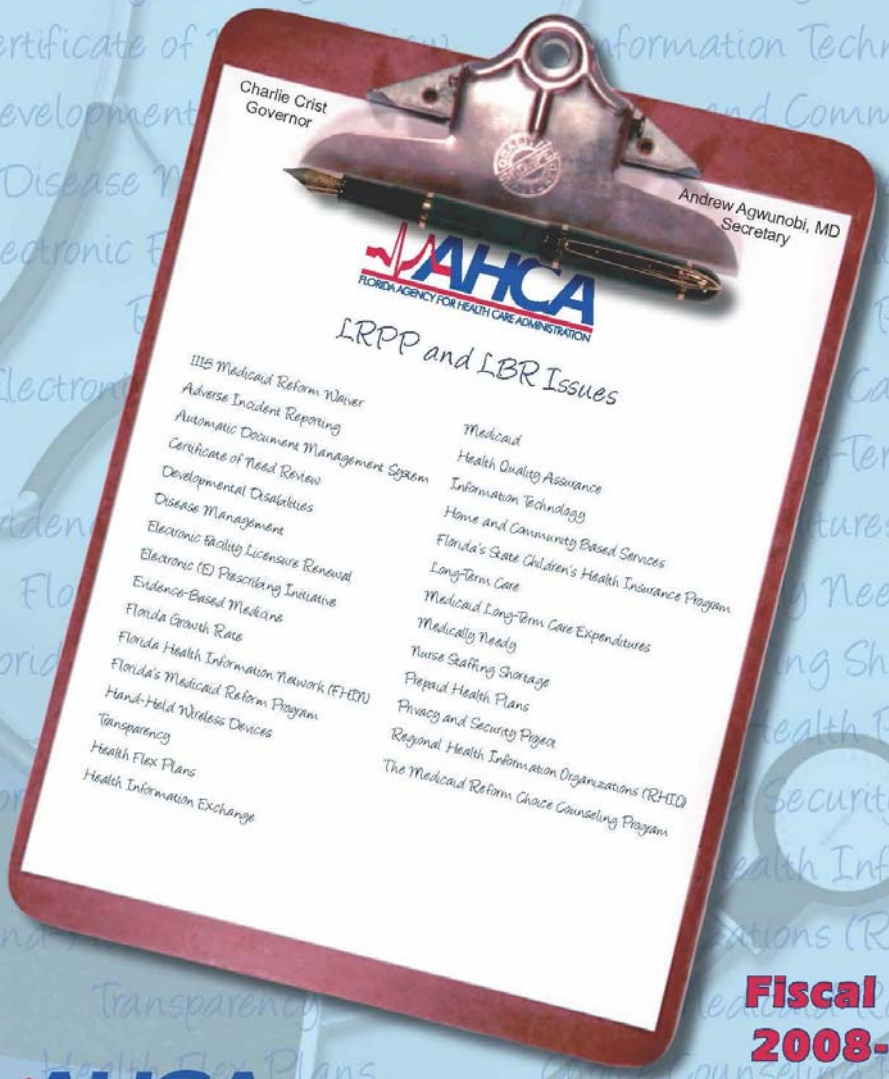
Agency for Health Care Administration

Long Range Program Plan



AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Fiscal Years 2008-2009 through 2012-2013

TABLE OF CONTENTS

Exhibits:

Agency for Health Care Administration's Management Team

Agency Secretary	**Andy Agwunobi, M.D.** (850) 922-3809
Chief of Staff	**Mark Thomas** (850) 922-7245
Deputy Secretary for Communications and Legislative Affairs	**Clint Furman** (850) 922-5583
Director, Florida Center for Health Information and Policy Analysis	**Vacant** (850) 922-7036
Director, Administrative Services	**Janet Parramore** (850) 488-2964
General Counsel	**Craig Smith** (850) 922-5873
Inspector General	**Linda Keen** (850) 921-4897
Deputy Secretary for Health Quality Assurance	**Elizabeth Dudek** (850) 414-9796
Deputy Secretary for Medicaid	**Tom Arnold** **(**850) 488-3560

Agency Mission

The Agency for Health Care Administration Champions Accessible, Affordable and 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 are 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 (Division of 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 (Division of Health Quality Assurance)
3.	**Goal 3**	To increase the availability of transparent health care data and information so consumers may make better informed selection and purchasing decisions.	Administration and Support (Florida Center for Health Information and Policy Analysis)
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 (Communications and Legislative Affairs)

Health Care Services
(Division of Medicaid)

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

Assistant Deputy Secretary for Medicaid Operations ..... Sybil Richard (850) 488-3560

Assistant Deputy Secretary for Medicaid Finance ..... Dyke Snipes (850) 488-3560

Bureaus ..... **Bureau Chiefs**

Medicaid Contract Management ..... Alan Strowd (850) 922-2726

Medicaid Health Systems Development ..... Brady Augustine (850) 922-7339

Medicaid Quality Management ..... Susan Dilmore (850) 413-8059

Medicaid Pharmacy Services ..... Linda Barnes, Acting (850) 922-0681

Medicaid Services ..... Beth Kidder (850) 488-9347

Medicaid Program Analysis ..... Phil Williams (850) 414-2756

Medicaid Area offices ..... Sybil Richard (850) 488-3560

Area Offices **Field Office Managers**

Area 1 ..... Delphine Metarko (850) 595-5700

Area 2a ..... Harold Walker, Acting (850) 921-8474

Area 2b ..... Harold Walker, Acting (850) 921-8474

Area 3a ..... Marilynn Schlott (386) 418-5350

Area 3b ..... Marilynn Schlott (386) 418-5350

Area 4 ..... Lisa Broward (904) 353-2100

Area 5 ..... Noreen Hemmen (727) 552-1191

Area 6 ..... Lorraine Kimbley-Campanaro, Acting (813) 871-7600

Area 7 ..... Charlene Holmes (407) 317-7851

Area 8 ..... Fran Nieves (941) 338-2620

Area 9 ..... Mark Pickering (561) 881-5080

Area 10 ..... Gail Wilk (954) 202-3200

Area 11 ..... Judith Rosenbaum (305) 499-2000

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: (Revised Objective) Under the Medicaid Reform 1115 Waiver, the growth in the per-member per-month (PMPM) expenditure should not exceed eight percent. The initial waiver was implemented in July 1, 2006, and expires June 30, 2011

Service Outcome Measure 1. A: Target weighted PMPM by State Fiscal Year

Service Outcome Measure Projection Table 1. A: Target Weighted PMPM by State Fiscal Year

Baseline/Year FY 2006-07	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
Weighted PMPM by State Fiscal Year $328.24	$382.86	$413.48	$446.56	$482.29*	$520.87*
0	7.4%	7.4%	7.4%	7.4%	7.4%

*Assumes Waiver is renewed for additional years

Objective 1. B: To **maintain or** improve baseline performance on 100 percent of all outcome measures developed under performance-based budgeting and the Long Range Program Plan by FY 2012-13

Service Outcome Measure 1. B: Percent maintained or improved in Medicaid's performance-based outcome indicators.

Service Outcome Measure Projection Table 1. B: Performance Based Medicaid Outcome Indicators tracked over time.

Baseline/Year FY 2007-08	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	FY 2012-13
Number of outcome indicators tracked over time 20	20	20	20	20	20

Baseline/Year FY 2007-08	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	FY 2012-13
Number of outcome measures maintained or improved N/A	N/A	N/A	N/A	N/A	N/A
Percent of outcomes maintained or improved N/A	N/A	N/A	N/A	N/A	N/A

Given the increased emphasis on performance measures, the Medicaid LRPP measures will be submitted for revision per Section 216.1827 (3)(a) F.S. with emphasis on improving the measures to more accurately tie in with the overall goals, programs and services in Florida Medicaid. This will necessitate deletion of 24 existing count measures, revisions to 9 measures, and the addition of 11 new measures.

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 2012-13.

****Due to a change in the number of waivers and the calculation method for long-term care expenditures relative to the Medicaid waiver programs, this measure is being re-calculated to better reflect projected expenditures and will be updated in the near future.****

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

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

Baseline/Year FY 2005-06	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	FY 2012-13
Current LTC Projections $2,677	$3,299	$3,662	$4,065	$4,512	$5,008
Revised LTC Projections $2,534	$3,061	$3,364	$3,697	$4,063	$4,465
LTC Savings $143	$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 2012-13.

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 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
Percent of MediPass patients that reported satisfaction with access to specialty care. 63%	71%	75%	80%	85%	90%

Objective 1. E: To maintain the percentage of the Medicaid budget used for capitated services to 26 percent by FY 2012-13.

Medicaid Program Analysis is requesting to eliminate this objective due to policy changes implemented as a result of direction change. Through the implementation of Medicaid Reform and other managed care expansion policies, the objective to maintain a previous percentage for this budget line is not longer applicable.

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 2012-13.

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 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
Services/programs with consumer directed incentives 1	2	3	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 2012-13.

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 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
Percent of physicians enrolled in Medicaid who use hand-held wireless devices to assist in prescribing 2%	10%	20%	35%	50%	60%

Linkage of Agency Goals and Programs to Governor's Priorities

	Governor's Priorities and Goals	Agency Goals and/or Programs
1.	Open Government	
2.	Plain Language	
3.	Safety and Security	
4.	Property Tax and Insurance Reform	
5.	Education Initiatives	
6.	Adoption/Abuse Prevention Initiatives	
7.	Civil Rights	
8.	Healthcare Initiatives	**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, Florida Statutes (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, 626 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, 58.8 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.

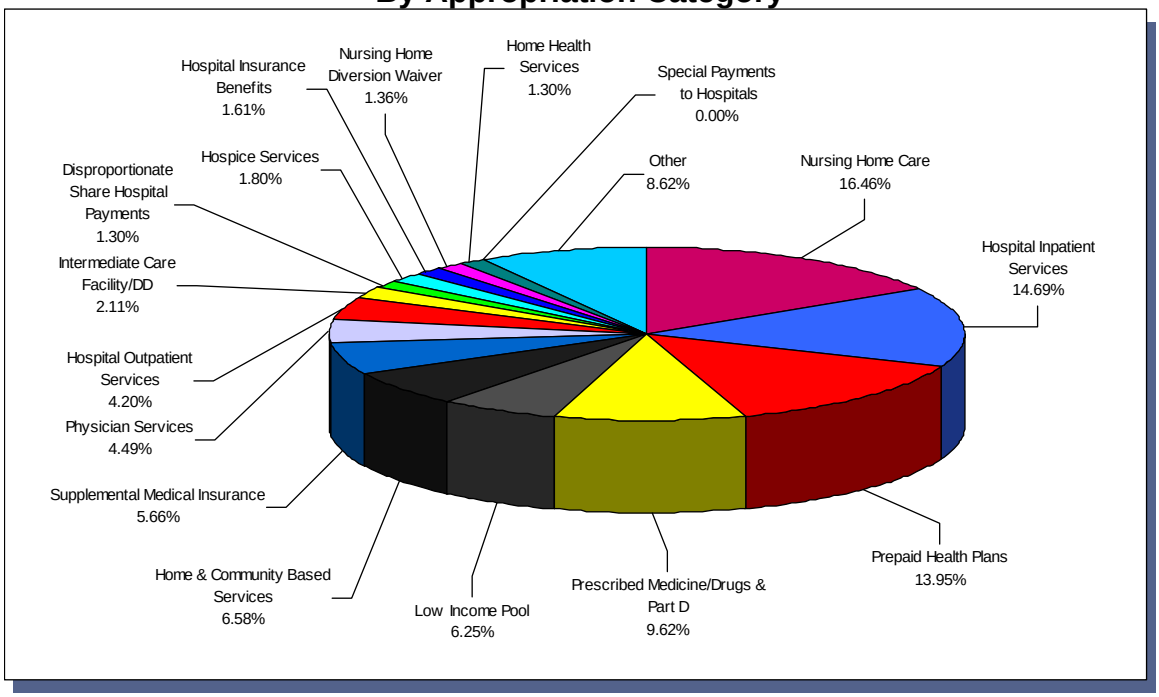
In July 2006 U.S. Census Bureau estimated Florida's population to be approximately 18.1 million, making it the fourth most populous state in the nation. Projections indicate that Florida will become the third most populous state by 2025; its growth rate is among the fastest in the nation.

As population grows, so does the need for health services. Florida has the highest percentage of elderly residents at 16.8 percent. The over 65 population is projected to grow to more than 3.4 million by 2010, nearly 18 percent of the state's total population. As the baby–boom generation reaches retirement age the demand for health services will continue to grow at an increasing rate. 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.

Expenditures in the Medicaid program grew at an average annual rate of 13 percent between Fiscal Year 1999-00 and Fiscal Year 2004-05. The primary factors contributing to the expenditure growth were prescription drug costs, increased costs of medical services, long-term care, and enrollment growth. Between FY2004-05 and FY2006-07, expenditures remained fairly flat, actually dropping slightly in FY 2005-06 and increasing by less than 3.5 percent by the end of FY 2006-07. The slowed growth in expenditures was driven by improvements in the economy and corresponding reduction in caseload, and changes to the Medicare pharmacy benefit. However, after the brief period of relatively flat expenditures, they are expected to increase 11.6 percent in FY 2007-08. The largest expenditure categories for FY 2007-08 are Nursing Home Care ($2.64 billion), Hospital Inpatient Services ($2.36 billion), Prepaid Health Plans ($2.19 billion), Prescription Services ($1.55 billion) and Home and Community Based Services ($1.05 billion). **Figure 1** shows Medicaid expenditures by appropriation category. **Figure 2** shows the largest expenditure categories by beneficiary type.

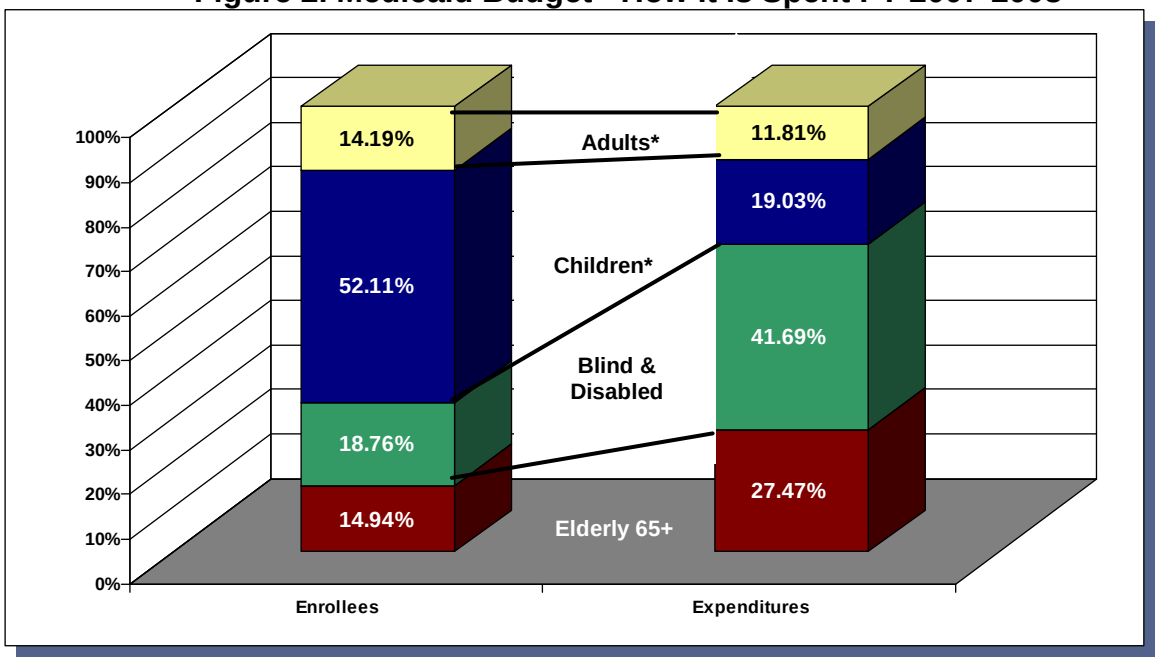
In 2006-07, Medicaid served 3.5 million beneficiaries and processed 145 million claims from approximately 80,000 providers. Medicaid is the second largest single program in the state budget behind public education, requiring more than 22 percent of the state's total budget, and is the largest source of federal funding for the state. While Medicaid caseloads are up almost 38 percent from over a decade ago, there has been a decline over the last two years. A large part of this decline can be attributed to a drop in the Children and Families population (also known as Temporary Aid to Needy Families (TANF)), whose numbers reflect external factors such as the state of the economy, the environment (such as the impact of hurricanes), and eligibility criteria set by State and Federal mandates, and are not within the Medicaid program's control. The average monthly caseload in FY 2007-08 is projected to be slightly less than 2.1 million. See **Figure 3** for average monthly caseloads between FY 1995-96 and FY 2007-08.

