Budget – July, 2006*

# LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Healthcare Administration**
**Program:** **Health Care Services**
**Service/Budget Entity:** **Medicaid Services to Individuals/68501400**
**Measure:** **Average number of months between pregnancies for those receiving family planning services**

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

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

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

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

**Reliability:**
The reliability is considered high; although the measure is only as accurate as the birth certificate, FMMIS, and eligibility files. The Department of Health is responsible for maintaining the birth certificate file. Inaccuracies have been documented in date of last menses, which resulted in some deliveries having a negative value for the inter-pregnancy interval. Problems were most likely due to poor data collection or data entry. These cases were eliminated from the analysis. Inaccuracies are not serious enough to jeopardize comparisons between programs or over time. Eligibility files are the responsibility of the Department of Children and Families. Early in the development of the eligibility system, some inaccuracies were found. The system is now considered accurate. It forms the basis on which claims for Medicaid services are paid. FMMIS data regarding services received is quite accurate, although some variation in number could occur as a result of the time that the extract from FMMIS is made. Providers have up to two years to submit claims and thus a few may be missed in order to present information in a timelier manner.

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

*Office of Policy and Budget – July, 2006*

# LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

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

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

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

**Data Sources and Methodology:**
The data source is the Medicaid Claims History from the Florida Medicaid Management Information System (FMMIS) accessed through the Medicaid Data Warehouse.

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

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

**Reliability:**
The unduplicated population can be reliably calculated.

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

**Data Sources and Methodology:**
The data source is the Medicaid Claims History from the Florida Medicaid Management Information System (FMMIS) accessed through the Medicaid Data Warehouse.

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

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Healthcare Administration**
**Program:** **Health Care Services**
**Service/Budget Entity:** **Medicaid Services to Individuals/68501400**
**Measure:** **Number of hospital inpatient services provided to children**

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

**Data Sources and Methodology:**
The data source is the Medicaid Claims History from the Florida Medicaid Management Information System (FMMIS) accessed through the Medicaid Data Warehouse.

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

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

**Data Sources and Methodology:**
The data source is the Medicaid Claims History from the Florida Medicaid Management Information System (FMMIS) accessed through the Medicaid Data Warehouse.

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

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Healthcare Administration**
**Program:** **Health Care Services**
**Service/Budget Entity:** **Medicaid Services to Individuals/68501400**
**Measure:** **Number of prescribed drugs provided to children**

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

**Data Sources and Methodology:**
The data source is the Medicaid Claims History from the Florida Medicaid Management Information System (FMMIS) accessed through the Medicaid Data Warehouse.

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

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

**Data Sources and Methodology:**
The data source is the Medicaid Claims History from the Florida Medicaid Management Information System (FMMIS) accessed through the Medicaid Data Warehouse.

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

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

**Data Sources and Methodology:**
The data source is the Medicaid Claims History from the Florida Medicaid Management Information System (FMMIS) accessed through the Medicaid Data Warehouse.

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

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Healthcare Administration**
**Program:** **Health Care Services**
**Service/Budget Entity:** **Medicaid Services to Individuals/68501400**
**Measure:** **Number of prescribed drugs provided to elders**

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

**Data Sources and Methodology:**
The data source is the Medicaid Claims History from the Florida Medicaid Management Information System (FMMIS) accessed through the Medicaid Data Warehouse.

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

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

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

*Office of Policy and Budget – July, 2006*

# LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

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

A component of Florida Kidcare is the expanded Medicaid eligibility group for infants to age one whose family income is above 185 percent but no more than 200 percent of the federal poverty level.

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

Using the Recipient Subsystem (eligibility file), the number of children enrolled in the Medicaid expansion group is determined using enrollment as of June of the fiscal year.

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

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

*Office of Policy and Budget – July, 2006*

# LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

**Data Sources and Methodology:**
The data source is all Medicaid paid claims data for those months in which AHCA made a payment for long term care services on behalf of someone who is developmentally disabled. (Home and Community based waiver services, Supported Living waiver services or Intermediate Care Facility Care Facility for the Developmentally Disabled).
Claims data are examined to determine for whom a payment was made for long-term care services. All claims for the month a payment was made are obtained. Claims are sorted by age of beneficiary. A beneficiary is only included once even in months when payments may be for more than one of the programs.

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

**Validity:**
Validity of the measure is fairly high. Some beneficiaries may be eligible for Medicare. If eligible for Medicare, hospital claims are paid for by Medicare. This should not affect the relative ratio of hospitalizations. A condition is considered ambulatory sensitive if provision of quality care could reduce or eliminate the need for hospitalization. Some hospitalizations will always occur due to patient non-compliance. However, Medicaid providers are expected to work with patients to increase their likelihood of compliance in addition to providing direct treatment. The hospital file does not designate whether someone is disabled or not, so this measure may include non-disabled people. The codes used to classify a hospital visit as ambulatory sensitive are a conservative number developed by Weissman as reported in "Rates of Avoidable Hospitalizations by Insurance Status in Massachusetts and Maryland" *Journal of the American Medical Association,* November 4, 1992. Some researchers have used additional conditions. The denominator used is other hospitalizations. Some researchers have used this to control for risk. Others have used the population enrolled as the denominator. This would be problematic for this population because Medicare pays for many claims.

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

**Data Sources and Methodology:**
The data source is the Medicaid Claims History from the Florida Medicaid Management Information System (FMMIS) accessed through the Medicaid Data Warehouse.

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

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

**Data Sources and Methodology:**
The data source is the Medicaid Claims History from the Florida Medicaid Management Information System (FMMIS) accessed through the Medicaid Data Warehouse.