Figure 1. Estimated Fiscal Year 2007-08 Medicaid Expenditures By Appropriation Category



Source: GAA 2007-08.

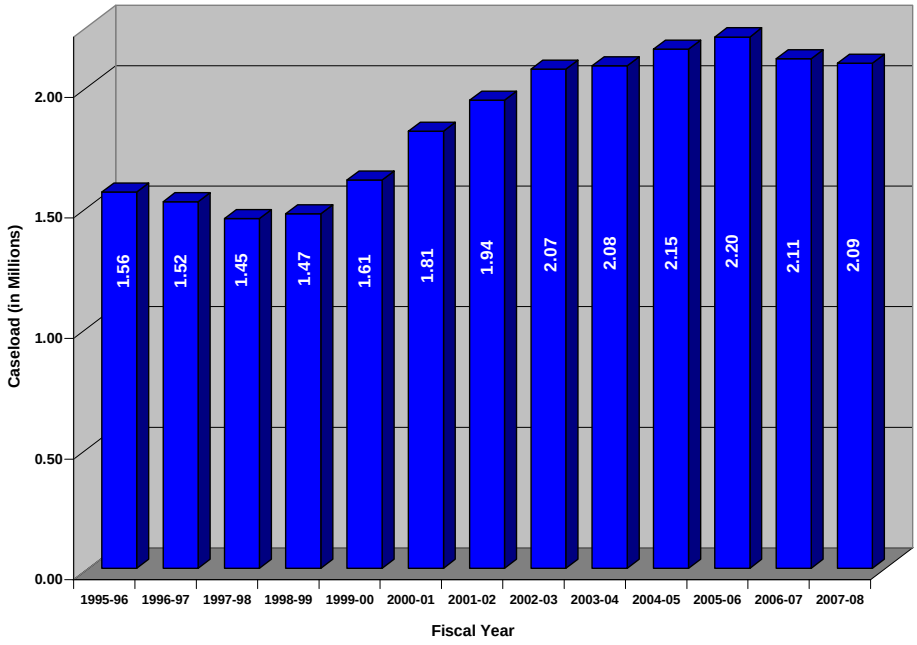
Figure 2. Medicaid Budget - How It Is Spent FY 2007-2008



*Adults and children refers to non disabled adults and children.

Source: Medicaid Program Analysis, August 2007

Figure 3. Average Medicaid Monthly Caseload, FY 1995-96 to FY 2007-08



Source: Social Services Estimating Conference: Medicaid Caseloads and Expenditures, July 30, 2007.

Medicaid Reform

Florida's Medicaid Reform program, created in Section 409.91211, F.S., with the passage of Senate Bill (SB) 838 (View Bill Info) during the 2005 Florida Legislative Session, authorized the Agency to seek 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 beneficiary outcomes in the Florida Medicaid program. The Agency received approval of the 1115 Medicaid Reform Waiver from Centers for Medicare and Medicaid Services on October 19, 2005, and authority to implement the program with the passage of House Bill (HB) 3B during the Florida Special Legislative Session in December 2005.

The Medicaid Reform program began on July 1, 2006, in Broward and Duval Counties. Since the program is a comprehensive demonstration that seeks to change the Medicaid delivery system, the state adopted a measured approach to implementation using a geographic and population phase-in. Expansion to Baker, Clay and Nassau counties began on July 1, 2007; the Florida Legislature will determine additional expansion counties.

The Medicaid Reform program is designed to transform the Medicaid program by empowering Medicaid beneficiaries to take control of their health care, provide more choices for beneficiaries, and enhance 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.

During the initial phase of implementation, children and families and related beneficiaries, and aged and disabled, non-Medicare eligible beneficiaries were required to enroll in a Medicaid Reform health plan. Some beneficiaries were allowed to voluntarily enroll in a Medicaid Reform health plan. Beneficiaries who were in the mandatory eligibility groups were given Medicaid Reform Choice Counseling materials and given 30-days to make a plan selection. If a beneficiary did not make a selection within the 30 day choice period, the Agency assigned the beneficiary to a Medicaid Reform health plan on criteria set forth in Section 409.91211, F.S. The first date of enrollment into a Medicaid Reform health plan was September 1, 2006

The Medicaid Reform Choice Counseling Program is designed to empower eligible beneficiaries to select a Medicaid Reform health plan that best meets their individual health care needs. The Agency established voluntary enrollment goals for the Choice Counseling Program. Each quarter, a minimum of 65 percent of the new Medicaid eligibles should voluntarily enroll in a Reform health plan. At the end of two years, this quarterly requirement increases to 80 percent for the Medicaid Choice Counseling Program.

During the first year of operation, the quarterly contract calculations of the voluntary plan enrollment rate in Broward and Duval counties is presented in Table 1 below. The lowest monthly voluntary plan enrollment rate was 57 percent and the high was 81 percent during the first year.

Table 1 New Eligible Voluntary Enrollment Rate October 1, 2006 – June 1, 2007	
Voluntary Enrollment Numbers for Newly Eligible Enrollees:	
1st quarter	
Voluntary Enrollment Rate	62%
2nd quarter	
Voluntary Enrollment Rate	66%
3rd quarter	
Voluntary Enrollment Rate	74.63%

The number of Reform plans contracted in Broward County by Medicaid was 15 by the end of FY 2006-2007, with 18 hospitals participating. In Duval County, seven plans were contracted, with 6 hospitals participating.

As Florida expands the Medicaid Reform Program statewide, the vast majority of Medicaid enrollees will be required to enroll in a Medicaid Reform health plan. When fully implemented, the Medicaid Reform Program is designed to be the state's primary delivery system, with only a few Medicaid eligibility groups of beneficiaries continuing to receive their health care services through the fee-for-service program. The fee-for-service program will be limited to certain Medicaid eligibility groups such as the Medically Needy and those with retroactive eligibility.

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

Source: Medicaid Health Systems Development, Medicaid Program Analysis, Medicaid Reform Choice Counseling end of year report, FY2006-07.

SCHIP/KidCare

Because of programmatic changes Florida KidCare enrollment declined between 2004 and 2006. Enrollment in Florida's State Children's Health Insurance Program a component of Florida KidCare was 331,281 in July 2004. In July 2006, SCHIP enrollment was 196,674, a 41 percent decrease.

In 2006, the Florida Legislature funded $1 million in matching grants for KidCare community outreach, and provided funding for maximum average monthly caseload 228,159 children in fiscal year 2006-07. In July 2006, the MediKids Full Pay component began, offering MediKids coverage to families with incomes over 200 percent of the federal poverty level. In 2007, the Florida legislature again funded $1 million in matching grants for KidCare community outreach. SCHIP enrollment in June 2007 was 224,575, a 16 percent increase from the 193,639 enrolled as of June 2006. The 2007/2008 Florida Legislature also increased funding for a target average monthly caseload of 236,609. Enrollment in the Title XXI programs will cease when enrollment reaches the General Appropriations Act (GAA) target enrollment ceiling.

While several of the programmatic changes from 2004 have since been eliminated, two of changes that remain in place are an income documentation requirement and a prohibition of enrollment for children who have access to employer-sponsored family health insurance coverage 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 updated the Florida Heath Insurance Study in CY 2004 and KidCare was credited with the decrease in the uninsured rate for children over the five year span between 1999 and 2004. The uninsured rate for children dropped 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.

Source: Florida KidCare Enrollment Reports, 2004 through 2007; KidCare Appropriations Social Services Estimating Conferences, FY 2006-07 and FY 2007-08; Florida Health Insurance Study, 2004.

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 2012-13." 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 90 to 100 days 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.

The Agency was also awarded a $1.7 million Transformation Grant to enhance the promotion of electronic prescribing by allowing physicians to dispense 10 day starter packs of generic medications directly from their offices. This service would only be made available via electronic prescribing with e-prescriptions going to the pharmacy of the patient's choice for the balance of the month's supply and the routine refills as required.

Other efforts to increase use of electronic records included working closely with the Governor's Health Information Infrastructure Advisory Board (Sunset June 30, 2007) 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 (such as those described below), and increased use of managed care under the Reform pilot. These measures are anticipated to facilitate Medicaid meeting Objective 1. A "To limit the increase in per-case-month expenditures for Medicaid beneficiaries to less than eight percent per year for FY 2007-08 through FY 2012-13."

One of the most comprehensive of these initiatives has targeted prescribed drug costs, which at the time controls were introduced, was the fastest growing item in Florida's Medicaid budget. Medicaid has achieved substantial savings with the limits imposed and as a result pharmacy costs have grown less when compared to total costs over the past few years.

To further offset the increases in drug costs, the FY 2005-06 GAA 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.

To compliment the above efforts to offset the increases in drug costs, the FY 2006-07 General Appropriations Act authorized Medicaid to pursue a contract for Medication Therapy Management. The Request For Proposal (RFP) has been completed and a vendor chosen for this service. The contract negotiations are on-going with an expected completion date of October 1, 2007.

Source: Medicaid Pharmacy Services, August 2007

Disease Management/Other programs

The Florida Medicaid Program was a pioneer in developing and implementing disease management initiatives to improve health care for the chronically ill while controlling costs. Focusing on prevention, education and increased self-management for Medicaid beneficiaries, 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 (ITN) as current disease management contracts were expiring. This ITN resulted in a statewide contract with one disease management entity to provide services to individuals with one or more of the following disease states: sickle cell disease, renal disease, congestive heart failure, chronic obstructive pulmonary disease, diabetes, hypertension, and asthma. Due to contracts expiring at the end of 2007, the State released an RFP for HIV/AIDS disease management services in Spring 2007. It is anticipated that a new contract for these services will begin January 1, 2008. The State is also working on contracting with two vendors selected to become specialty pharmacies to manage beneficiaries with hemophilia.

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 to care. The Agency selected a vendor to provide capitated dental services to most children enrolled in Medicaid in Miami-Dade County. The Agency allows the vendor to provide a financial incentive to providers in the plan that provide 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 Service 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.

Source: Medicaid Health Systems Development, Disease Management Office, August 2007

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 utilization is greatest among the population aged 85 and over. 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 Supreme Court Olmstead decision, 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 existing elderly population coupled with a 60 percent growth rate over the last decade for individuals age 85 and older who are more likely to need nursing home assistance. Florida ranks 42nd 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.

Growth in the nursing home budget slowed with the expansion of Medicaid alternatives. Even so, Florida's 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 2012-13."

Source: Centers for Medicare and Medicaid Services, 2006; Social Services Estimating Conference, 2007.

Developmental Disabilities

The Agency has been particularly successful in serving individuals with developmental disabilities in the community. As of July 2007, there were 31,410 individuals 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 14,538. Funding was appropriated to offer waiver services to individuals identified in a crisis situation and for children being served by the Department of

Children and Family in Community Based Care for FY 2006-07. The waiting list includes 4,635 individuals (31.8 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 was directed by the 2007 Florida Legislature to create a four-tiered waiver system of care for beneficiaries with developmental disabilities. The agency has already begun work on this tiered system which will include two new waivers and an amendment to the current Developmental Disabilities Waiver. Beneficiaries will be assigned to the appropriate tier based on identified service needs and historic service utilization.

Finally, the Agency has federal approval to administer the Familial Dysautonomia (FD) Waiver for individuals diagnosed with FD. Consumer and provider enrollment began July 2006.

Source: Bureau of Medicaid Services, Developmental Disabilities and Special Programs Section

MMIS Development/Fiscal Agent Procurement

The Agency has selected a new fiscal agent and is continuing 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/Implementation/index.shtml

FLORIDA MEDICAID LONG RANGE PROGRAM PLAN: A NOTE RELATING TO REVISION OF THE PERFORMANCE MEASURES

Background:

Since the inception of the Long Range Program Plan (LRPP), Medicaid has tried to balance the need for accurate performance measures, tied to program goals, with available data and resources. These measures were revisited in March 2007 and after extensive review, it was determined that not all of the current measures best reflect Medicaid's mission, goals, or programmatic structure. Given the increased emphasis on performance measures, the Medicaid LRPP measures will be submitted for revision per Section 216.1827 (3) (a) F.S. with emphasis on improving the measures to more accurately tie in with the overall goals, programs and services in Florida Medicaid.

LRPP Exhibits II, III, IV, and V do not reflect the proposed new measures for Medicaid which will be handled elsewhere through the Budget Amendment process. However, this brief overview including the following two pages of tables, is provided to help clarify the intended direction of future reporting and to also provide a clearer understanding of the proposed changes to activities and measures that better illustrate Medicaid's performance of its mission.

Summary:

Several of the measures in this report have been marked for deletion. Revisions or replacements to the existing measures, as well as deletion of out-dated measures will be submitted through the budget amendment process.

In all, Medicaid will request that 24 existing measures be deleted. In addition, nine measures will be submitted for revision, along with 11 proposed new measures. Of the 24 measures targeted for deletion, 18 are outputs (counts) that while indicative of the size and scope of the Medicaid program, are not measures that can be affected by anything Medicaid does or has control over programmatically. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate. The remaining six measures are being deleted in favor similar measures that are better defined along programmatic lines.

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 7065 Web Page | PDF	No later than December 31, 2007, the agency shall provide a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives containing and analysis of the merits and challenges of seeking a waiver to implement a voluntary program that integrates payments and services for dually enrolled Medicare and Medicaid beneficiaries who are 65 years of age or older.	Medicaid

Source: Medicaid Quality Management, Project Management Office, August 2007.

Health Care Regulation

(Division of Health Quality Assurance**)**

Deputy Secretary for Health Quality Assurance ..... Elizabeth Dudek (850) 414-9796

- Assistant Deputy Secretary for Health Quality Assurance Rebecca Knapp (850) 414-9796

Bureaus.....**Bureau Chiefs**

Health Facility Regulation .....Jeff Gregg (850) 922-0791

Plans and Construction ..... Skip Gregory (850) 487-0713

Managed Health Care .....Thomas Warring (850) 922-6830

Long Term Care Services ..... Molly McKinstry (850) 414-9707

Field Operations..... Polly Weaver (850) 414-0355

- **Area Offices** **Field Office Managers**

Area 1/2 .....Barbara Alford (850) 922-8844

Area 3 ..... Kris Mennella (386) 418-5314

Area 4 .....Nancy Marsh (904) 359-6046

Area 5/6 ..... Pat Reid-Caufman (727) 552-1133

Area 7 .....Joel Libby (407) 245-0850

Area 8/11 ..... Kris Mennella (239) 338-2366
.....(305) 499-2165

Area 9/10 ..... Diane Reiland (561) 480-0156

Health Care Regulation

(Division of Health Quality Assurance)

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

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 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
Average annual number of renewal applications 11,380	569	1,707	3,414	4,552	5,690
Percent applications received via Internet 0%	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/License Ease 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 will 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 2012-2013

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 2010-11.

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 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-2013
Number of public record requests handled by the Division of Health Quality Assurance 3,723	2,606	2,234	1,862	Completed in previous year	Completed in previous year
Percentage reduction in the public records requests handled by the Division of Health Quality Assurance	30%	40%	50%	Completed in previous year	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 has been implemented in all field offices and in all licensure units in the division; however, there are various additional units that are still in the process of implementation in 2007-08. However, the system is so new that significant results will not be experienced until FY 2008-09. In the interim, we have seen a

reduction in the numbers of public information requests made to the division, although most continue to come into the long term care area.

Objective 2. C: To increase to 60 percent the percentage of managed care plans that meet the statewide average on each reported measure by FY 2012-13.

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 2008-09	FY 2009-10	FY 2010-11	FY 2011-2012	FY 2012-2013
Percentage of Medicaid HMOs that reach the statewide average on the reported HEDIS measures 53.0%	40%	45%	50%	55%	60%

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. A review of the measures for 2006 was telling. In January 2007, the External Quality Review Organization reported results on six HEDIS measures for the calendar year 2006:

- 87% of all plans were above the Medicaid average on only on 1 measure
- On all other measures, the majority of plans (ranging from 46% to 72%) were below the Medicaid average.

The Agency believes a goal of 60 percent might be more realistic for these plans and has altered the above measure to address that reality.

Objective 2. D: To increase the numbers of fully operational Health Flex plans to 20 by FY 2012-13.

Service Outcome Measure 2. D: The numbers of Health Flex plans that are fully operational at the end of FY 2012-13.

Service Outcome Measure Projection Table 2. D:

Baseline/Year FY 2003-04	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
The number of approved, fully operational Health Flex plans 4	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 2012-13.

As of August 2007, there were only five operational Health Flex plans. Of the five plans, only two can be considered successful. 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. Last year, the Division proposed giving this objective an additional year to succeed or be eliminated in the next planning document. As the additional year has not proven helpful, the objective is being eliminated with this planning document. The Health Flex law is scheduled to expire on July 1, 2008.

Linkage of Agency Goals and Programs to Governor's Priorities

	Governor's Priorities and Goals	Agency Goals and/or Programs
1.	Open Government	
2.	Plain Language	
3.	Safety and Security	.
4.	Property Tax and Insurance Reform	
5.	Education Initiatives	
6.	Adoption/Abuse Prevention Initiatives	
7.	Civil Rights	
8.	Healthcare Initiatives	**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 the Governor's priority for healthcare initiatives, including consumer driven healthcare; improving health care through innovation; and working to create standards for best practices to improve outcomes in all healthcare settings. 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, skilled nursing facilities and laboratories.

Nurse Staffing Shortages

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 2007), (full report) 11 percent of the registered nursing positions in Florida hospitals were vacant in June 2006. While this statistic trended down to 8.2 percent in 2005, it has now begun trending upward once again, even though it represents significant improvement over the 15.6 percent overall vacancy rate experienced in CY 2001. In North Florida, the vacancy rate was up to 14 percent! Turnover statistics also increased back to 13 percent, which was above the last high level noted in 2003. 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. To address the nursing shortage in Florida, hospital providers (the primary employers of nurses) offer competitive salaries and sign-on bonuses of $1,000 to $9,000. Agency staff members are clearly prime candidates for facility positions since they not only possess clinical credentials and skills but also have regulatory expertise and can provide guidance to providers regarding regulatory compliance. Furthermore, staff members are required to complete comprehensive training while employed with the Agency, represents an expenditure that is not recoverable. Survey staff receives offers from health care providers that are often well above—sometimes even double--their current surveyor salaries.

As of June 20, 2007, the field offices where the majority of health quality assurance nurses are employed, had a 14.2 percent vacancy rate for registered nurses as compared to an 8.6 percent vacancy rate for all other types of field office staff. This also compares unfavorably to last year's vacancy rate, which was only 12.6 percent. Efforts are in process to increase salaries for nurse surveyor positions through a legislative budget request. These staff members are on call 24/7/365 and salaries are not commensurate with the level of their responsibilities.

A recent review of surveyor salaries in the US has indicated that the starting surveyor salary in Florida is among the lowest in the nation; the disparity of starting surveyor

salaries between Florida and other states is as much as $40,000. The average salary for existing nurses in Florida facilities is $60,000 and higher depending on experience and location, while the average nurse surveyor salary is approximately $45,000 annually. In addition, the median salary for contract nurses in the hospital setting is $45 per hour (over $93,000 annually). Private sector benefits, including salaries and bonuses have surpassed what is available through the current state agency staffing/rate scheme. During the 2007 Legislative Session, the Agency filed a legislative budget request to increase salary levels for the field survey staff. That request would have brought starting salaries of registered nurses to a minimum of $50,000.

Long Term Care Facilities

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 2006 was 88.22 percent, up by 0.40 percent since the prior year. As of March 1, 2007, there were 79,527 licensed and 1,054 approved community nursing home beds in Florida. This represents practically no change from the prior year's total available beds. Medicaid occupancy for CY 2006 was 61.14 percent; six-month occupancy was 61.35 percent during the period July 2006 through December 2006. The percentage increase was created by nursing home closures in 2006. For the first half of 2006, Medicaid occupancy was 60.91 percent, trending upward to 61.35 percent for the second half of 2006. Total occupancy for the first half of 2006 was 88.51 percent versus 87.94 percent for the second half of that calendar year. More beds came on line during the second half of 2006 and but because some were delicensed, the resulting net increase in beds was 190 during the second half of the calendar year.

Overall, Florida's facilities are still improving in some respects. For FY 2006-2007, the most recent year for which complete information is available, conditional days in nursing homes declined to 3,208, down by nearly 73 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 provided in part by Florida's Quality Improvement Organization, 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 2006-2007 report, entitled "Nursing Home and Assisted Living Facility: Adverse Incidents," specifically notes the following:

July 1, 2006 to June 30, 2007

- 4,728 reported adverse incidents occurring with associated outcomes.
- 38 on-site visits to nursing homes and 26 on-site visits to assisted living facilities specifically in response to adverse incidents requiring investigations. These surveys resulted in findings of Class I & II deficiencies in two nursing homes and four assisted living facilities.

- 97 practitioner cases opened by the Department of Health in response to adverse incident reports resulting in 25 license revocations or suspensions.
- 0.57 percent of all nursing home incidents involve the death of a resident compared to 1.78 percent in assisted living facilities.

Comments

- Adverse incident and liability claim information currently available is self-reported and is not subject to verification or audit.
- All data reported are based upon the information received by the Agency from nursing homes and assisted living facilities unless otherwise indicated.
- Counties are not included in tables if no information has been reported.

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.

Another benchmark measure of quality in long term care facilities moved in the opposite direction in 2006/07. That measure is the numbers of serious deficiencies in nursing homes—those listed as Level G or higher. The solid downward trend that occurred from 1998/99 through 2005/06 brought serious deficiencies down from a high of 11.8 percent of total deficiencies to a low of 1.69 percent of total deficiencies. However, in 2006/07, the percent of total deficiencies ranked at Level G or higher rose to 2.18 percent.

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 provided clinical direction on the content of administrative rules for licensure of adult cardiovascular services. When the rules are finalized in 2007, 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 seven years, increasing from 3,984 to 7,547. Increasing numbers of complaints place additional resource requirements upon the Agency in this 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 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, 5 USC § 552, for all the programs and facilities it regulates. This responsibility has grown in complexity over time, and in FY 2006-07, the Agency received 3,000 public information requests, 2,497 (83.2%) of which were made to the Division of Health Quality Assurance. The percentage of such requests to the Agency related to Division activities is increasing steadily over time.

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.

Thus far, the Agency has not experienced problems with the increased public scrutiny afforded by Amendment 7. The Agency did receive one request for an incident report from a law firm concerning the firm's client and citing the amendment as the basis for requesting the report. The Agency had no incident report relating to the client. There is a lawsuit pending before the Florida Supreme Court that may decide whether the amendment is preempted by federal law. The Agency is not a party to that lawsuit.

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, 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.

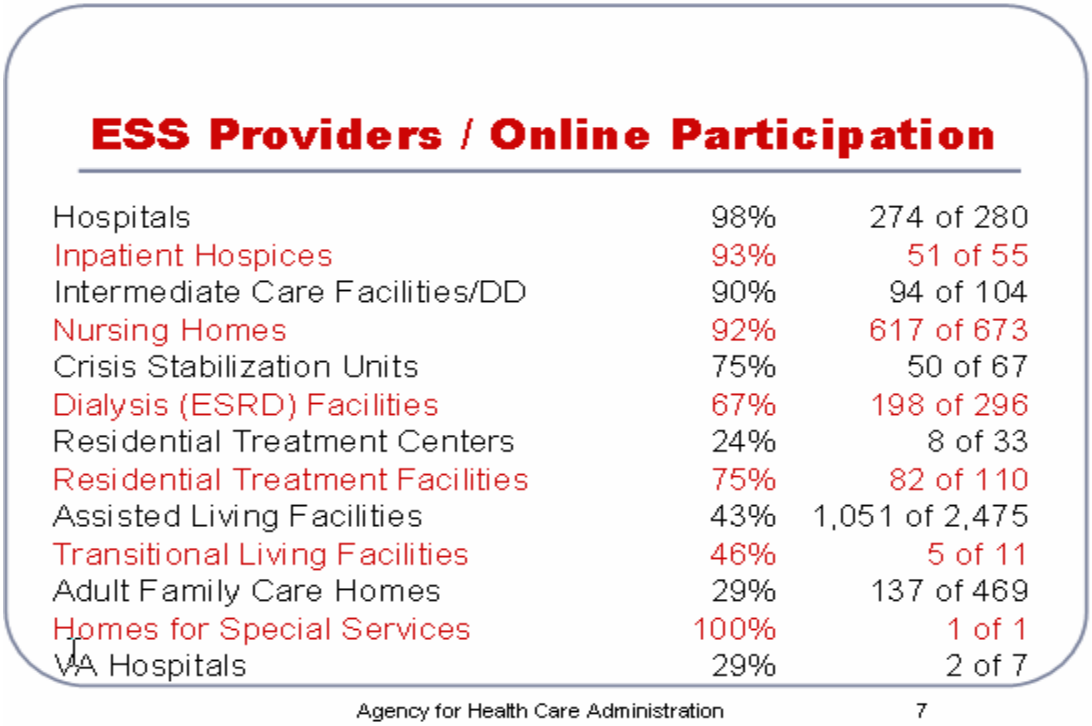
In an additional effort to streamline operations, the Agency plans to offer provider facilities the opportunity to renew their licenses online. This requires the technology to create an online identity management application as well as new programming. The Agency is still in the planning stages on this initiative, and rule promulgation is in process.

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 an on-line tracking system for emergency situations. This system, called the Emergency Status System, or ESS, has developed over a three-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. Recent indications are that the system is gaining acceptance in the provider community. Note participation statistics below as of August 7, 2007.

Figure 4:



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 2006, there were 38 licensed Health Maintenance Organizations (HMOs), up from 37 in 2005. The following statistics are based on data available for these 38 HMOs. Data show enrollment in Florida's HMOs has declined from 4.5 million in CY 2001 to 3.6 million in CY 2006 (AHCA and OIR Data Reports). Aetna had the largest market share with 563,302 enrollees, followed by Humana with 452,083, 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 523,571, which would place WellCare second.

The decline in enrollment did not negatively affect the profitability of Florida's HMOs. In CY 2006, the HMO industry reported an overall net income of $623.4 million, down from $699.9 million in 2005, but up from $478.6 million in CY 2003. HMOs have clearly recovered from the losses incurred in earlier years.

As of December 2006, 20 of the HMOs offered commercial managed care, 26 provided a Medicare product and 13 offered Medicaid plans. Seven HMOs offer all three product lines.

There has been a recent decrease in Medicaid enrollment reflective of the decreasing Medicaid caseload. Medicaid HMO enrollment decreased from 760,207 as of December 2004, to 711,255 in December 2006, or 6.4 percent. HealthEase and Staywell, both product lines of WellCare,

had the largest market share with 353,424 enrollees or 50 percent, followed by AMERIGROUP with 139,872, or 20 percent.

Medicaid HMOs reported operating income of $95.8 million in CY 2006 compared to $30.3 million in CY 2005 for the Medicaid product line only. The consolidated HMO operating income for the 13 HMOs over all product lines grew from $107.3 million in CY 2005 to $316 million in CY 2006.

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 one to five 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 five if it falls one 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 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 uses the Subscriber Assistance Program mandated under Section 408.7056 , F.S. In FY 2006-07, this program reviewed more than 408 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. HMOs 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 174 cases in CY 2004, 175 cases in CY 2005, and 59 cases in CY 2006.

The ongoing process of Medicaid Reform is the single greatest challenge to the Agency's managed care regulatory staff. While the overall goals of stabilizing the growth in Medicaid spending and involving Medicaid beneficiaries in making healthy decisions is in the best interests of all concerned, the transition from the standardized benefit program and fee for service health care delivery system is arduous. Medicaid Reform poses many unique challenges to the Agency's staff. The ongoing transition from non-reform to reform over the next five years will require all involved to be keenly aware of the differences in the programs and understand the needs of the beneficiaries and health care providers.

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 and various concerned groups have met with Agency representatives in an effort to address concerns about insufficient numbers of emergency room physicians, insufficient numbers and types of specialists in emergency rooms and chronic overcrowding... The Florida Hospital Association (FHA) 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 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.

Last year, the Agency was involved in litigation regarding off site emergency departments. Off site emergency departments are departments of an existing hospital that are not located on the main campus of the hospital. The 2007 Legislature passed **CS/SB 1758** which would have extended the moratorium on off premises emergency departments to January 1, 2009. Governor Crist vetoed the bill, stating that a continued moratorium on such facilities would restrict competition and consumer options in a time of overcrowded emergency rooms and long waiting times for patients. He directed the Agency to work with the Legislature and Florida's hospital providers to assess additional standards, including patient transportation protocols and distance requirements between off-site emergency departments and full service hospitals as well as standards for other aspects of emergency care, including access to specialty and ancillary services. Subsequently, the hospitals that were suing the Agency over off-premises emergency rules dropped their litigation; and meetings to address standards are ongoing...

Emergency department issues will be the subject of 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 2006-07 was the fourth 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 1, 2007, the Agency has licensed 2,299 clinics and provided exemption certificates to 5,622 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. The personal injury protection provisions are scheduled to sunset October 1, 2007 unless reinstated by special session of Florida's Legislature... Health care providers that benefit from the requirement for personal injury protection insurance, including hospitals, health care clinics and various practitioners, are attempting to retain this insurance provision. However, regardless of whether PIP provisions sunset, all health care clinics will still require licensure unless they are exempt under the law. 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, 14 clinic licenses have been revoked, 122 licenses have been denied, and 29 clinics have licensure issues in litigation. Nine of the 14 revocations occurred in Dade County, two were in Broward County, and one each in Duval and Hillsborough Counties. The Division of Insurance Fraud arrested 39 healthcare clinic professionals/employees at 24 clinics during fiscal year 2006/07. Of these 39 individuals, 16 were clinic owners.

Status of Legislation

The major legislation from the CY 2007 Legislative Session for the Division of Health Quality Assurance the so-called "Core Revisor Bill", revised individual statutes for facility licensure to delete redundant or superseded provisions addressed by the Health Care Licensing Procedures Act, passed in 2006 as Chapter 408, Part II, Florida Statutes. This legislation is in the ongoing

process of implementation. The Division of Health Quality Assurance received several additional mandates. Additional legislation passed during the CY 2007 session requires the Division to:

- 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. (This reflects a re-appropriation of funds originally allocated in 2006.)

- Establish a one year pilot program in Orange and Pasco counties and a one year pilot program in Manatee, Sarasota and DeSoto counties to offer health care services during the weekend and after regular business hours. The Division must develop procedures for operating the pilot programs and submit a report in January 2008 on the success and outcomes achieved by the pilot programs. An appropriation of $3.5 million is tied to this project. The contracts for these pilot programs are completed and at this writing are being signed by the PCANs in Orange, Pasco and Manatee Counties.

- Develop rules requiring certain licensed hospitals to participate in clinical outcome reporting systems operated by the American College of Cardiology and the Society for Thoracic Surgeons. These rules are in the promulgation process with the first workshop having been held on August 14, 2007.

Bills passed and signed into law also permit the Division's offices to:

- Informally review hospice facility plans prior to construction to assist the facility to comply with the Florida Building Code requirements and Agency rules.

- Review use of disaster premises by adult day care centers quarterly and extend us of these alternate premises beyond the initial 1,890 days allowed by law.

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 2009-2010 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 in play for the 2008 legislative session.	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	Transfer of the Medical Services Unit of Workers' Compensation Program to the Department of Financial Services.	Section 440.13 F.S.	None	None	Revise Section 440.13 F.S. to change all references to the Agency for Health Care Administration to references to the Department of Financial Services.