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

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Healthcare 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** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

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

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

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

*Office of Policy and Budget – July, 2006*

# LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

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

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

**Data Sources and Methodology:**
The data sources are the Medicaid Claims History and the Medicaid Recipient Subsystem (eligibility file) from the Florida Medicaid Management Information System (FMMIS) accessed through the Medicaid Data Warehouse.

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

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Healthcare Administration**
**Program:** **Health Care Services**
**Service/Budget Entity:** **Medicaid Prepaid Health Plans/68501600**
**Measure:** **Number of case months services purchased (families)**

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

**Data Sources and Methodology:**
The data sources are the Medicaid Claims History and the Medicaid Recipient Subsystem (eligibility file) from the Florida Medicaid Management Information System (FMMIS) accessed through the Medicaid Data Warehouse.

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

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Health Care Administration**
**Program:** **Health Quality Assurance**
**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** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure not 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 nursing homes in which deficiencies are found during the period that pose a serious threat to the health, safety, or welfare of the public divided by the total number of nursing home facilities during the period. Deficiencies that pose a serious threat to the health, safety, or welfare of the public can arise from any type of survey (initial, renewal, complaint investigation, etc.).

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

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

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Health Care Administration**
**Program:** **Health Quality Assurance**
**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** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure not 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 closed investigations of unlicensed activity resulting in a cease and desist order subsequent to a previous investigation of the same facility for unlicensed activity also resulting in the issuance of a cease and desist order, divided by the total number of investigations of confirmed unlicensed activity during the period.

Each confirmed complaint of unlicensed activity, which would result in a cease and desist order is maintained in the Florida Regulatory and Enforcement System (FRAES).

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

Each confirmed complaint of unlicensed activity, which would result in a cease and desist order is maintained in the Florida Regulatory and Enforcement System (FRAES).

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Health Care Administration**
**Program:** **Health Quality Assurance**
**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.**

**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 Complaint Administration Unit in consultation with 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.

**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.

*Office of Policy and Budget – July, 2006*

# LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Health Care Administration**
**Program:** **Health Quality Assurance**
**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** (check one):
☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure not 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 accredited hospitals and ambulatory surgical centers (ASCs) that have been cited for deficiencies during the period, divided by the total number of accredited hospitals and ASCs. Deficiencies that are cited are not tabulated individually (i.e. if five deficiencies are cited during a survey, it is reported as one deficiency in the numerator). In addition, deficiencies that are noted include any and all deficiencies from minor to severe. A national accrediting body confers accreditation. If a facility is accredited, a full licensure survey is not required to be performed biennially. A validation survey (same as a full licensure survey) is performed on a sample of facilities. Deficiencies may also be found during complaint investigations of accredited facilities. A life safety inspection is required annually for hospitals and ASCs. Life safety inspections evaluate the control and prevention of fire and other life-threatening conditions on the premises for the purpose of preserving human life. Emergency access standards require every hospital to treat and/or stabilize any patient admitted for an emergency medical condition.

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

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure not 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 state accreditation validation surveys conducted for hospitals and ambulatory surgical centers that are consistent with findings noted during the accreditation survey divided by the total number of validation surveys performed during the period. A state validation survey is performed, at minimum, on a 5% sample of accredited hospitals and ambulatory surgical centers that have received their accreditation surveys. This measure does not include federal accreditation validation surveys.

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

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

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Health Care Administration**
**Program:** **Health Quality Assurance**
**Service/Budget Entity:** **Health Care Reculation/6700700**
**Measure:** **Percent of assisted living facilities with deficiencies that pose a serious threat to the health, safety or welfare of the public**

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure not 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 assisted living facilities in which deficiencies are found during the period that pose a serious threat to the health, safety, or welfare of the public, divided by the total number of assisted living facilities during the period. Deficiencies that pose a serious threat to the health, safety, or welfare of the public are classified as Class I deficiencies (statutorily defined). These deficiencies can arise from any type of survey (initial, renewal, complaint investigation, etc.).

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

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

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

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

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Health Care Administration**
**Program:** **Health Quality Assurance**
**Service/Budget Entity:** **Health Care Regulation/68700700**
**Measure:** **Percent of clinical laboratories with deficiencies that pose a serious threat for not complying with life safety, licensure or emergency access standards**

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure not 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 clinical laboratories in which deficiencies are found during the period that pose a serious threat to the health, safety, or welfare of the public, divided by the total number of clinical laboratories during the period. Deficiencies that pose a serious threat to the health, safety, or welfare of the public can arise from any type of survey (initial, renewal, complaint investigation, etc.).

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

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Health Care Administration**
**Program:** **Health Quality Assurance**
**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** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure not 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 ambulatory surgical centers in which deficiencies are found during the period that pose a serious threat to the health, safety, or welfare of the public, divided by the total number of ambulatory surgical centers during the period. Deficiencies that pose a serious threat to the health, safety or welfare of the public can arise from any type of survey (initial, renewal, complaint investigation, etc.).

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

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Health Care Administration**
**Program:** **Health Quality Assurance**
**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** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure not 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 hospitals in which deficiencies are found during the period that pose a serious threat to the health, safety, or welfare of the public by program divided by the total number of hospitals during the period. Deficiencies that pose a serious threat to the health, safety or welfare of the public can arise from any type of survey (initial, renewal, complaint investigation, etc.).

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

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Health Care Administration**
**Program:** **Health Quality Assurance**
**Service/Budget Entity:** **Health Care Regulation/68700700**
**Measure:** **Percent of hospitals that fail to report serious incidents (Agency identified)**

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure not previously approved or for which validity, reliability and/or methodology information has not been provided.