List of All Task Forces and Studies in Progress

Number	Bill Cite	Ongoing Task Forces and Studies Required by Legislation	Division Assigned
1.	HB 329 Page 40 Line 1160 Web Page	The Agency shall establish a technical advisory panel to develop procedures and standards for measuring outcomes of interventional cardiac programs. Further detail: The panel membership is specified to include representatives of the Florida Hospital Association, Florida Society of Thoracic and Cardiovascular Surgeons, Florida Chapter of the American College of Cardiology, Florida Chapter of the American Heart Association, and others with experience in statistics and outcome measurement.	Health Quality Assurance
2.	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*. The advisory group has fulfilled all of its functions but continues to meet on an ongoing basis as needed due to the cutting edge nature of this subject. If successful, the current LBR on an outcome measurement database/system for adult hospital-based cardiac care will require their input.	Health Quality Assurance

Number	Bill Cite	Ongoing Task Forces and Studies	Division Assigned
3.	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
4.	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**.** This was completed. The Office of Program Policy Analysis & Government Accountability (OPPAGA) report entitled, "Patient Safety Corporation Has Made Progress; Needs to Continue Developing Its Infrastructure", indicated the corporation had expended approximately $1.3 million, the majority being for the development of a near-miss reporting system pilot supporting initial database development and participation for a maximum of 25 health care facilities. Recent indications are that the system has had only 19 volunteer hospitals reporting. While monies have been appropriated to the Agency for funding to the corporation, subsection 381.0273 (9), Florida Statutes, entitled Funding, states: "The corporation is required to seek private sector funding and apply for grants to accomplish its goals and duties." Further the OPPAGA report found "Although the Legislature directed the corporation to seek private-sector funding and apply for grants, it has not yet done so. Seeking external funding sources could reduce or eliminate the need for state funding."	OPPAGA has the lead on this issue. Health Quality Assurance will assist.

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

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

Executive Direction

Agency Secretary.....Andy Agwunobi, M.D. (850) 922-3809

Chief of Staff ..... Mark Thomas (850) 922-5583

- Washington Office..... Monica Henriques (202) 624-5885

- Florida Center for Health Information and Policy Analysis
  Director .....(Vacant) (850) 922-7036
  Bureau Chief.....(Vacant) (850) 922-7036
  - Research and Development.....(Vacant) (850) 922-3012
  - Data Collection and Quality Assurance.....(Vacant) (850) 922-5531
  - Data Dissemination, and Interim Bureau Chief .....Beth Eastman (850) 922-3803
  - Health Information and Technology ..... Christopher Sullivan, PhD (850) 414-5421
  - Federal and State Projects Coordinator..... Carolyn Turner (850) 922-5861
  - Long-Range Program Plan..... Jerome Todd (850) 922-7710

- Administrative Services
  Director.....Janet Parramore (850) 488-2964

  - Budget Office.....Tom Denmark (850) 922-8414
  - Finance & Accounting ..... Paula Shirley (850) 488-5869
  - Human Resources.....James Haynes (850) 922-8435
  - Support Services.....Don McAlpin (850) 921-4406
  - Information Technology.....Frank Folmar (850) 921-7922

Division of Communications and Legislative Affairs
Deputy Secretary .....Clint Fuhrman (850)-922-5583

  - Legislative Affairs .....Mike Murtha (850) 922-5584
  - Communications.....Doc Kokol (850) 413-9666
  - Community Resources ..... Linda Fagan (850) 413-9284
  - Multimedia Design Unit ..... Marti Holland (850) 414-7570

General Counsel.....Craig Smith (850) 922-5873

- Deputy General Counsel.....Bill Roberts (850) -922-5873

Inspector General ..... Linda Keen (850) 921-4897

  - Medicaid Program Integrity .....Ken Yon (850) 921-1802
  - Internal Audit .....Michael Blackburn (850)-414-5419
  - Investigations ..... Jerome Worley (850) 487-3697
  - HIPAA Privacy and Security Compliance.....John Collins 850- 487-9906

Executive Direction

Chief of Staff (Florida Center for Health Information and Policy Analysis)

Goal 3: Increase the availability of transparent health care data and information so consumers may make better informed selection and purchasing decisions.

Objective 3. A: Shorten the length of time required to process and post certified patient data on *www.FloridaHealthFinder.gov* from 485 days to a maximum of 198 days by FY 2012-13.

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.FloridaHealthFinder.gov*.

Service Outcome Measure Projection Table 3. A:

Baseline/ Year FY 2005-06	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
Number of days from data receipt to posting on website	485	388	310	248	198
% Decrease in days to post on website *	0%	20%	20%	20%	20%

*% decrease was reduced to 20% based on the decision to maintain current certification deadlines in rule.

The purpose of Objective 3.A is to promote streamlined and enhanced data processing functions (collection, auditing, certification, database upload, maintenance and dissemination) in a climate of growing production demands with faster consumer accessibility to high quality health data information within existing personnel resources.
The Agency should take advantage of all technologies to speed data processing and public reporting. The Agency submitted a 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. The Florida Center will

determine which technology and process strategies are best to accomplish this objective and it will develop a LBR to acquire resources needed to improve data processing.

Objective 3.B: To increase by 10 percent annually through FY 2012-13 the average daily number of persons who visits *www.FloridaHealthFinder.gov*.

Service Outcome Measure 3.B: The average daily number of website visits to www.FloridaHealthFinder.gov. (This measure more accurately reflects the number of people who access the website, instead of the number of times any page within the website is opened. Ordinarily, a person will have one session in which many pages are opened. The baseline number below is taken from the original Agency website www.FloridaHealthStat.com.)

Service Outcome Measure Projection Table 3.B:

Baseline/Year FY 2006-07	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
Average number of sessions on web site per day 3,107	3,418	3,760	4,136	4,550	5,005
Annual percent of increase in the number of sessions begun per day	10%	10%	10%	10%	10%

Objective 3. C: To increase at a non-linear rate of five percent annually, through FY 2012-13, the number of practitioners using electronic medical record systems connected to a Regional Health Information Organization that is part of the Florida Health Information Network.*

Service Outcome Measure 3. C: The number of practitioners adopting electronic medical record systems and connecting to a Florida Health Information Network Regional Health Information Organization.

Discussion: Research on the adoption rate of electronic medical record systems indicates a penetration rate of roughly 25 percent of physicians across the country in 2006, as shown in Figure five, based on a study by Ford, et al.[1] The projected diffusion of electronic medical

[1] Ford, E.W., Menachemi, N, Phillips, M.T. (2006). *Predicting the Adoption of Electronic Health Records by Physicians: When Will Health Care be Paperless?* Journal of the American Medical Informatics Association Volume 13 Number 1 Jan / Feb 2006

records systems shows three scenarios, from optimistic to conservative, with the upper curve at about 60 percent of physician adopting by 2012, and the conservative estimate projecting only 40 percent of physicians adopting by 2012. The intent of the electronic medical record pilot project is to optimize the adoption rate of electronic medical record systems by physicians, and aim for a 20 percent increase in the percentage of practitioners with electronic medical record systems by 2012. To accomplish this it will be necessary to lower the barriers to entry for physicians by offering a low-cost software solution, and to provide training and communication opportunities to make physicians aware of the opportunity. Both of these activities are part of the proposed pilot project. The estimated percentage of physicians in Florida in 2007 is 20 percent, which forms the baseline for adoption of electronic medical record systems.

Figure 5:

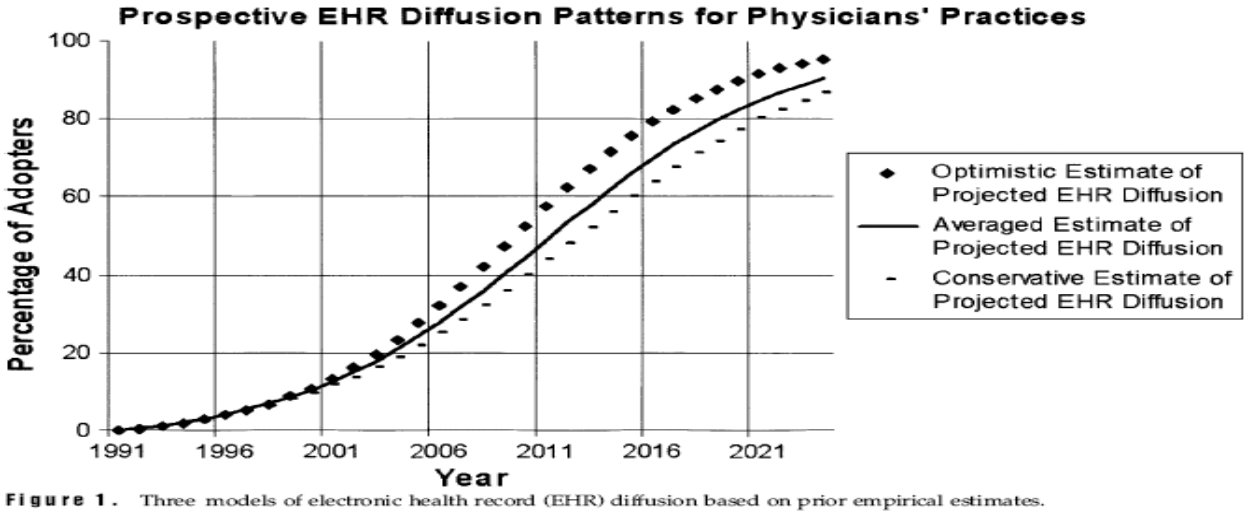


Figure 1. Three models of electronic health record (EHR) diffusion based on prior empirical estimates.

Service Outcome Measure Projection Table 3. C (1):

Baseline/Year FY 2006-07	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
Percentage of Florida physicians using electronic medical records 20%	20%	25%	30%	35%	40%
Projected annual percent of increase in the number of records accessed (see table)	0%	5%	5%	5%	5%

This objective has been changed from last year's LRPP. The new objective is based on the adoption of electronic medical records systems by physicians rather than on the use of the network to access medical records

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

	Governor's Priorities and Goals	Agency Goals and/or Programs
1.	Open Government	
2.	Plain Language Initiative	**Goal 3:** To increase the availability of transparent health care data and information so consumers may make better informed selection and purchasing decisions. .
3.	Safety and Security	
4.	Property Tax and Insurance Reform	
5.	Education Initiatives	**Goal 3:** To increase the availability of transparent health care data and information so consumers may make better informed selection and purchasing decisions.
6.	Adoption/Abuse Prevention Initiatives	
7.	Civil Rights	
8.	Health Care Initiatives	**Goal 3:** To increase the availability of transparent health care data and information so consumers may make better informed selection and purchasing decisions.

Trends and Conditions Statement:

Office of Data Collection and Quality Assurance

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 on a quarterly basis.

Collection of Patient Data:

Hospital inpatient data collection is authorized under s. 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 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 255 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 2,828,495 records in 2006 for an increase of 21.1 percent. The number of records continues a steady 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 59B-9, Florida Administrative Code.

The ambulatory patient data collection database (initiated in 1997) is a companion to the hospital inpatient database. The Florida Center currently receives patient-level data from approximately 570 facilities (ambulatory surgical centers, hospitals, cardiac catheterization labs and lithotripsy centers.) 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.

The number of ambulatory patient records submitted increased from 2,278,559 records in 2000 to 3,157,915 records in 2006, for an increase 27.8 percent.

Emergency Department data collection is authorized in s. 408.061 (1), F.S., and is implemented under Chapter 59B-9, Florida Administrative Code. A significant change to the ambulatory patient data rule required the new reporting of hospital emergency department data beginning January 1, 2005. There were 5,075,679 emergency department discharges in 2005 and 5,730,442 discharges in 2006 for an increase of 11.4 percent.

Comprehensive inpatient rehabilitation data collection is authorized under s. 408.061 (1) (e), F.S., and is implemented under Chapter 59E-7.201, Florida Administrative Code.

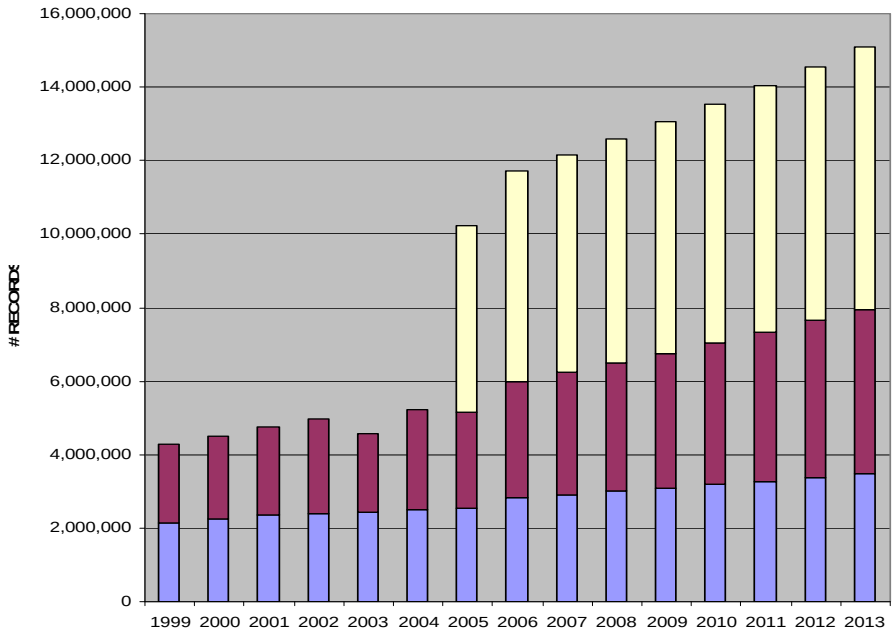
The comprehensive inpatient rehabilitation database (initiated in 1993) is a companion to the hospital inpatient and the ambulatory patient databases. Although there are far fewer comprehensive inpatient rehabilitation records than hospital inpatient or ambulatory, rehabilitation care continues to be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

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

The number of comprehensive inpatient rehabilitation discharge records submitted decreased from 18,216 in 2000 to 16,917 in 2006 for a decrease of 7.1 percent.

As additional resource, the following tables provide a visual comparison for the historic, current and projected volume of data collected.

Figure 6: DATA COLLECTION HISTORICAL TREND
Number of Records/ Discharged Patients



	Emergency Department
	Ambulatory Surgery
	Hospital Inpatient

Figure 7:

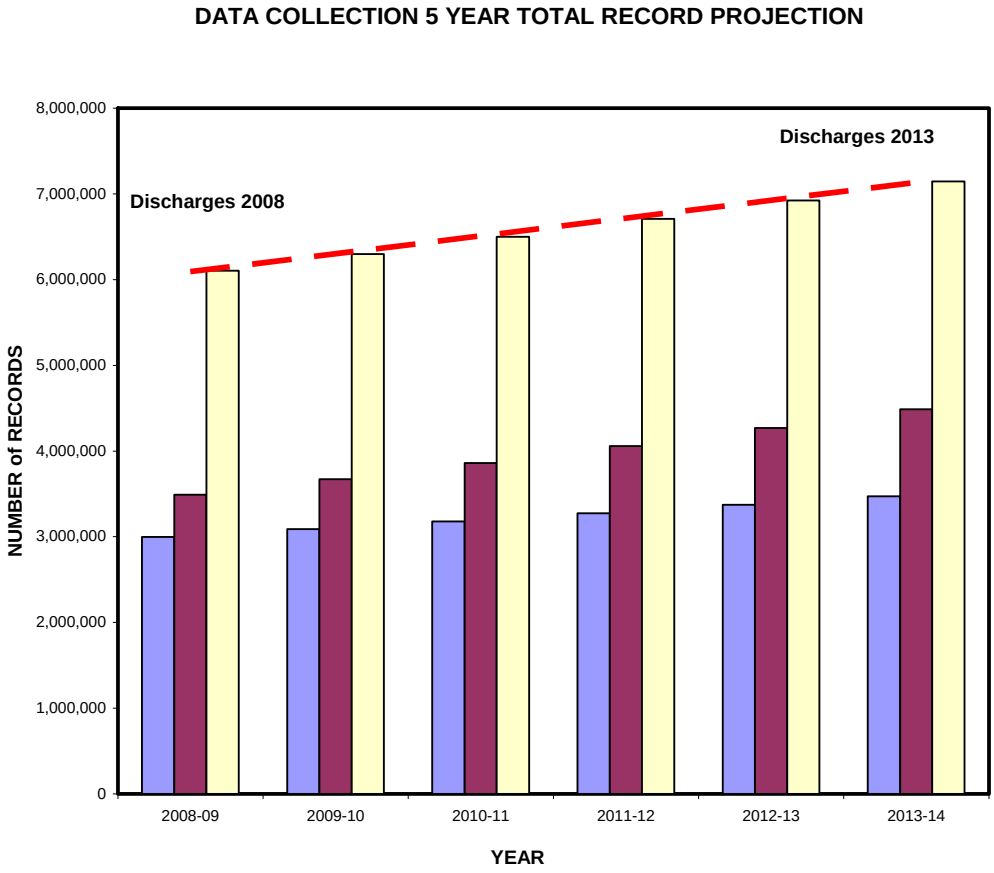


Figure 8: Growth Increase Based On Historical Records

Fiscal Year / Record Type	2008-09	2009-10	2010-11	2011-12	2012-13
IP Hospital Inpatient	2,999,003	3,088,073	3,179,789	3,274,228	3,371,472
AMB Ambulatory Surgery	3,491,555	3,671,371	3,860,446	4,059,258	4,268,309
ED Emergency Department	6,103,058	6,298,356	6,499,903	6,707,899	6,922,551
TOTAL Records	12,593,616	13,057,800	13,540,138	14,041,385	14,562,332

Record volumes have exceeded anticipated record counts due to emergency department data collection implemented per Chapter 59B-9 F.A.C.