**Data Sources and Methodology:**
The data source is the field surveys of hospitals and ambulatory surgical centers. Risk Management surveys are tracked in FRAES/LicenseEase with a specific indicator for failure to report. Reports are run periodically regarding facilities that fail to report incidents to AHCA. A comparison is made of facilities that failed to report relative to facilities surveyed to produce a percentage of hospitals that fail to report.

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

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

*Office of Policy and Budget – July, 2006*

# LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Health Care Administration**
**Program:** **Health Quality Assurance**
**Service/Budget Entity:** **Health Care Regulation/68700700**
**Measure:** **Percent of new Medicaid beneficiaries voluntarily selecting a managed care plan.**

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure not previously approved or for which validity, reliability and/or methodology information has not been provided.

**Data Sources and Methodology:**
The source of the data is the Florida Medicaid Management Information System. Florida law mandates that Medicaid beneficiaries eligible for managed care must be enrolled either with the MediPass program or with a Medicaid managed care organization. Eligible beneficiaries are given 30 days from the date that the Medicaid eligibility begins to select a plan. If beneficiaries do not voluntarily select either MediPass or a managed care plan, they are mandatorily assigned to MediPass or a managed care plan. The voluntary enrollment rate is calculated each month by dividing the number of beneficiaries voluntarily selecting a managed care plan or enrolling in MediPass divided by the total number of newly eligible Medicaid enrollees. A "newly eligible" is defined as a person who has not participated in a managed care plan within the previous 60 days prior to enrollment. The total number of "newly eligibles" excludes Medicaid beneficiaries that are exempted from mandatory assignment.

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Health Care Administration**
**Program:** **Health Quality Assurance**
**Service/Budget Entity:** **Health Care Regulation/68700700**
**Measure:** **Percent of complaints of HMO patient dumping received that are investigated**

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure not previously approved or for which validity, reliability and/or methodology information has not been provided.

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

The agency received 0 patient complaints related to health plan "dumping" in FY 2003-2004 and 0 complaints in FY 2004-2005.

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Health Care Administration**
**Program:** **Health Quality Assurance**
**Service/Budget Entity:** **Health Care Regulation/68700700**
**Measure:** **Percent of facility patient dumping complaints investigated**
**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure not previously approved or for which validity, reliability and/or methodology information has not been provided.

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

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Health Care Administration**
**Program:** **Health Quality Assurance**
**Service/Budget Entity:** **Health Care Regulation/68700700**
**Measure:** **Number of inquiries to the call center regarding practitioner licensure and disciplinary information**

**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:**

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

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Health Care Administration**
**Program:** **Health Quality Assurance**
**Service/Budget Entity:** **Health Care Regulation/68700700**
**Measure:** **Total number of full facility quality-of-care surveys conducted**
**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:**
A full facility survey is defined as initial, validation, and renewal licensure and certification surveys. Plans and Construction surveys are not included. Licensure and certification surveys performed together, for the same facility, count as one survey. Full surveys do not include separate life safety surveys, risk management surveys, or complaint investigations. All state and certification full facility surveys are entered into the Florida Regulatory and Enforcement System (FRAES). This allows a count of the actual number of surveys conducted during any given period. FRAES training is offered on an on-going basis to both area office and central office personnel to ensure that the information is being accurately captured and reported in the system. Centralized aggregation of this data will ensure consistency among several facility types.

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

**Reliability:**
Survey data are maintained in FRAES and centrally collected. Centralized collection of FRAES data, and management review of supporting data should ensure accurate and consistent reporting, resulting in reliability of the measure.

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure not previously approved or for which validity, reliability and/or methodology information has not been provided.

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

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Health Care Administration**
**Program:** **Health Quality Assurance**
**Service/Budget Entity:** **Health Care Regulation/68700700**
**Measure:** **Number of construction reviews performed (plans and construction)**

**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure not previously approved or for which validity, reliability and/or methodology information has not been provided.

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

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

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

*Office of Policy and Budget – July, 2006*

## LRPP EXHIBIT IV: Performance Measure Validity and Reliability

**Department:** **Agency for Health Care Administration**
**Program:** **Health Quality Assurance**
**Service/Budget Entity:** **Health Care Regulation/68700700**
**Measure:** **Number of new enrollees provided choice counseling**
**Action** (check one):

☐ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure not previously approved or for which validity, reliability and/or methodology information has not been provided.

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

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

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

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

*Office of Policy and Budget – July, 2006*

## LRPP Exhibit V: Identification of Associated Activity Contributing to Performance Measures

| Measure Number | Approved Performance Measures for FY 2006-07 (Words) | | Associated Activities Title |
|---|---|---|---|
| | **Administration and Support - 68200000** | | |
| 1 | Administrative costs as a percent of total agency costs | | Executive Direction ACT0010 |
| 2 | Administrative positions as a percent of total agency positions | | Executive Direction ACT0010 |
| | **Children's Special Health Care - 68500100** | | |
| 3 | Percent of hospitalizations for conditions preventable by good ambulatory care | | Purchase MediKids Program Services ACT5110<br>Purchase Children's Medical Services Network Services ACT5120<br>Purchase Florida Healthy Kids Corporation Services ACT5130 |
| 4 | Percent of eligible uninsured children who receive health benefits coverage | | Purchase MediKids Program Services ACT5110<br>Purchase Children's Medical Services Network Services ACT5120<br>Purchase Florida Healthy Kids Corporation Services ACT5130 |

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|---|---|---|---|
| 5 | Percent of children enrolled with up-to-date immunizations | | Purchase MediKids Program Services ACT5110<br>Purchase Children's Medical Services Network Services ACT5120<br>Purchase Florida Healthy Kids Corporation Services ACT5130 |
| 6 | 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 | | Purchase MediKids Program Services ACT5110<br>Purchase Children's Medical Services Network Services ACT5120<br>Purchase Florida Healthy Kids Corporation Services ACT5130 |
| 7 | Percent of families satisfied with the care provided under the program | | Purchase MediKids Program Services ACT5110<br>Purchase Children's Medical Services Network Services ACT5120<br>Purchase Florida Healthy Kids Corporation Services ACT5130 |
| 8 | Total number of XXI-eligible children enrolled in Kidcare | | Purchase MediKids Program Services ACT5110<br>Purchase Children's Medical Services Network Services ACT5120<br>Purchase Florida Healthy Kids Corporation Services ACT5130 |

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|---|---|---|---|
| 9 | Number of Title XXI-eligible children enrolled in Florida Healthy Kids | | Purchase Florida Healthy Kids Corporation Services ACT5130 |
| 10 | Number of Title XXI-eligible children enrolled in Medikids | | Purchase MediKids Program Services ACT5110 |
| 11 | Number of Title XXI-eligible children enrolled in Children's Medical Services Network | | Purchase Children's Medical Services Network Services ACT5120 |
| | **Executive Director/Support Services - 68500200** | | |
| 12 | Program administrative costs as a percent of total program costs | | Executive Direction ACT0010 |
| 13 | Average number of days between receipt of clean Medicaid claim and payment | | Fiscal Agent Contract ACT5260 |

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|---|---|---|---|
| 14 | Number of Medicaid claims received | | Fiscal Agent Contract ACT5260 |
| | **Medicaid Services - Individuals - 68501400** | | |
| 15 | Percent of hospitalizations that are preventable by good ambulatory care | | Hospital Inpatient -Elderly and Disabled/fee for service ACT4010<br>Hospital Inpatient ACT4210<br>Hospital Inpatient ACT 4510<br>Hospital Inpatient ACT 4710 |
| 16 | Percent of women receiving adequate prenatal care | | Physician Services ACT4230<br>Clinic Services ACT4330 |
| 17 | Neonatal mortality rate per 1000 | | Hospital Inpatient ACT4210<br>Physician Services ACT4230 |
| 18 | Average number of months between pregnancies for those receiving family planning services | | Physician Services ACT4230<br>Clinic Services ACT4330 |

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|---|---|---|---|
| 19 | Percent of eligible children who received all required components of EPSDT screen | | Physician Services ACT4230<br>Early Periodic Screening Diagnosis & Treatment ACT4260 |
| 20 | Number of children ages 1-20 enrolled in Medicaid | | All Activities under Budget Entities 68501400 and 68501600 |
| 21 | Number of children receiving EPSDT services | | Physician Services ACT4230<br>Early Periodic Screening Diagnosis & Treatment ACT4260 |
| 22 | Number of hospital inpatient services provided to children | | Hospital Inpatient ACT4210 |
| 23 | Number of physician services provided to children | | Physician Services ACT4230 |
| 24 | Number of prescribed drugs provided to children | | Prescribed Medicines 4220 |

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|---|---|---|---|
| 25 | Number of hospital inpatient services provided to elders | | Hospital Inpatient -Elderly and Disabled/fee for service ACT4010<br>Hospital Insurance Benefit-Elderly and Disabled /Fee for service ACT4120 |
| 26 | Number of physician services provided to elders | | Physician Services-Elderly and Disabled/fee for service ACT4030 |
| 27 | Number of prescribed drugs provided to elders | | Prescribed Medicines- Elderly and Disabled/fee for service ACT4020 |
| 28 | Number of children enrolled in the Medicaid Expansion | | All Activities under Women and Children/Fee for Service/MediPass |
| | **Medicaid Long Term Care - 68501500** | | |
| 29 | Percent of hospitalizations for conditions preventable with good ambulatory care | | Nursing Home Care ACT5020<br>Home and Community Based Services ACT5030<br>Capitated Nursing Home Diversion Waiver ACT5060 |

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|---|---|---|---|
| 30 | Number of case months (home and community-based services) | | Home and Community Based Services ACT5030<br>Capitated Nursing Home Diversion Waiver ACT5060 |
| 31 | Number of case months services purchased (Nursing Home) | | Nursing Home Care ACT5020 |
| | **Medicaid Prepaid Health Plan - 68501600** | | |
| 32 | Percent of hospitalizations for conditions preventable by good ambulatory care | | Prepaid Health Plans Elderly and Disabled ACT1620<br>Prepaid Health Plans - Family ACT1650 |
| 33 | Percent of women and child hospitalizations for conditions preventable with good ambulatory care | | Prepaid Health Plans - Family ACT1650 |
| 34 | Number of case months services purchased (elderly and disabled) | | Prepaid Health Plans Elderly and Disabled ACT1620 |
| 35 | Number of case months services purchased (families) | | Prepaid Health Plans - Family ACT1650 |