Hospital Inpatient Data Collection

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, level III 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 (inclusive of Medicaid, Medicare, and Commercial HMO and self-pay) 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 2005, the rule for inpatient data collection, Ch. 59E-7.012 , F.A.C., was changed to require hospitals to send their data to the Florida Center via the Internet as of January 1, 2006. 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 Florida Center computers, 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, along with other technical enhancements, will result in greater efficiencies and continued decrease in the time required to process inpatient data.

Also in 2005, the Florida Center amended the rules governing hospital inpatient data collection, Ch. 59E-7.014 F.A.C., 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 (POA) for each of the other diagnostic codes reported; this measure

indicates whether the patient entered the hospital with the condition, or if it developed after admission. This measure was to be reported beginning on January 1, 2007. Due to ongoing changes projected by the Centers for Medicare and Medicaid (CMS), the Agency reopened the rule to allow modification and expansion of the required reportable to include POA for reported principal diagnoses and e-codes.

Surgical Infection Prevention Measures

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 one 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, 2005. Hospitals began reporting SIP data on all eligible patients beginning the second quarter of 2005. Additional staff resources were not added to establish protocol and process the SIP data submissions. Although the initial intent was to display data from the State collection, data currently displayed on the website continues to be drawn from the Centers for Medicaid and Medicare Services (CMS), not from the State database.

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 and progressively more 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 even more valuable in studying the trends in Florida health care.

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

Through 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 during the reporting period may request exemption from submitting data for that 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. More information about data confidentiality issues is presented in the "Data Dissemination" chapter.

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, F.A.C, 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. Other substantial changes relate to the addition, deletion and modification of specific data elements, codes and standards. Please see Appendix A: Facility Performance Status Report for more details on changes to this rule.

Emergency Department Data Collection

Emergency Department data collection is authorized in 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 include, 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, F.A.C.). 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 s. 408.061 (1) (e), F.S., and is implemented under Chapter 59E-7.201 Florida Administrative Code.

The comprehensive inpatient rehabilitation data contains patient-level discharge information from Florida's 14 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.

System of Patient Data Collection
The Florida Center is compelled to analyze the current system of data processing from the point of collection to the dissemination and publication of health information.

The demand for health care transparency continues to drive the Florida Center to collect growing volumes of complex data, faster and more efficiently. There is a corresponding need for greater technological supports to collect, validate and analyze the data.

The Agency seeks to more rapidly accept and process the growing volumes of electronic data submissions while continuing to assure accuracy and validity. The desired outcome is a faster turn-around of information and accessibility by all stakeholders (consumer, researcher, facilities and policy drivers.) It is anticipated that technical enhancements and increased automation will greatly accelerate the Agency's capability to collect, audit and disseminate data, enhance the State's health care database and improve the availability of information for consumer websites. Reducing the time between initial data report and the timely dissemination of public information is critical to all decision makers, consumers and policy drivers.

This vision must be supported with resources. The Florida Center was unsuccessful in its FY 2007-2008 legislative budget request (LBR) attempt to secure the necessary funds to begin evaluation of the current system. A similar LBR is prepared for FY 2008-09. This will be the first of several necessary budget requests to support the technological phases to incrementally address current data collection system deficiencies. The launch of the analysis and upgrade development is unlikely to occur without sufficient funding. The estimated cost to conduct this

analysis is $250,000. Future requests will be directly determined by the results of that systems analysis.

Office of Data Dissemination

Health care transparency in the health care delivery system is a compelling need and concern for all health care constituents. This 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 (Agency) 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 as mandated in the CY 2004 House Bill 1629 (Affordable Health Care) (Web Page | PDF) and CY 2006 House Bill 7073 (Health Care Information) (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 can be possible with the effective use of information technology in improving health care. The Agency 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 affords Florida an opportunity for collaboration among health care stakeholders to develop an effective health information system. There have been many calls from political leaders and policymakers for development of a system that will provide consumers access to more information and data that will assist them in making informed health care selection and purchasing decisions.

The Agency for Health Care Administration was charged with developing website access to consumer health care information. In response the Agency's Florida Center for Health Information and Policy Analysis (Florida Center) launched www.FloridaHealthStat.com in January 2000. The site provided a list of licensed health care facilities; patient data from hospitals and ambulatory surgery centers; information on insurance programs, prescription drug programs, and seniors; a drug price comparison tool; consumer publications; statistical reports and much more. From July 2003 through June 2007, FloridaHealthStat.com received 2,860,000 visitors.

In November 2005, as legislatively mandated, the Florida Center developed FloridaCompareCare.gov. This consumer-focused website provided performance data for selected medical conditions and procedures in Florida's short-term acute care hospitals and ambulatory surgery centers. Consumers could view data on hospitalizations, length of stay, mortality and infection rates in hospitals and the numbers of visits and charges at ambulatory surgery centers. In 2006 a health plan comparison tool was added to the site, including information on access, quality of care, financial performance, and a membership satisfaction survey.

From November 2005 through June 2007, FloridaCompareCare.gov received 426,500 visitors. FloridaCompareCare.gov has received national attention from such organizations as the

National Association of Health Data Organizations (NAHDO), (www.nahdo.org) the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention, and others.

With a proven record of community outreach and education through these two websites, plans were made to combine the two sites into one central location, to make access and navigation easier for the public. In the fall of 2007 FloridaHealthStat.com and FloridaCompareCare.gov were combined into one central website, *www.FloridaHealthFinder.gov*.

This provided an opportunity to update and expand on the website content and to create an attractive format. Input from consumers was gathered through a website usability study conducted in several locations across Florida in 2006, giving us hands-on information for improving website navigation and content. With a commitment to continually improve on the information provided to the public, the new site will include the A.D.A.M. Medical Encyclopedia and a quick reference Symptom Navigator, and in spring 2008 physician comparison information will be added to the site.

Providing information through a website allows for quick update and dissemination of information, allowing us to respond quickly to developing health care trends, to address concerns expressed to us by consumers, and allows us to update data more quickly as it becomes available. It also provides for a wider dissemination of information, as compared to using only a print format.

For example, since consumers can contact us through the website we quickly learned that many people have questions about health insurance in general and about their need for services due to insufficient insurance coverage or lack there of. In response we added additional insurance information to the site, including links to the Florida Department of Insurance, as well as information on Medicaid and Medicare. We also created an extensive Medical Help Resources page that includes referrals to direct medical and social services for Floridians.

Another example is related to the over utilization or inappropriate use of emergency rooms for non-urgent care. We added educational information about emergency room care and the Medical Help Resources section provides alternative choices for non-urgent care as well as preventive care.

We respond directly to consumer inquiries sent through the website “Contact Us” link and have referred consumers to the correct information, agency, or private organization where they have found the assistance or information they needed after having spent days, months, or even years searching. Employees of other state agencies and community-based programs have told us they use the website’s list of health care facilities or the Medical Help Resources to assist their clients.

Additionally, health care professionals and researchers use the website data search tools to conduct health care research, look at health care trends, and contribute to health care literature and research.

The variety and wealth of information on the Agency’s website helps Floridians be well-informed health consumers. It allows consumers to compare costs and quality measures, and gives them the power of choice. When consumers can make choices about where they want to receive their health care, based on quality of care and costs, it gives them greater control over their

health care outcomes. These choices can influence rising health care costs and create incentives for health care providers to create a higher quality products and better delivery.

The *www.FloridaHealthFinder.gov website* provides health care information directly to the public and is able to continue this work with recurring funds of $266,000 to maintain the website; these funds are used to contract with a vendor to develop, host and maintain the website. Various deliverables include calculating outcome measures, updating the website on a quarterly basis, incorporating future outcome measures following national standards, and website utilization reports.

Health Plan Performance Reporting
Since 1999, health plan performance data have been reported to the Florida Center by all of Florida's licensed health maintenance organizations (HMOs) for each line of business (commercial, Medicare, Medicaid and Healthy Kids). There are two major sources of data in this reporting system:

- Health plan quality indicator data, as required under § 641.59 (9), Florida Statutes, known as the Health Plan Employer Data & Information Set (HEDIS); and,

- Health plan member satisfaction information, as required under § 641.58 (4), Florida Statutes, known as the Consumer Assessment of Health Plan Survey (CAHPS).

Quality indicator data typically display the percentage of eligible members who have received a specific health care service during the measurement year. The indicators reported to the Agency include measures of chronic disease management, preventive health care, prenatal care and checkups for infants, children, and adolescents.

The member satisfaction survey data contain the results of an annual statewide survey of a sample of members in each HMO. The data contain the responses of members to a set of approximately 40 questions regarding their experience with their health plan. The survey includes questions about health care utilization, access to care and specialists, communicating with health care providers, customer service, experience with claims processing and overall satisfaction with the health plan.

Prior to 2006, the Florida Center annually published summary results from these two data sets, in the *Florida HMO Report*, (http://healthplans.floridahealthstat.com/)along with "check mark" ratings that ranked each health plan on each summary indicator and survey question. In 2006, these results were posted to the Agency's website www.FloridaCompareCare.gov.

State Consumer Health Information and Policy Advisory Council (http://ahca.myflorida.com/SCHS/chis.shtml)

The State Consumer Health Information and Policy Advisory Council (Advisory Council) has played an integral role in the development and expansion of health care transparency in Florida. The Advisory Council has worked closely with the Florida Center for Health Information and Policy Analysis (Florida Center), in choosing the type of health care data to be collected, the use of this data, and the development of health care reports as well as the FloridaHealthStat.com, FloridaCompareCare.gov, and *www.FloridaHealthFinder.gov* websites.

Through the use of technical workgroups the Advisory Council members and Florida Center staff have developed and implemented action plans in these developments. The technical workgroups include: Health Plan Workgroup, Hospital-Acquired Infection Workgroup, Facilities/Ambulatory Surgical Center Website Workgroup, Physicians Workgroup, and Public Relations Workgroup.

Since November 2005, the Advisory Council has assisted the Florida Center in the following accomplishments:

- Launch www.FloridaCompareCare.gov, making Florida the first state to publicly report hospital infection rates and mortality rates;
- Develop a communications plan for www.FloridaCompareCare.gov, including an action plan and budget needs to implement the plan;
- Develop and launch the health plan comparison tool on www.FloridaCompareCare.gov;
- Add pediatric care data to www.FloridaCompareCare.gov, making Florida the first state to publicly report specific data on pediatric conditions and procedures; and
- Preparation and research in the current development of the web-based physician comparison tool, to be added in spring 2008.

Some Advisory Council recommendations for future development include:

- Keep informed about national transparency initiatives and the State of Florida's status in regards to same;
- Explore policy development as it relates to transparency;
- Examine rules to see if we need to expand on current data collection;
- Discuss expansion of current measures and inclusion of additional measures;
- Review current methodologies for public reporting and attendant policy issues;
- Expand reporting to possibly include other health care facility types;
- Review current regulatory and legislative mandates and authorities and the impact on the Agency, the Advisory Council and their mission, vision and purpose; and

- Expand information on the site, including a list of community and urgent care centers for non-emergency events, enhancement of pediatric data, ambulatory surgery data on procedures for children, separate readmissions data for pediatrics and adults, based on the initial admission, and more.

Consumer Communication Campaign
Since the launch of FloridaHealthStat.com in 2000 and FloridaCompareCare.gov in 2005, the Florida Center and the Agency for Health Care Administration have used outreach programs and activities to promote consumers awareness and use of the websites. With the launch of the new central website, we are again marketing the value and availability of the site.

In cooperation with the State Consumer Health Information and Policy Advisory Council (Advisory Council) and its Public Relations Workgroup, the Florida Center for Health Information and Policy Analysis (Florida Center) is developing a communications plan for use in conducting community outreach activities. These activities shall include participating in conferences, 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 inform their membership about the Agency's website.

Although Florida leads the nation in providing transparent health care information through the Agency's website there is a need to be more aggressive about our efforts to keep the public informed about health care availability. The Florida Center and the Advisory Council are working hard to promote and encourage Floridians to use the Agency's website.

In FY 2007-08 a the Florida Center requested $500,000 recurring dollars to conduct a communication outreach campaign to inform Floridians of the availability of health care information on FloridaHealthStat.com and FloridaCompareCare.gov. While this LBR was not approved, the need still exists for education and community outreach to inform the public about the availability of Web-based health care information on *www.FloridaHealthFinder.gov*. The Florida Center will continue to use the avenues currently available for educating consumers and will work with appropriate stakeholders to develop and implement further outreach.

The Agency's website initiatives are leading the nation in health care transparency and technology. Florida was the first state in the nation to publicly report infection 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, the Legislature must continue to appropriate funds to the Agency for Health Care Administration.

In compliance with the Governor's instructions to reduce government spending by 10 percent, the Florida Center did not propose a FY 2008-09 LBR to expand the scope and functionality of *www.FloridaHealthFinder.gov*. However consumers will demand the Florida Center do whatever is necessary to take the website to the next level required to make it competitive and at the front of national advancements in public reporting. As the public become more accustomed to using and relying upon the Agency's website as its primary source of reliable transparent health care information and data, they will demand more. The required technology needed to respond to this anticipated demand is available now, but it can be expensive to acquire and maintain. The benefits to be acquired from investing in intelligent data collection and public reporting health care technology are significant.

To ensure our technology development dollars will be invested properly, the Florida Center is working with our stakeholders in a deliberative approach to build a website system that will advance Florida into the next decade of information processing and distribution. Activities includes consultation with state and federal organizations, corporate leaders, the health care provider community and consumers to ensure that a through assessment is completed prior to requesting money to expand technology.

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 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.

In July 2006, the Office of Health Information Technology was formed in the Agency following passage of the Coordinated Health Care Information and Transparency Act of 2006. This bill added language to § 408.05 (4) 9, F.S. authorizing the Agency to:

- Monitor innovations in health information technology, informatics, and the exchange of health information;
- Maintain a repository of technical resources to support the development of a health information network;
- Administer, manage, and monitor grants for planning, implementation, or training projects to advance the development of a health information network;
- Oversee, manage, and evaluate the integration of health care data from each state agency that collects, stores, and reports on health care issues; and make that health care data available to health care practitioners through a state health information network.

The Office of Health Information Technology has a staff of three. They serve as staff support for the Governor's Health Information Infrastructure Advisory Board (Governor's HII Advisory Board) and manage the Florida Health Information Network (FHIN) Grants Program to Regional Health Information Organizations (RHIO) in Florida. In the 2006-2007 grant cycle there were six health information exchange projects funded through the FHIN Grants Program. In addition to managing payments, staff collect monthly and quarterly progress updates, and coordinate quarterly meetings to promote open communication among the Regional Health Information Organization members. The office is also creating a health information technology resource center to provide information on state and federal grant opportunities and on the latest software and hardware trends in health care informatics to the health information exchanges in Florida.

The Office of Health Information Technology has been active in writing and administering a number of federal grants. In 2006, the office helped staff the Florida Privacy and Security Project as part of the national Health Information Security and Privacy Collaboration, initiated by the Office of the National Coordinator for Health Information Technology and the National Governor's Association. The Governor's Health Information Infrastructure Advisory Board was the Steering Committee.

In the fall of 2006, the office participated in a Medicaid Transformation Grant proposal that was submitted to the Centers for Medicare and Medicaid Services (CMS) by the Agency. This project proposed the creation of a shared electronic health record system by integrating claims from Florida Medicaid and two or more private payers. The goal of the proposal was to make the claims information accessible to authorized Medicaid clinicians through a secure website operated by a Regional Health Information Organization. The goals of the project were to integrate payer health records in an operational health information network and deliver up-to-date information on recent medical encounters to physicians over a secure network connection. The project hoped to demonstrate cost savings and improved clinical outcomes for the targeted non-institutionalized non-elderly population, and assess the impact of the payer health records on the sustainability of the health information network. The proposal was not funded in the first round of selection, but was rewritten and resubmitted to CMS when a second round of transformation grants was announced in 2007.

In the fall of 2006, the office responded to an Order by the Federal Communications Commission that established a pilot program to fund the construction of broad band networks for public and non-profit health care providers. The intent of the order was to enhance their access to advanced telecommunications and information services, and innovative telehealth and telemedicine services. The grants were expected to promote connecting rural hospitals with their urban counterparts. The office formed a collaboration with interested parties in the *Department of Health, the Department of Management Services, the Executive Office of the Governor , the Florida Hospital Association, the Florida Medical Association, the Florida State University College of Medicine, the University of Florida College of Medicine, North Florida Medical (FACHC MEMBERS) Centers, Federally Qualified Health Centers (FQHC) Center, the Community Health Informatics Organization the Big Bend Regional Healthcare Information Organization, Florida LambdaRail and Nemours.*

Working with this group the Office of Health Information Technology developed a response to the Federal Communication Commission order by proposing to connect nine rural hospitals located in Florida's Panhandle rural health region with urban providers in Pensacola and Tallahassee with an I Gigabit dedicated broad band network and extend services from the Big Bend RHIO to these rural providers. The proposal would also provide access to Children's Medical Services telehealth applications in North Florida, promote telehealth applications for chronic disease monitoring in the home, and develop a funding formula for sustainability of services to eligible providers in rural counties or underserved areas. The Broadband Pilot Program proposal was submitted in May 2007.

Creation of Health Information Technology Committee and
Accomplishment of Governor's Health Information Infrastructure Advisory Board

The Governor's Health Information Infrastructure Advisory Board (Board) sunset June 30, 2007 after completing its work. As a result of the leadership of the Board the Agency is able to move forward in implementing the programs and plans recommended by the Board and health care stakeholders. The Agency will establish a Committee through the State Consumer Health

Information and Policy Advisory Council to enable the Agency to continue to collaborate with stakeholders and provide guidance to the Agency as it continues to implement the Florida Health Information Network.

Under the leadership of the Board, the Agency 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 (Florida's Health Information Infrastructure Governance). 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 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 and three additional projects have been implemented in 2007. These projects were funded, in part, by the FHIN Grants Program and received matching funding from stakeholders through their Regional Health Information Organization (RHIO). Operational health information exchange projects are located in Pensacola, Tallahassee, Jacksonville, Tampa, West Palm Beach, and Miami-Dade. An additional project is funded for development in Orlando during FY 2007-2008.

C. Board members 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 secure system that would interconnect the local health information network. The strategic plan and development roadmap for the Florida Health Information Network (FHIN) are in place and are broadly recognized throughout the country as models for the development of statewide networks.

D. The Agency and Board were successful in securing the passage of legislation (HB 7073) in 2006 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.

E. Because of the quality of that planning and the progress made on the statewide network, the Department of Defense has selected Florida as its first state-level partner with which it will share health information. That partnership will assist in treating the 700,000 Floridians and countless visitors who are active duty, reserve, National Guard and retired service members and their families.

Florida's health information infrastructure initiative has achieved a scope of stakeholder involvement that includes the leadership of hospitals, medical groups, laboratories, payers, 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.

The new Health Information Technology Committee will be broadly representative of health care stakeholders with expertise in health information technology and medical informatics. The Committee shall advise the Agency of developments in the health information technology field and consult with health information technology initiatives operating within the public and private sector. The Committee shall provide guidance for health information exchanges operating in Florida to ensure the privacy of health information including recommendations for demonstrated interoperability consistent with widely adopted standards or standards accepted by a recognized organization that establishes national standards for electronic information networks.

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 a First Interim Report to Governor Jeb Bush 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. This second strategy was pursued through the FHIN Grants Program. A third strategy was also proposed that would set up a state level server to integrate the local health information exchanges and provide for health record exchange across the state. The last strategy was taken up in the fall of 2005.

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 statewide 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* (FHIN White Paper, Version 6.2 March 2007) (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 discussed the relevant concerns and 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 state level server 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 among the public and private sectors, state and local governments, RHIOs and health information exchanges, providers, employers, consumers, health plans and payers. 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.

The expectation is that, when built the FHIN state level server will broker data requests from providers in the RHIOS, 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 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 EMR systems 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.). The FHIN did not fare as well in the 2007 legislative session. CS/HB 1121 proposed to create the Florida Health Information Network Corporation and was passed unanimously by each House committee. Its companion bill, SB 2350, while passing successfully through the Senate committees, did not come up for a vote on the Senate floor, and died at the end of the session.

The failure to receive legislative funding for the FHIN state level server in 2007 led the Agency to rethink its strategy for creating the statewide health care network. The first strategy of enhancing the adoption of electronic health records among physicians became more attractive as an alternative approach. The Agency has proposed focusing on a pilot project to encourage physicians to adopt EMR systems. A project of this type would have several positive outcomes. One would be to motivate more physicians to use EMRs; the use of EMRs would increase the amount of digitized data available to the local RHIO networks; finally, if the RHIOs were to take on the provision of EMRs as application service providers, they would create a potential revenue stream for their organizations.

To this end, the Agency seeks funding from the Legislature to conduct a pilot project to encourage the adoption of e-prescribing and electronic medical record systems by Medicaid physicians, and to develop a clinical data repository for health information exchange among Medicaid providers, and for inclusion in the personal health records of Medicaid beneficiaries. The Agency also seeks to carry out the Memorandum of Agreement between the State of Florida and the Department of Defense for the bi-directional exchange of clinical health care data between civilian and military physicians. The pilot project would use a web-based version of the Armed Forces Health Longitudinal Technology Application (AHLTA) system, licensed to the State of Florida by the Department of Defense. The AHLTA system would be offered at no charge to the Medicaid physicians for the period of the pilot project, and would be accompanied by training and technical support.

The intent of the was to create a gateway to the Department of Defense AHLTA system and to license the electronic medical record software to the Agency to make medical records of military personnel available to civilian physicians, and to create a means by which the military medical database could be updated with clinical records from non-military providers. The Memorandum of Agreement spelled out the goal of sharing "clinical information maintained by AHLTA with authorized and authenticated users of the FHIN and its constituent health information exchanges treating Department of Defense beneficiaries. This will enhance the delivery of health care to Department of Defense beneficiaries within the state of Florida and be done in a manner in compliance with Federal and Florida state laws and regulations."

For these reasons the Agency proposes to conduct the pilot project to encourage Medicaid physicians to adopt the AHLTA electronic medical record system by providing free access to the software for the period of the project. The pilot project will be coordinated with the Florida RHIOs, in selected communities. The project will include a communication campaign to a targeted group of Medicaid physicians, an assessment of workflow in the physician's offices and a training program to help the physicians integrate the software system into their workflow. To

accomplish this project the Agency plans to license a web-based version of the military AHLTA system and to develop a network infrastructure to provide access to the AHLTA system by physicians across the state.

The outcome of the project will be to increase adoption of electronic medical records systems by Florida's physicians, to generate the exchange of clinical records for patient care at the local level and to improve the quality of health care for Medicaid beneficiaries, and ultimately all Floridians, through the efficient transfer of health care records.

A corollary to encouraging physicians to adopt EMRs for the purpose of putting clinical data into the health information exchanges is for the Agency to provide state level health care data held by state agencies to the Florida RHIOs. The Coordinated Health Care Information and Transparency Act of 2006 authorized the Agency to "initiate, oversee, manage, and evaluate 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." (§408.05 (4) (c) F.S.). The Legislature clearly gives the Agency the authority to obtain health care datasets from the state agencies that hold them, with the goal of integrating the stage agency health care databases to make the data available to physicians for their treatment of patients. The Agency thus proposes to integrate health care databases held in the State of Florida agencies, for example the inpatient, outpatient and emergency department data held by the Agency, and datasets held by the Department of Health and county health departments, the Department of Elder Affairs, the Departments of Corrections and Juvenile Justice, the Department of Children and Families, the Department of Education and the Department of Financial Services' Division of Workers' Compensation. Once the health care data are integrated, the Agency data, with data from other agencies, can be pushed to the Florida RHIOs to provide background health care data to physicians, as directed by statute.

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 in subsequent years. 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.

   During the CY 2006 legislative session, the Legislature 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

   As in CY 2006, for the CY 2007 legislative session, the Legislature appropriated $2 million for the FHIN Grants Program for FY 2007-2008. Upon announcing the grant, the Agency received 15 proposals, worth $5.2 million. After reviewing the proposals and presentations, the Board was required to make a number of very difficult decisions. Nine projects were offered funding. One Planning, seven Operations and Evaluation, and one Training projects were funded. The Planning grant was awarded to the Florida Department of Veterans' Affairs. The seven Operations and Evaluation grants were awarded to the Big Bend Regional Healthcare Information Organization, Duval County Health Department, Florida Healthcare Coalition, Northwest Florida Regional Health Information Organization, Palm Beach County Community Health Alliance, South Florida Health Information Initiative, and Tampa Bay Regional Health Information Organization. The Training grant was awarded to

the Florida Association of Regional Health Information Organizations through the Palm Beach County Community Health Alliance.

For the CY 2008 legislative session, the Agency has submitted a Legislative Budget Request in the amount of $6.75 million to continue funding the grants program in FY 2008-2009 pursuant to s. 408.05 (4) 9 (b), F.S., and s. 408.062 (5), F.S. This appropriation will continue the incremental development of the Florida Health Information Network (FHIN) through the funding of local health information projects and outreach to promote the adoption of electronic health records. The total amount of state funding requested for the FHIN Grants Program is $6.75 million in FY 2008-2009. The proposed funding includes $2.8 million for training and technical assistance grants.

Through the efforts of Governor Crist, former 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, payers, 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.

Electronic Prescribing Initiative

In 2007, legislation passed authorizing the Agency to create and maintain a clearinghouse on electronic prescribing. The Florida Legislature directed the Agency to develop an electronic prescribing clearinghouse to "promote the implementation of electronic prescribing by healthcare practitioners, healthcare facilities, and pharmacies in order to prevent prescription drug abuse, improve patient safety, and reduce unnecessary prescriptions." Section 408.0611 F.S. provides that the Agency is to:

- Establish an informational clearinghouse on the Agency's website;
- Collaborate with stakeholders to create the clearinghouse; and
- Report on the progress of implementation to the Governor and the Legislature.

The Agency will create and convene quarterly meetings of a State Electronic Prescribing Advisory Panel representing the following stakeholder groups:

- Organizations that represent healthcare practitioners;
- Organizations that represent healthcare facilities;
- Organizations that represent pharmacies;
- Organizations that operate electronic prescribing networks;
- Organizations that create electronic prescribing products; and
- Regional health information organizations.

The Advisory Panel will be responsible for assisting the Agency is assessing and accelerating the implementation of electronic prescribing. The Advisory Panel will develop recommendations regarding public and private sector incentives for adoption, ensure coordination with private sector initiatives, and identify appropriate measures for tracking adoption that could be used in incentive programs and for measuring statewide rates of adoption.

The Florida Electronic Prescribing Clearinghouse website will be developed to describe e-prescribing software, summarize research on e-prescribing and direct physicians to e-prescribing resources at the state and national level. Specifically, the website will contain:

- Information regarding the process of electronic prescribing and the availability of electronic prescribing products, including no-cost or low-cost products;
- Information regarding the advantages of electronic prescribing, including using medication history data to prevent drug interactions, prevent allergic reactions, and deter doctor and pharmacy shopping for controlled substances;
- Links to federal and private sector websites that provide guidance on selecting an appropriate electronic prescribing product; and
- Links to state, federal, and private sector incentive programs for the implementation of electronic prescribing.

The Electronic Prescribing Clearinghouse website will officially go online October 1, 2007. It will be maintained as a repository of information about e-prescribing software vendors, research articles and meeting summaries for the Advisory Panel.

Privacy and Security Project

The Agency for Health Care Administration (Agency) was awarded a contract by RTI International, Inc. (RTI) to participate in the Health Information Security and Privacy Collaboration Project (HISPC) in May of 2006 as the lead Agency for Florida. The HISPC Project is part of a national effort managed by the U.S. Department of Health and Human Services Office of the National Coordinator for Health Information (ONC), the Agency for Healthcare Research and Quality (AHRQ) and the National Governor's Association (NGA).

Florida's participation in the HISPC Project of 2006-2007 resulted in the preparation of a comprehensive Implementation Plan for protecting the confidentiality of electronic health records. The Implementation Plan envisions the creation of a more efficient, and effective, health care delivery system that provides patients and clinicians with immediate access to electronic health records through a privacy-protected and secure system of health information networks.

The Florida Privacy and Security Project (Project) found that a significant barrier to health information exchange in Florida is the difficulty of determining applicable law given the numerous laws and regulations that address various aspects of health information exchange in an often fragmented manner. Florida laws and regulations were created to address the transfer of paper documents from one entity to another and do not contemplate the benefits of the sharing of electronic records among groups of clinicians or provide guidelines for these types of activities.

Florida laws and regulations were found in many cases to be inconsistent with Federal law, most notably the HIPAA privacy and security regulations. Additionally, in several areas Florida law was found to be inconsistent with other applicable Florida law. These inconsistencies, among other things, have led to confusion among health care providers resulting in reluctance to participate in regional health information networks, reluctance to use or accept electronic

prescribing, and a system that fails to meet its potential to better coordinate patient care or respond in an emergency.

The Florida Project found (as did other States) that reluctance to participate in health information exchange also stems from fears of litigation or other perceptions of increased risk that might occur as a result of the mistakes of other organizations participating in the health information exchange. The Project found that there is a lack of familiarity with electronic health information exchange at a practical level since few systems are operating on a widespread basis in Florida. Organizations do not have policies and procedures to guide their involvement with RHIOs. A risk mitigation tool to assist Florida's RHIOs in developing risk mitigation strategies will reduce these concerns by systematically addressing these issues.

In July of 2007 the Agency received a contract extension for continued funding through December 2007. During the six months of the HISPC Implementation Project extension, the Agency proposes to carry out specific activities related to implementation plan goals.

One of the goals calls for the establishment of uniform privacy policies to support the private and secure exchange of electronic health information through legislation and organizational policy changes. To address the need for legislative changes, the Agency will reconvene the Project's Legal Committee to evaluate the current status of legal guidelines and make recommendations on the implementation of clear and concise legal standards for health information exchange.

To support organizational policy changes, the Agency proposes to develop a risk assessment tool for use by regional health information organizations (RHIOs) or other health information exchanges in developing risk mitigation strategies for the protection of consumers and participating providers. The use of the tool will help provide assurances to health care providers that the RHIO has assessed the risks to security and developed policies to protect patient health information.

The Agency also proposes to implement specific activities that will raise consumer awareness and enable both providers and consumers to be knowledgeable users of electronic health records. The Agency proposes to engage consumers and providers through educational outreach sessions and obtain consumer views about their own access through personal health record systems. As part of these activities, the Agency will increase provider and consumer awareness, identify provider and consumer champions, and establish a speakers' bureau to extend and continue the consumer outreach activities.

Additional Projects to Support Health Information Exchange

The Agency has engaged in several other projects to promote health information exchange in Florida, notably in writing grants to support pilot projects. Two grants that were written in 2007 were a Medicaid transformation grant and a rural broadband pilot project proposal for the Federal Communication Commission. A third long term project was initiated with the signing of a Memorandum of Agreement between the State of Florida and the Department of Defense to promote bilateral health information exchange between the two co-signees.

<u>Medicaid Transformation Grant</u>

In the "Florida Health Information Network Pilot Project for the Clinical Coordination of Military and Medicaid Health Care Services" the Agency proposed to create an electronic health record

network that integrates clinical data from Florida Medicaid providers and the Department of Defense's clinical information system, the Armed Forces Health Longitudinal Technology Application (AHLTA). The network will be web-based and accessible to patients and authorized providers through a secure site operated by the North West Florida Regional Health Information Organization (North West Florida RHIO). Medicaid physicians will be given access to the AHLTA electronic medical record software and will be connected to an application service provider network operated by the Agency for Health Care Administration. During the project period, safety net clinics participating in North West Florida RHIO will be interconnected and additional private practices will be recruited.