| | **Health Care Regulation - 68700700** | | |
|---|---|---|---|
| 36 | Percent of nursing home facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public | | Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 |
| | | | Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020 |
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| 37 | 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 | | Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 |
| | | | Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020 |
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| 38 | Percent of Priority I consumer complaints about licensed facilities and programs that are investigated within 48 hours | | Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 |
| | | | Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020 |
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| 39 | Percent of accredited hospitals and ambulatory surgical centers cited for not complying with life safety, licensure or emergency access standards | | Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 |
| | | | Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020 |
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| 40 | Percent of validation surveys that are consistent with findings noted during the accreditation survey | | Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 |
| | | | Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020 |
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| 41 | Percent of assisted living facilities with deficiencies that pose a serious threat to the health, safety or welfare of the public | | Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 |
| | | | Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020 |
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| 42 | Percent of home health facilities with deficiencies that pose a serious threat to the health, safety or welfare of the public | | Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 |
| | | | Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020 |
| | | | |
| | | | |
| 43 | Percent of clinical laboratories with deficiencies that pose a serious threat for not complying with life safety, licensure or emergency access standards | | Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 |
| | | | Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020 |
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|---|---|---|---|
| 44 | Percent of ambulatory surgical centers with deficiencies that pose a serious threat to the health, safety or welfare of the public | | Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 |
| | | | Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020 |
| | | | |
| | | | |
| 45 | Percent of hospitals with deficiencies that pose a serious threat to the health, safety or welfare of the public | | Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 |
| | | | Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020 |
| | | | |
| | | | |
| 46 | Percent of hospitals that fail to report serious incidents (agency identified) | | Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 |
| | | | Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020 |
| | | | |
| | | | |
| 47 | Percent of new Medicaid beneficiaries voluntarily selecting managed care plan | | Health Facilities and Practitioner Regulation - Medicaid Choice Counseling ACT7150 |
| | | | |
| | | | |
| 48 | Percent of complaints of HMO patient dumping received that are investigated | | Managed Health Care ACT7090 |
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|---|---|---|---|
| 49 | Percent of complaints of facility patient dumping received that are investigated | | Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 |
| | | | Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020 |
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| | | | |
| 50 | Number of inquiries to the call center regarding practitioner licensure and disciplinary information | | Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020 |
| | | | |
| | | | |
| 51 | Total number of full facility quality-of-care surveys conducted | | Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 |
| | | | Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020 |
| | | | |
| 52 | Average processing time (in days) for Statewide Provider and Subscriber Assistance Panel cases | | Subscriber Assistance Panel ACT7130 |
| | | | |
| 53 | Number of construction reviews performed (plans and construction) | | Plans & Construction ACT7080 |
| | | | |
| 54 | Number of new enrollees provided choice counseling | | Health Facilities and Practitioner Regulation - Medicaid Choice Counseling ACT7150 |
| | | | |

# Exhibit VI: Agency- Level Unit Cost Summary

| AGENCY FOR HEALTH CARE ADMINISTRATION | FISCAL YEAR 2005-06 | | | |
|---|---|---|---|---|
| SECTION I: BUDGET | OPERATING | | | FIXED CAPITAL OUTLAY |
| TOTAL ALL FUNDS GENERAL APPROPRIATIONS ACT | | 15,900,314,799 | | 0 |
| ADJUSTMENTS TO GENERAL APPROPRIATIONS ACT (Supplementals, Vetoes, Budget Amendments, etc.) | | 26,530,731 | | 0 |
| FINAL BUDGET FOR AGENCY | | 15,926,845,530 | | 0 |
| | | | | |
| SECTION II: ACTIVITIES * MEASURES | Number of Units | *(1) Unit Cost* | *(2) Expenditures (Allocated)* | *(3) FCO* |
| *Executive Direction, Administrative Support and Information Technology (2)* | | | | 0 |
| Prepaid Health Plans - Elderly And Disabled * Number of case months Medicaid program services purchased | 1,466,184 | 604.73 | 886,638,818 | |
| Prepaid Health Plans - Families * Number of case months Medicaid program services purchased | 7,782,684 | 131.62 | 1,024,339,052 | |
| Elderly And Disabled/Fee For Service/Medipass - Hospital Inpatient * Number of case months Medicaid program services purchased | 6,427,296 | 257.01 | 1,651,906,702 | |
| Elderly And Disabled/Fee For Service/Medipass - Prescribed Medicines * Number of case months Medicaid program services purchased | 6,427,296 | 201.04 | 1,292,119,656 | |
| Elderly And Disabled/Fee For Service/Medipass - Physician Services * Number of case months Medicaid program services purchased | 6,427,296 | 49.56 | 318,519,026 | |
| Elderly And Disabled/Fee For Service/Medipass - Hospital Outpatient * Number of case months Medicaid program services purchased | 6,427,296 | 40.46 | 260,038,249 | |
| Elderly And Disabled/Fee For Service/Medipass - Supplemental Medical Insurance * Number of case months Medicaid program services purchased | 5,157,648 | 122.12 | 629,874,268 | |
| Elderly And Disabled/Fee For Service/Medipass - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased | 897,468 | 11.58 | 10,394,248 | |
| Elderly And Disabled/Fee For Service/Medipass - Patient Transportation * Number of case months Medicaid program services purchased | 6,427,296 | 8.51 | 54,670,188 | |
| Elderly And Disabled/Fee For Service/Medipass - Case Management * Number of case months Medicaid program services purchased | 2,537,712 | 38.70 | 98,216,128 | |
| Elderly And Disabled/Fee For Service/Medipass - Home Health Services * Number of case months Medicaid program services purchased | 6,427,296 | 9.58 | 61,568,360 | |

| | | | | | |
|---|---|---|---|---|---|
| Elderly And Disabled/Fee For Service/Medipass - Therapeutic Services For Children * Number of case months Medicaid program services purchased | 1,148,412 | 32.46 | 37,272,586 | | |
| Elderly And Disabled/Fee For Service/Medipass - Hospital Insurance Benefit * Number of case months Medicaid program services purchased | 4,433,088 | 24.47 | 108,460,172 | | |
| Elderly And Disabled/Fee For Service/Medipass - Hospice * Number of case months Medicaid program services purchased | 6,427,296 | 23.27 | 149,577,686 | | |
| Elderly And Disabled/Fee For Service/Medipass - Private Duty Nursing * Number of case months Medicaid program services purchased | 1,148,412 | 102.04 | 117,185,078 | | |
| Elderly And Disabled/Fee For Service/Medipass - Other * Number of case months Medicaid program services purchased | 6,427,296 | 68.72 | 441,685,319 | | |
| Women And Children/Fee For Service/Medipass - Hospital Inpatient * Number of case months Medicaid program services purchased | 9,558,948 | 121.24 | 1,158,967,332 | | |
| Women And Children/Fee For Service/Medipass - Prescribed Medicines * Number of case months Medicaid program services purchased | 9,558,948 | 43.99 | 420,465,182 | | |
| Women And Children/Fee For Service / Medipass - Physician Services * Number of case months Medicaid program services purchased | 9,558,948 | 42.95 | 410,518,454 | | |
| Women And Children/Fee For Service / Medipass - Hospital Outpatient * Number of case months Medicaid program services purchased | 9,558,948 | 35.30 | 337,445,284 | | |
| Women And Children/Fee For Service / Medipass - Supplemental Medical Insurance * Number of case months Medicaid program services purchased | 17,700 | 6,502.90 | 115,101,266 | | |
| Women And Children/Fee For Service / Medipass - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased | 7,706,580 | 16.17 | 124,581,906 | | |
| Women And Children/Fee For Service / Medipass - Patient Transportation * Number of case months Medicaid program services purchased | 9,558,948 | 6.22 | 59,478,590 | | |
| Women And Children/Fee For Service / Medipass - Case Management * Number of case months Medicaid program services purchased | 194,796 | 61.37 | 11,953,826 | | |
| Women And Children/Fee For Service / Medipass - Home Health Services * Number of case months Medicaid program services purchased | 9,558,948 | 11.69 | 111,732,265 | | |
| Women And Children/Fee For Service / Medipass - Therapeutic Services For Children * Number of case months Medicaid program services purchased | 7,706,580 | 14.45 | 111,386,427 | | |
| Women And Children/Fee For Service / Medipass - Clinic Services * Number of case months and Medicaid program services purchased | 9,558,948 | 8.52 | 81,402,210 | | |
| Women And Children/Fee For Service / Medipass - Other * Number of case months Medicaid program services purchased | 9,558,948 | 34.10 | 325,981,214 | | |

| | | | | |
|---|---|---|---|---|
| Medically Needy - Hospital Inpatient * Number of case months Medicaid program services purchased | 335,592 | 641.11 | 215,150,333 | |
| Medically Needy - Prescribed Medicines * Number of case months Medicaid program services purchased | 335,592 | 548.18 | 183,965,370 | |
| Medically Needy - Physician Services * Number of case months Medicaid program services purchased | 335,592 | 131.31 | 44,066,953 | |
| Medically Needy - Hospital Outpatient * Number of case months Medicaid program services purchased | 335,592 | 156.29 | 52,449,604 | |
| Medically Needy - Supplemental Medical Insurance * Number of case months Medicaid program services purchased | 10,812 | 360.17 | 3,894,123 | |
| Medically Needy - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased | 48,600 | 11.15 | 542,073 | |
| Medically Needy - Patient Transportation * Number of case months Medicaid program services purchased | 335,592 | 5.89 | 1,976,443 | |
| Medically Needy - Case Management * Number of case months Medicaid program services purchased | 23,316 | 75.37 | 1,757,257 | |
| Medically Needy - Home Health Services * Number of case months Medicaid program services purchased | 335,592 | 4.84 | 1,625,140 | |
| Medically Needy - Therapeutic Services For Children * Number of case months Medicaid program services purchased | 48,612 | 1.53 | 74,366 | |
| Medically Needy - Other * Number of case months Medicaid program services purchased | 335,592 | 76.30 | 25,605,524 | |
| Refugees - Hospital Inpatient * Number of case months Medicaid program services purchased | 65,628 | 37.22 | 2,442,577 | |
| Refugees - Prescribed Medicines * Number of case months Medicaid program services purchased | 65,628 | 3,118.56 | 204,665,099 | |
| Refugees - Physician Services * Number of case months Medicaid program services purchased | 65,628 | 53.74 | 3,526,573 | |
| Refugees - Hospital Outpatient * Number of case months Medicaid program services purchased | 65,628 | 18.84 | 1,236,465 | |
| Refugees - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased | 12,468 | 24.02 | 299,457 | |
| Refugees - Patient Transportation * Number of case months Medicaid program services purchased | 65,628 | 1.12 | 73,676 | |
| Refugees - Case Management * Number of case months Medicaid program services purchased | 120 | 53.49 | 6,418 | |
| Refugees - Home Health Services * Number of case months Medicaid program services purchased | 65,628 | 2.21 | 144,910 | |
| Refugees - Therapeutic Services For Children * Number of case months Medicaid program services purchased | 20,436 | 0.74 | 15,023 | |
| Refugees - Other * Number of case months Medicaid program services purchased | 65,628 | 41.56 | 2,727,818 | |
| Nursing Home Care * Number of case months Medicaid program services purchased | 557,112 | 4,603.05 | 2,564,416,920 | |
| Home And Community Based Services * Number of case months Medicaid program services purchased | 571,710 | 1,445.32 | 826,306,462 | |