The project will address the six dimensions of quality established by the Institute of Medicine: safety, effectiveness, timeliness, patient centeredness, efficiency and equity. The proposed system will integrate health records in the network, deliver information over a secure connection, provide decision-support tools, support quality improvement, demonstrate cost saving and improved clinical outcomes, and assess the sustainability of the health information network. The project will provide and support the AHLTA electronic medical records system for clinicians and facilities that lack the means to adopt and maintain the requisite information technology. This is an important bridge over the digital divide for rural, small physician practices and/or indigent care settings, and is a potential first step toward adoption of electronic systems by currently "non-wired" providers. Installation of the AHLTA software will give providers access to a fully functional web-based electronic medical record.

The resulting patient-centric records will contain information from Medicaid providers and military health system providers. The combined record will enable improved coordination of care for current and former military personnel who have family members receiving Medicaid services. The system also has the potential to greatly improve the coordination of care of uninsured patients. The program will be developed with the guidance of physicians through a clinical advisory board, ensuring a sound clinical base. The project will demonstrate improvements in the quality and outcomes of patient care, cost savings, physician satisfaction and a system that is secure, interoperable, scalable and replicable in other regions and states.

Federal Communication Commission Rural Broadband Pilot Project

The Agency and the Big Bend Regional Healthcare Information Organization, with a group of health care stakeholders from the public and private sectors, propose to connect nine hospitals in eight rural counties in the Panhandle and Big Bend regions of north Florida and connect them to the Big Bend Regional Healthcare Information Organization in Tallahassee and the Escambia Health Information Network in Pensacola. Health information exchange services delivered to the urban hospitals in Tallahassee and Pensacola can then be extended to the rural hospitals. The nine rural hospitals will also have access to pediatric telehealth services from Children's Medical Services in the Florida Department of Health and from the Nemours children's medical system. Continuing education services from the Florida State University College of Medicine can be offered to rural physicians.

The proposed pilot project will employ an existing ten gigabit per second optical fiber network built by the Florida LambdaRail that runs throughout the state and parallels Interstate10 in North Florida. The Agency for Health Care Administration and the Big Bend Regional Healthcare Information Organization propose to construct gigabit fiber facilities from the Florida LambdaRail interface points, to a constructed point of presence (POP) in each of the eight counties, and then construct gigabit last mile connections to the nine rural hospitals in the project.

Once the connections are complete, then each of the hospitals will be connected to the Big Bend Regional Healthcare Information Organization, which will provide secure messaging services and facilitate the transmission of large imaging files, to facilitate the transfer of x-rays, MRIs, CAT scans from fixed or mobile imaging units and other digital files between the rural and urban specialty providers in their network. Building the gigabit fiber network will occur in the first year of funding. In year two of the proposed project, a broadband wireless network will be installed in each county to provide broadband connectivity to each of the community health centers and not-for-profit clinics in each county. The health information exchange services of the Big Bend RHIO will be extended to these clinics. Implementing the broadband wireless network will expand the number of telehealth services available to rural physicians, and should result in better quality of care for their rural patients.

A key objective of the project is to establish a self-sustaining operational model that balances the benefits and costs of the network on all participants including urban providers, rural providers and the private sector. The network will be sustained by the revenues generated by user fees for services which will be established by the Big Bend RHIO.

Memorandum of Agreement between the Agency and Department of Defense

The Memorandum of Agreement established the formal collaboration between the Office of the Assistant Secretary of Defense for Health Affairs and the State of Florida Agency for Health Care Administration and the Florida Health Information Network to support the bi-directional exchange of electronic health information for our shared patients. The intent was to implement a system for the secure, bi-directional sharing of electronic medical information between the Department of Defense Military Health System and authorized users of the Florida Health Information Network to promote improvements in the quality and efficiency of healthcare for Department of Defense beneficiaries in Florida.

The usefulness of interoperable health information exchanges is currently limited by the relatively modest amount of electronic patient information available to be delivered across the network to clinicians at the point of care. The usefulness of health information networks and their impact on care delivery could be greatly improved by the integration of existing sources of meaningful electronic patient data into the network including AHLTA, Department of Defense electronic health record system. Because of the comprehensiveness of the clinical data AHLTA collects, and because of the high number of active duty and retired military and their dependents living in or visiting the state of Florida, data from AHLTA represents to FHIN an attractive component of the electronic patient data to be shared across the network.

Clinical records from AHLTA, in combination with other datasets such as patient information currently held by health plans, would enable the FHIN to offer users a critical mass of useful patient data so that requests to the network for patient information would likely yield productive responses. Such early proofs of the network's usefulness will in turn drive ever-increasing clinician utilization of the network as a source of critical patient information. In that way, the FHIN will accomplish its mission of providing authorized network users with potentially outcome-determinative patient information when and where needed. At the same time, this health information exchange will increase the amount of private sector electronic health care data available to the Department of Defense in AHLTA on its beneficiaries. This will enhance their continuity of care if they are also seen at military treatment facilities.

List of Potential Policy Changes Affecting Agency Budget Requests

Number	Potential Policy Changes	Reference LRPP Goals	The Legislative Budget Requests (LBR) Affected	Impact on Policy if LBR Request is not Approved
1.	Expansion of FHIN Grants Program	3	Expansion of FHIN Grants Program	The development of the Florida health information network (FHIN) is unlikely to occur without sufficient funding from both public and private sources.
2.	Development of Patient Safety Program	3	Patient Safety Staffing	The patient safety program will not be able to fully analyze patient data and develop a system for using the data in patient safety and adverse incident prevention.
3.	Enhance efficiency of patient data collection and dissemination systems.	3	Data Collection and Dissemination Upgrade	If this issue is not funded, the Florida Center will experience a growing lag in the receipt and processing of adequate data to use in analyzing Florida's health care data.

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
1.	The Agency will implement a patient safety program.	Amend s. 395.0197 F.S.	N/A	The Agency shall analyze and provide data to hospitals to facilitate patient safety.	Streamline current adverse incident reporting system.
2.	Expansion of Technical Assistance	s. 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 s. 408.05 (4), F.S.
3.	Establish the Florida Health Information Network (FHIN) Electronic Health Record Pilot Project	s. 408.062 (5) F.S.	The Agency shall implement plan for FHIN EHR Pilot Project	The Agency shall extend the FHIN Grants Program to include support for pilot programs to support the adoption of EHR	Increase the FHIN Grants appropriation to include funding for pilot projects.
4.	The Agency shall facilitate the development of an organized system of Regional Health Information Organizations.	Create new Sections 405.001 – 405.005 F.S.	N/A	The Agency will regulate Regional Health Information Organizations.	Statutorily establish standards for designation of Regional Health Information Organizations.

List of All Task Forces and Studies in Progress

Number	Bill Cite	Ongoing Task Forces and Studies Required in by Legislation	Division Assigned
1.	N/A	The Florida Center is participating as a State subcontractor in a national study to develop recommendation for ensuring the privacy and security of electronic health records.	Florida Center for Health Information and Policy Analysis
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.	Florida Center for Health Information and Policy Analysis

Number	Bill Cite	Ongoing Task Forces and Studies Required by Legislation	Division Assigned
3.	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.	Florida Center for Health Information and Policy Analysis
4.	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.	Florida Center for Health Information and Policy Analysis
5.	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.	Florida Center for Health Information and Policy Analysis
6.	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.	Florida Center for Health Information and Policy Analysis

Number	Bill Cite	Ongoing Task Forces and Studies Required by Legislation	Division Assigned
7.	HB-1629 Web Page	Requires the State Center for Health Statistics in conjunction with the State Comprehensive Health Information System Advisory Council, to develop and implement a long-range plan for making available performance outcome and financial data that will allow consumers to compare health care services. The 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.*	Florida Center for Health Information and Policy Analysis
8.	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.	Florida Center for Health Information and Policy Analysis
9.	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 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-	Florida Center for Health Information and Policy Analysis

		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.	

Number	Bill Cite	Ongoing Task Forces and Studies Required by Legislation	Division Assigned
10.	HB-7073 Web Page Lines 60-91	The comprehensive health information system operated by the Florida Center 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: (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. (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. (c) Environmental, social, and other health hazards. (d) Health knowledge and practices of the people in this state and determinants of health and nutritional practices and status. (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. (f) Utilization of health care by type of provider. (g) Health care costs and financing, including trends in health care prices and costs, the sources of payment for health care services, and federal, state, and local expenditures for health care. (h) Family formation, growth, and dissolution. (i) The extent of public and private health insurance coverage in this state. (j) The quality of care provided by various health care providers.	Florida Center for Health Information and Policy Analysis

Number	Bill Cite	Ongoing Task Forces and Studies Required by Legislation	Division Assigned
11.	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: 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. 3. Identify health care data gaps and provide technical private organizations for meeting documented health care data needs. 4. Assist other organizations in developing statistical abstracts of their data sets that could be used by the center. 5. Provide statistical support to state agencies with regard to the use of databases maintained by the center. 6. To the extent possible, respond to multiple requests for information not currently collected by the center or available from other sources by initiating data collection. 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. 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. 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 of a health information network. information organizations, public health	Florida Center for Health Information and Policy Analysis

		departments, or state agencies that submit proposals for planning, implementation, or ensure the effective outcome of the health information project. (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 and make that data available to any health care practitioner through a state health information network.	
12.	HB-7073 Web Page 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: (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. (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. (c) The center shall provide indexing, abstracting, translation, publication, and other services leading to a more effective and timely dissemination of health care statistics. (d) The center shall be responsible for publishing and disseminating an annual report on the center's activities. (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	Florida Center for Health Information and Policy Analysis

		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.	
13.	HB-7073 Web Page Lines 478-524	408.062 Research, analyses, studies, and reports.-- (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: (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 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. (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	Florida Center for Health Information and Policy Analysis

		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.	
14.	**HB 1155** Lines 180-184 ss. 408.0611(3) F.S.	The agency shall work in collaboration with private-sector electronic prescribing initiatives and relevant stakeholders to create a clearinghouse of information on electronic prescribing for health care practitioners, health care facilities, and pharmacies.	Florida Center for Health Information and Policy Analysis
15.	**HB 1155** Lines 190-207 ss. 408.0611(3) F.S.	The agency shall, by October 1, 2007: (a) provide on its website: 1. Information regarding the process of electronic prescribing and the availability of electronic prescribing products, including no-cost or low-cost products; 2. Information regarding the advantages of electronic prescribing, including using medication history data to prevent drug interactions, prevent allergic reactions, and deter doctor and pharmacy shopping for controlled substances; 3. Links to federal and private-sector websites that provide guidance on selecting an appropriate electronic prescribing product; and 4. Links to state, federal, and private-sector incentive programs for the implementation of electronic prescribing. (b) Convene quarterly meetings of the stakeholders to assess and accelerate the implementation of electronic prescribing.	Florida Center for Health Information and Policy Analysis
16.	**HB 1155** Lines 208-213 ss. 408.0611 (3) F.S.	Pursuant to s. 408.061 , the agency shall monitor the implementation of electronic prescribing by health care practitioners, health care facilities, and pharmacies. By January 31 of each year, the agency shall report on the progress of implementation of electronic prescribing to the Governor and the Legislature..	Florida Center for Health Information and Policy Analysis
17.	**HB 1155** Lines 210-213 ss. 408.0611(3) F.S.	By January 31 of each year, the agency shall report on the progress of implementation of electronic prescribing to the Governor and the Legislature.	Florida Center for Health Information and Policy Analysis

18.	**SB 2800** Line 176 **Ch. 2007-72**	From the funds in Specific Appropriation 176, $200,000 in non-recurring general revenue funds shall be used to contract for the development of a minimum set of quality outcome measures for the following disease states: cancer; cardiac surgery; diabetes; intensive care; kidney disease; and arthritis. Outcome measures shall be directed toward assessing value for patients including both outcome and costs over the full cycle of care.	Florida Center for Health Information and Policy Analysis
19.	**SB 2800** Line 177 **Ch. 2007-72**	From the Special Categories Grants and Aids-Florida Health Information Network Grants- From Tobacco Settlement Trust Fund, 2,000,000	Florida Center for Health Information and Policy Analysis

Inspector General

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

Objective 4: To increase by eight percent annually through FY 2010-11 and to increase by nine percent annually through FY 2012-13, 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 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
$16,674,293 Actual Collections	$23,606,016	$25,494,497	$27,534,057	$29,736,782	$32,115,725
Percent of Projection Increase	8%	8%	8%	9%	9%

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 to the Governor's Priorities

Governor's Priorities	Agency Goals and Priorities
1. Open Government	
2. Plain Language Initiative	Goal 4. To combat fraud, waste and abuse in the Florida Medicaid Program
3. Safety and Security	
4. Property Tax and Insurance Reform	
5. Education Initiatives	
6. Adoption/Abuse Prevention Initiatives	
7. Civil Rights	
8. Healthcare Initiatives	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 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 of $50 million in 2007, $50 million in 2008 and $75 million in fiscal year 2009 and each year thereafter. The new MIP, as instituted by the Centers for Medicare and Medicaid Services (CMS), is 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.

With this implementation, the bureau chief of MPI was invited to serve on a national panel to discuss new and innovative ways to fight fraud and abuse, with Florida being held up as the standard to meet. Florida is also one of four states to be chosen to pilot federal audits of our Medicaid providers. Florida is also one of the few states to have a close working relationship with the Medicaid Fraud Control Unit. In FY 2005-06, MPI referred 225 providers to Medicaid Fraud Control Unit (MFCU) for investigation and an additional 55 providers for informational purposes.

In keeping with the Governor's priority to implement Plain Language, all standard correspondence generated by Medicaid Program Integrity to Medicaid providers is being rewritten. It is our goal to convey our policies and procedures in a clear, concise and straight-forward communication to ensure understanding and compliance.

To help assure that Medicaid Reform does indeed, create more accessible and affordable health care for Florida citizens, the Office of the Inspector General will help build the Medicaid fraud infrastructure needed to continue with Medicaid Reform, spear-head an Agency-wide fraud and abuse strategic plan and oversee Medicaid Program Integrity in their responsibilities to audit and investigate fraud, abuse, waste and mismanagement within the Medicaid program.

List of Potential Policy Changes Affecting the Agency's Legislative Budget Request, and the Governor's Recommended Budget

Number	List of Potential Policy Changes	Describe the Legislative Budget Requests or Governor's Recommended Budget Item(s) Affected	Describe the Potential Policy Impact if the LBR or the Governor's Recommended Budget Recommendation is not Approved
1	None		

List of Changes Which Would Require Legislative Action, Including the Elimination of Programs, Services and/or Activities

Numbe	Change in Current Programs	Statutory Reference (Update hyperlinks)	Changes in Current Services	Changes in Current Activities	Describe Substantive Legislative Actions Required to Support Policy Changes
1	None				

List of All Task Forces, Studies, etc., in Progress

Number	Bill Cite	Task Forces and Studies Required by FY 2006-07 Legislation	Agency Staff Assigned	Action Required Due Date
1	None			

Division of Communications and Legislative Affairs

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 Division of Communications and Legislative Affairs 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 Division of Communications and Legislative Affairs.

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

Baseline/Year FY 2006-07	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
6234 Number of correspondence pieces tracked by the Agency's correspondence Unit	6485	6615	6747	6881	7019
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 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
3215 Number of Public Records Requests tracked through the Agency.	3344	3411	3480	3549	3620
Annual percent of increase	2%	2%	2%	2%	2%

Please note that factors outside of Agency control strongly impact the number of public records requests 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) (c):

Baseline/Year FY 2003-04	FY 2008-09	FY 2009-10	FY 2010-11	FY 20011-12	FY 2012-13
489 Number of Constituent and Legislative Inquiries handled by the Legislative Affairs Office.	508	518	529	539	550
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 2006-07	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
277 Number of Legislative Bills tracked & analyzed	283	289	295	301	307
Annual percent of increase	2%	2%	2%	2%	2%

Fiscal Year 2006-07 reflects the change in tracking of relief bills. Instead of tracking and analyzing all relief bills, the Legislative Affairs office only sends out those relief bills for analysis that are enrolled. This is a decrease of approximately 150 bills each legislative session. 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 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
941 Number of phone contacts received by the Communication Office from Media Representatives	979	998	1018	1038	1059
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 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
1,178 Number of design and production jobs completed by Multimedia Unit	1,225	1,250	1,275	1,300	1326
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.	Open Government	**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.
2.	Plain Language Initiative	**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.
3.	Safety and Security	
4.	Property Tax and Insurance Reform	
5.	Education Initiatives	
6.	Adoption/Abuse Prevention Initiatives	
7.	Civil Rights	
8.	Healthcare Initiatives	**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.