| | | | | | |
|---|---|---|---|---|---|
| Intermediate Care Facilities For The Developmentally Disabled - Sunland Centers * Number of case months Medicaid program services purchased | 11,352 | 11,375.82 | 129,138,266 | | |
| Mental Health Disproportionate Share Program * Number of case months Medicaid program services purchased | 540 | 114,467.49 | 61,812,444 | | |
| Long Term Care - Other * Number of case months Medicaid program services purchased | 207,510 | 2,530.13 | 525,026,345 | | |
| Purchase Medikids Program Services * Number of case months | 198,969 | 212.77 | 42,333,897 | | |
| Purchase Children's Medical Services Network Services * Number of case months | 96,103 | 585.36 | 56,255,294 | | |
| Purchase Florida Healthy Kids Corporation Services * Number of case months | 2,339,836 | 87.67 | 205,142,385 | | |
| Certificate Of Need/Financial Analysis * Number of certificate of need (CON) requests/financial reviews conducted | 1,877 | 857.28 | 1,609,114 | | |
| Health Facility Regulation (compliance, Licensure, Complaints) - Tallahassee * Number of licensure applications | 26,800 | 491.90 | 13,183,022 | | |
| Facility Field Operations (compliance, Complaints) - Field Offices Survey Staff * Number of surveys and complaint investigations | 22,940 | 1,592.59 | 36,534,059 | | |
| Health Standards And Quality * Number of transactions | 2,115,841 | 2.02 | 4,268,017 | | |
| Plans And Construction * Number of reviews performed | 4,535 | 1,154.87 | 5,237,325 | | |
| Managed Health Care * Number of HMO and workers' compensation arrangement surveys | 329 | 13,289.96 | 4,372,397 | | |
| Organ And Tissue Donor * Number of donor designations | 1,491,259 | 0.17 | 247,608 | | |
| Background Screening * Number of requests for screenings | 46,860 | 16.41 | 768,991 | | |
| Subscriber Assistance Panel * Number of cases | 345 | 2,512.10 | 866,673 | | |
| Health Facilities And Practitioner Regulation - Medicaid Choice Counseling * Number of new enrollees provided choice counseling | 487,089 | 14.46 | 7,041,745 | | |
| | | | | | |
| TOTAL | | | 15,642,285,659 | | |
| SECTION III: RECONCILIATION TO BUDGET | | | | | |
| PASS THROUGHS | | | | | |
| TRANSFER - STATE AGENCIES | | | | | |
| AID TO LOCAL GOVERNMENTS | | | | | |
| PAYMENT OF PENSIONS, BENEFITS AND CLAIMS | | | | | |
| OTHER | | | 4,566,564 | | |
| REVERSIONS | | | 279,993,359 | | |
| | | | | | |
| TOTAL BUDGET FOR AGENCY (Total Activities + Pass Throughs + Reversions) - Should equal Section I above. (4) | | | 15,926,845,582 | | |
| SCHEDULE VI: AGENCY-LEVEL UNIT COST SUMMARY | | | | | |

(1) Some activity unit costs may be overstated due to the allocation of double budgeted items.
(2) Expenditures associated with Executive Direction, Administrative Support and Information Technology have been allocated based on FTE. Other allocation methodologies could result in significantly different unit costs per activity.
(3) Information for FCO depicts amounts for current year appropriations only. Additional information and systems are needed to develop meaningful FCO unit costs.
(4) Final Budget for Agency and Total Budget for Agency may not equal due to rounding.

# Glossary of Terms and Acronyms:

**Activity**: A unit of work which has identifiable starting and ending points, consumes resources, and produces outputs. Unit cost information is determined using the outputs of activities.

**Actual Expenditures**: Includes prior year actual disbursements, payables and encumbrances. The payables and encumbrances are certified forward at the end of the fiscal year. They may be disbursed between July 1 and December 31 of the subsequent fiscal year. Certified forward amounts are included in the year in which the funds are committed and not shown in the year the funds are disbursed.

**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

**Appropriation Category**: The lowest level line item of funding in the General Appropriations Act which represents a major expenditure classification of the budget entity. Within budget entities, these categories may include: salaries and benefits, other personal services (OPS), expenses, operating capital outlay, data processing services, fixed capital outlay, etc. These categories are defined within this glossary under individual listings. For a complete listing of all appropriation categories, please
refer to the ACTR section in the LAS/PBS User's Manual for instructions on ordering a report.

**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.

**Baseline Data**: Indicators of a state agency's current performance level, pursuant to guidelines established by the Executive Office of the Governor in consultation with legislative appropriations and appropriate substantive committees.

**Budget Entity**: A unit or function at the lowest level to which funds are specifically appropriated in the appropriations act. "Budget entity" and "service" have the same meaning.

**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.

**CIO -** Chief Information Officer

**CIP -** Capital Improvements Program Plan

**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.

**D3-A**: A legislative budget request (LBR) exhibit which presents a narrative explanation and justification for each issue for the requested years.

**Demand**: The number of output units which are eligible to benefit from a service or activity.

**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.

**EOG -** Executive Office of the Governor

**EPO:** Exclusive Provider Organization

**Estimated Expenditures**: Includes the amount estimated to be expended during the current fiscal year. These amounts will be computer generated based on the current year appropriations adjusted for vetoes and special appropriations bills.

**FCO -** Fixed Capital Outlay

**FFMIS -** Florida Financial Management Information System

**Fixed Capital Outlay**: Real property (land, buildings including appurtenances, fixtures and fixed equipment, structures, etc.), including additions, replacements, major repairs, and renovations to real property which materially extend its useful life or materially improve or change its functional use. Includes furniture and equipment necessary to furnish and operate a new or improved facility.

**FLAIR -** Florida Accounting Information Resource Subsystem

**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.

**F.S. -** Florida Statutes

**GAA -** General Appropriations Act

**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.

**GR -** General Revenue Fund

**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.

**HIPAA:** Health Insurance Portability and Accountability Act of 1996

**HMO:** Health Maintenance Organization

**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.

**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.

**Indicator**: A single quantitative or qualitative statement that reports information about the nature of a condition, entity or activity. This term is used commonly as a synonym for the word "measure." Information Technology Resources: Includes data processing-related hardware, software, services, telecommunications, supplies, personnel, facility resources, maintenance, and training.

**Input**: See Performance Measure.

**IOE** - Itemization of Expenditure

**IT -** Information Technology

**Judicial Branch**: All officers, employees, and offices of the Supreme Court, district courts of appeal, circuit courts, county courts, and the Judicial Qualifications Commission.

**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.

**LAN -** Local Area Network

**LAS/PBS:** Legislative Appropriations System/Planning and Budgeting Subsystem. The statewide appropriations and budgeting system owned and maintained by the Executive Office of the Governor.

**LBC -** Legislative Budget Commission

**LBR -** Legislative Budget Request

**Legislative Budget Commission**: A standing joint committee of the Legislature. The Commission was created to: review and approve/disapprove agency requests to amend original approved budgets; review agency spending plans; and take other actions related to the fiscal matters of the state, as authorized in statute. It is composed of 14 members appointed by the President of the Senate and by the Speaker of the House of Representatives to two-year terms, running from the organization of one Legislature to the organization of the next Legislature.

**Legislative Budget Request**: A request to the Legislature, filed pursuant to section 216.023, Florida Statutes, or supplemental detailed requests filed with the Legislature, for the amounts of money an agency or branch of government believes will be needed to perform the functions that it is authorized, or which it is requesting authorization by law, to perform.

**L.O.F. -** Laws of Florida

**LRPP -** Long-Range Program Plan

**Long-Range Program Plan**: A plan developed on an annual basis by each state agency that is policy based, priority-driven, accountable, and developed through careful examination and justification of all programs and their associated costs. Each plan is developed by examining the needs of agency customers and clients and proposing programs and associated costs to address those needs based on state priorities as established by law, the agency mission, and legislative authorization. The plan provides the framework and context for preparing the legislative budget request and includes performance indicators for evaluating the impact of programs and agency performance.

**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.

**MAN** - Metropolitan Area Network (Information Technology

**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.

**NASBO -** National Association of State Budget Officers

**Narrative**: Justification for each service and activity is required at the program component detail level. Explanation, in many instances, will be required to provide a full understanding of how the dollar requirements were computed.

**Nonrecurring**: Expenditure or revenue which is not expected to be needed or available after the current fiscal year.

**OPPAGA:** Office of Program Policy and Government Accountability

**OPB -** Office of Policy and Budget, Executive Office of the Governor

**Outcome**: See Performance Measure.

**Output**: See Performance Measure.

**Outsourcing**: Means the process of contracting with a vendor(s) to provide a service or an activity and there is a transfer of management responsibility for the delivery of resources and the performance of those resources. Outsourcing includes everything from contracting for minor administration tasks to contracting for major portions of activities or services which support the agency mission.

**Pass Through**: Funds the state distributes directly to other entities, e.g., local governments, without being managed by the agency distributing the funds. These funds flow through the agency's budget; however, the agency has no discretion regarding how the funds are spent, and the activities (outputs) associated with the expenditure of funds are not measured at the state level. ***NOTE: This definition of "pass through" applies ONLY for the purposes of long-range program planning.***

**PBPB/PB2 -** Performance-Based Program Budgeting

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

**Performance Ledger**: The official compilation of information about state agency performance-based programs and measures, including approved programs, approved outputs and outcomes, baseline data, approved standards for each performance measure and any approved adjustments thereto, as well as actual agency performance for each measure.

**Performance Measure**: A quantitative or qualitative indicator used to assess state agency performance.

- Input means the quantities of resources used to produce goods or services and the demand for those goods and services.

- Outcome means an indicator of the actual impact or public benefit of a service.

- Output means the actual service or product delivered by a state agency.

**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)

**Policy Area**: A grouping of related activities to meet the needs of customers or clients which reflects major statewide priorities. Policy areas summarize data at a statewide level by using the first two digits of the ten-digit LAS/PBS program component code. Data collection will sum across state agencies when using this statewide code.

**PPO:** Preferred Provider Organization

**Primary Service Outcome Measure:** The service outcome measure which is approved as the performance measure which best reflects and measures the intended outcome of a service. Generally, there is only one primary service outcome measure for each agency service.

**Privatization**: Occurs when the state relinquishes its responsibility or maintains some partnership type of role in the delivery of an activity or service.

**Program**: A set of services and activities undertaken in accordance with a plan of action organized to realize identifiable goals and objectives based on legislative authorization (a program can consist of single or multiple services). For purposes of budget development, programs are identified in the General Appropriations Act by a title that begins with the word "Program." In some instances a program consists of several services, and in other cases the program has no services delineated within it; the service is the program in these cases. The LAS/PBS code is used for purposes of both program identification and service identification. "Service" is a "budget entity" for purposes of the LRPP.

**Program Purpose Statement**: A brief description of approved program responsibility and policy goals. The purpose statement relates directly to the agency mission and reflects essential services of the program needed to accomplish the agency's mission.

**Program Component**: An aggregation of generally related objectives which, because of their special character, related workload and interrelated output, can logically be considered an entity for purposes of organization, management, accounting, reporting, and budgeting.

**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.

**Reliability**: The extent to which the measuring procedure yields the same results on repeated trials and data are complete and sufficiently error free for the intended use.
Service: See Budget Entity.

**Standard**: The level of performance of an outcome or output.

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

**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.

**STO -** State Technology Office

**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.

**SWOT -** Strengths, Weaknesses, Opportunities and Threats

**TANF:** Temporary Assistance for Needy Families

**TCS -** Trends and Conditions Statement

**TF -** Trust Fund

**TRW -** Technology Review Workgroup

**Unit Cost**: The average total cost of producing a single unit of output – goods and services for a specific agency activity.

**Validity**: The appropriateness of the measuring instrument in relation to the purpose for which it is being used.

**WAGES** - Work and Gain Economic Stability (Agency for Workforce Innovation)

**WAN** - Wide Area Network (Information Technology)