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 Division of Communications and Legislative Affairs 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 Division of Communications and Legislative Affairs. This important point should be taken into consideration when viewing the service outcome measure descriptions of this document.

The Division of Communications and Legislative Affairs has both internal and external goals to further its objective of representing the Agency to the public, governmental entities and members of the press. In each instance we will harness those technological advances in the areas of information gathering and dissemination to supplement our strategic plan. Internally, we will keep a constant and "plain language" flow of current information to all agency members in order that they may provide input throughout the process. This will be accomplished by holding Legislative and Plain Language Seminars for new and current employees, conducting agency wide teleconferences and authoring informational documents in the most clear and concise manner.

Externally, we will continue to restructure our areas of responsibility, providing for transparent access to inquiries by interested parties in a timely manner. Further, we will take steps to insure that the goals and objectives of our agency are progressively communicated to all decision makers with both credibility and expertise.

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		

Exhibits:

Exhibit I:

Agency Workforce Plan (Not Required)

Exhibit II:

Performance Measures and Standards

LRPP Exhibit II - Performance Measures and Standards

Department: AGENCY FOR HEALTH CARE ADMINISTRATION

68200000 Program: Administration and Support

Approved Performance Measures (Words)	Approved Prior Year Standards FY 2006-07 (Numbers)	Prior Year Actual FY 2006-07 (Numbers)	Approved Standards for FY 2007-08 (Numbers)	Requested FY 2008-09 Standard (Numbers)
Administrative costs as a percent of total agency costs	0.11%	0.10%	0.11%	0.10%
Administrative positions as a percent of total agency positions	11.45%	11.17%	11.45%	11.17%

68500000 Program: Health Care Services

68500100 Children's Special Health Care

Approved Performance Measures (Words)	Approved Prior Year Standards FY 2006-07 (Numbers)	Prior Year Actual FY 2006-07 (Numbers)	Approved Standards for FY 2007-08 (Numbers)	Requested FY 2008-09 Standard (Numbers)
Percent of hospitalizations for conditions preventable by good ambulatory care	7.7%	8.9%	7.7%	*
Percent of eligible uninsured children receiving health benefits coverage	100%	Unknown	100%	*
Percent of children enrolled with up-to-date immunizations	85%	Unknown	85%	90%*
Percent of compliance with the standards established in the Guidelines for Health Supervision of Children and Youth as developed by the American Academy of Pediatrics for children eligible under the program	97%	90.0%	97%	*
Percent of families satisfied with the care provided under the program	90%	86.0%	95%	90%*

*Under budget review for impending budget amendment

Department: AGENCY FOR HEALTH CARE ADMINISTRATION

Approved Performance Measures (Words)	Approved Prior Year Standards FY 2006-07 (Numbers)	Prior Year Actual FY 2006-07 (Numbers)	Approved Standards for FY 2007-08 (Numbers)	Requested FY 2008-09 Standard (Numbers)
Total number of uninsured children enrolled in Kidcare	351,301	204,350	228,159	*
Number of uninsured children enrolled in Florida Healthy Kids	306,444	172,335	195,867	*
Number of uninsured children enrolled in Medikids	34,804	20,630	21,000	*
Number of uninsured children enrolled in Children's Medical Services Network	10,053	11,385	10,053	*

68500200 Executive Direction and Support Services

Approved Performance Measures (Words)	Approved Prior Year Standards FY 2006-07 (Numbers)	Prior Year Actual FY 2006-07 (Numbers)	Approved Standards for FY 2007-08 (Numbers)	Requested FY 2008-09 Standard (Numbers)
Program administrative costs as a percent of total program costs	1.44%	1.50%	1.44%	2.00%
Average number of days between receipt of clean Medicaid claim and payment	15	9.3	15	7
Number of Medicaid claims received	145,101,035	129,333,224	145,101,035	*

*Under budget review for impending budget amendment

Department: AGENCY FOR HEALTH CARE ADMINISTRATION

68501400 Medicaid Services to Individuals

Approved Performance Measures (Words)	Approved Prior Year Standards FY 2006-07 (Numbers)	Prior Year Actual FY 2006-07 (Numbers)	Approved Standards for FY 2007-08 (Numbers)	Requested FY 2008-09 Standard (Numbers)
Percent of hospitalizations that are preventable by good ambulatory care	11%	18.0%	11%	*
Percent of women receiving adequate prenatal care	86%	82.0%	86%	90%*
Neonatal mortality rate per 1000	4.7	4.8	4.7	4.5*
Average number of months between pregnancies for those receiving family planning services	35	36.6	35	35*
Percent of eligible children who received all required components of EPSDT screen	64%	62%	64%	80%*
Number of children ages 1-20 enrolled in Medicaid	1,590,866	1,529,965	1,590,866	*
Number of children receiving EPSDT services	407,052	337,311	407,052	*
Number of hospital inpatient services provided to children	92,960	104,615	92,960	*
Number of physician services provided to children	6,457,900	7,051,231	6,457,900	*
Number of prescribed drugs provided to children	4,444,636	4,989,964	4,444,636	*
Number of hospital inpatient services provided to elders	100,808	95,521	100,808	*
Number of physician services provided to elders	1,436,160	681,689	1,436,160	*
Number of prescribed drugs provided to elders	15,214,293	1,384,948	15,214,293	*
Number of uninsured children enrolled in the Medicaid Expansion	3,529	2,933	1,227	*

*Under budget review for impending budget amendment

Department: AGENCY FOR HEALTH CARE ADMINISTRATION

68501500 Medicaid Long Term Care

Approved Performance Measures (Words)	Approved Prior Year Standards FY 2006-07 (Numbers)	Prior Year Actual FY 2006-07 (Numbers)	Approved Standards for FY 2007-08 (Numbers)	Requested FY 2008-09 Standard (Numbers)
Percent of hospitalizations for conditions preventable with good ambulatory care	12.60%	10.2%	12.60%	*
Number of case months (home and community-based services)	550,436	681,049	550,436	*
Number of case months services purchased (Nursing Home)	619,387	553,596	619,387	*

68501600 Medicaid Prepaid Health Plan

Approved Performance Measures (Words)	Approved Prior Year Standards FY 2006-07 (Numbers)	Prior Year Actual FY 2006-07 (Numbers)	Approved Standards for FY 2007-08 (Numbers)	Requested FY 2008-09 Standard (Numbers)
Percent of hospitalizations for conditions preventable by good ambulatory care	13%	7%	13%	*
Percent of women and child hospitalizations for conditions preventable with good ambulatory care	14.50%	14.50%	16.00%	*
Number of case months services purchased (elderly and disabled)	1,877,040	1,733,532	1,877,040	*
Number of case months services purchased (families)	9,396,828	9,025,368	9,850,224	*

*Under budget review for impending budget amendment

Department: AGENCY FOR HEALTH CARE ADMINISTRATION

68700000 Program: Health Care Regulation
68700700 Health Care Regulation

Approved Performance Measures (Words)	Approved Prior Year Standards FY 2006-07 (Numbers)	Prior Year Actual FY 2006-07 (Numbers)	Approved Standards for FY 2007-08 (Numbers)	Requested FY 2008-09 Standard (Numbers)
Percent of nursing home facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0%	3.14%	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%	*
Percent of Priority I consumer complaints about licensed facilities and programs that are investigated within 48 hours	100%	99.63%	100%	*
Percent of accredited hospitals and ambulatory surgical centers cited for not complying with life safety, licensure, or emergency access standards	25%	29.60%	25%	*
Percent of validation surveys that are consistent with findings noted during the accreditation survey	98%	100%	98%	*
Percent of assisted living facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0%	0.97%	0%	*
Percent of home health facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0%	0.16%	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%	*
Percent of ambulatory surgical centers with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0%	0.26%	0%	*
Percent of hospitals with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0%	7.14%	0%	*

*Under budget review for impending budget amendment

Department: AGENCY FOR HEALTH CARE ADMINISTRATION

Approved Performance Measures (Words)	Approved Prior Year Standards FY 2006-07 (Numbers)	Prior Year Actual FY 2006-07 (Numbers)	Approved Standards for FY 2007-08 (Numbers)	Requested FY 2008-09 Standard (Numbers)
Percent of hospitals that fail to report serious incidents (agency identified)	6%	3.38%	6%	*
Percent of new Medicaid recipients voluntarily selecting managed care plan	50%	50.93%	50%	N/A
Percent of complaints of HMO patient dumping received that are investigated	100%	N/A	100%	*
Percent of complaints of facility patient dumping received that are investigated	100%	100%	100%	100%
Approved Performance Measures (Words)	Approved Prior Year Standards FY 2006-07 (Numbers)	Prior Year Actual FY 2006-07 (Numbers)	Approved Standards for FY 2007-08 (Numbers)	Requested FY 2008-09 Standard (Numbers)
Number or complaints of facility patient dumping received that are investigated	N/A	1	N/A	N/A
Number of inquiries to the call center regarding practitioner licensure and disciplinary information	30,000	6,014	30,000	*
Total number of full facility quality-of-care surveys conducted	7,550	7,139	7,550	*
Average processing time (in days) for Subscriber Assistance Program cases.	53	27	53	53
Number of construction reviews performed (plans and construction)	4,500	4,725	4,500	*
Number of new enrollees provided with choice counseling	520,000	451,630	520,000	*

*Under budget review for impending budget amendment

LRPP Exhibit III:

Assessment of Performance for Approved Performance Measures

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
7.7%	8.9%	1.2%	15.6%

Factors Accounting for the Difference:

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

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: While ambulatory sensitive hospitalizations remain an accepted national standard as part of an overall evaluation of access and preventive care services, the population groups previously defined in the Long-Range Program plan did not accurately address the issue along programmatic lines. The existing measures should be dropped in favor of measures that will more directly reflect program decisions, policies, and services.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☒ Other (Identify)
Recommendations: The Agency is requesting that this measure be deleted in favor of a more meaningful measure.

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
100%	Unknown	n/a	n/a

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: As designed this

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: In order to be accurate, this measure requires an annual update on the number of uninsured children in Florida as well as detailed knowledge of their eligibility for the program. Estimates of the uninsured are not available on an annual basis (the last update was in 2004) and it is impossible to determine the eligibility of uninsured children who do not apply for the program. As designed, the measure cannot be calculated with any degree of accuracy.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☒ Other (Identify)
Recommendations: The Agency is requesting that this measure be revised in favor of a more meaningful measure.

Office of Policy and Budget – July 2007

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%	Unknown	n/a	n/a

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect
☒ Other (Identify)
Explanation: This measure used to be collected through parent interviews during the annual KidCare evaluation. After submitting a change in methodology for this measure in previous years, the evaluator discontinued collecting this information.

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 were 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. This measure was deleted in favor of a more accurate and meaningful measure.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: The Agency is requesting that this measure be revised to a more meaningful measure.

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Children's Special Health Care
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
- ☐ 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
97%	90.1%	5.1%	5.9%

Factors Accounting for the Difference:

Internal Factors (check all that apply):

- ☐ Personnel Factors
- ☐ Competing Priorities
- ☐ Previous Estimate Incorrect
- ☐ Staff Capacity
- ☐ Level of Training
- ☐ Other (Identify)

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: 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
- ☐ Personnel
- ☐ Technology
- ☒ Other (Identify)

Recommendations: The Agency is requesting that this measure be deleted in favor of a more meaningful measure.

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid 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%	86%	(4%)	(4.4%)

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: 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 is requesting a revision to the measure to reflect national standards.

Office of Policy and Budget – July 2007

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 Title XXI eligible 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	204,350	(146,951)	(41.8%)

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 indicator does not measure program performance and should be deleted in favor of measures more reflective of program efforts and services. While indicative of the size and scope of the KidCare program, the caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: The Agency is requesting that this output (count) measure be deleted.

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	172,335	(134,109)	(43.8%)

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 indicator does not measure program performance and should be deleted in favor of measures more reflective of program efforts and services. While indicative of the size and scope of the KidCare program, the caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: The Agency is requesting that this output (count) measure be deleted.

Office of Policy and Budget – July 2007

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	20,630	(14,174)	(40.7%)

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: This indicator does not measure program performance and should be deleted in favor of measures more reflective of program efforts and services. While indicative of the size and scope of the KidCare program, the caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: The Agency is requesting that this output (count) measure be deleted.

Office of Policy and Budget – July 2007

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	11,385	1,332	13.2%

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 indicator does not measure program performance and should be deleted in favor of measures more reflective of program efforts and services. While indicative of the size and scope of the KidCare program, the caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: The Agency is requesting that this output (count) measure be deleted.

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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
1.44%	1.5%	.06%	.0416%

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: Good management practices & technology

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:

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: **Agency for Health Care Administration**
Program: **Health Care Services**
Service/Budget Entity: **Executive Directions & Support Services/68500200**
Measure: **Average number of days between receipt of clean Medicaid claim and payment**

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	9.3	(5.7)	(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: Technology systems increased capability

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:

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: **Agency for Health Care Administration**
Program: **Health Care Services**
Service/Budget Entity: **Executive Direction & Support Services/68500200**
Measure: **Number of Medicaid Claims Received**

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
145,101,035	129,333,224	(15,767,811)	(10.9%)

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: Actual numbers less than projected

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 does not measure program performance and should be deleted in favor of measures more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: The Agency is requesting that this output (count) measure be deleted.

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
11%	17.6%	6.6%	60.0%

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: While ambulatory sensitive hospitalizations remain an accepted national standard as part of an overall evaluation of access and preventive care services, the population groups previously defined in the Long-Range Program plan did not accurately address the issue along programmatic lines. The existing measures are therefore being dropped in favor of measures that will more directly reflect program decisions, policies, and services.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☒ Other (Identify)
Recommendations: The Agency is requesting that this measure be deleted in favor of a more meaningful measure.

Office of Policy and Budget – July 2007

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%	82%	(4%)	(4.7%)

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: 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.

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. AHCA needs to continue to work with DOH to ensure family planning services are available to women who need them and qualify.

The Agency is requesting a revision to the standard for this measure to 90% to reflect the anticipated improvement to prenatal care access.

Office of Policy and Budget – July 2007

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	4.8	.1	2.1%

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: The neo-natal mortality rates mirror 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. Health awareness outreach programs should be explored. Medicaid Reform and the emphasis on healthy behaviors may impact this measure favorably.

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: **Agency for Health Care Administration**
Program: **Health Care Services**
Service/Budget Entity: **Medicaid Services to Inviduals/68501400**
Measure: **Average number of months between pregnancies for women in Medicaid**

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
35	36.6	1.6	.05%

Factors Accounting for the Difference:
Internal Factors (check all that apply):

- ☐ Personnel Factors
- ☐ Competing Priorities
- ☐ Previous Estimate Incorrect
- ☐ Staff Capacity
- ☐ Level of Training
- ☒ Other (Identify)

Explanation: Family Planning Waiver and family planning counseling and services.

External Factors (check all that apply):

- ☐ Resources Unavailable
- ☐ Legal/Legislative Change
- ☐ Target Population Change
- ☐ This Program/Service Cannot Fix the Problem
- ☐ Current Laws Are Working Against the Agency Mission
- ☐ Technological Problems
- ☐ Natural Disaster
- ☐ Other (Identify)

Explanation:

Management Efforts to Address Differences/Problems (check all that apply):

- ☐ Training
- ☐ Personnel
- ☐ Technology
- ☐ Other (Identify)

Recommendations:

Office of Policy and Budget – July 2007

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%	62%	(2%)	(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: EPSDT screening is largely dependent on parental compliance with standards. Medicaid physicians are required to provide educational information on the importance of EPSDT screening. Also, the percentage of eligibles screened has a direct correlation to the fee levels for Child Health Check-Ups. The reimbursement rates for these services are set externally and are beyond the Agency's control.

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.

The Agency is requesting a revision to the Standard to 80% to reflect national goals for this program.

Office of Policy and Budget – July 2007

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	1,529,965	(60,901)	(3.83%)

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 does not measure program performance and should be deleted in favor of measures more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations:
The Agency is requesting that this output (count) measure be deleted.

Office of Policy and Budget – July 2007

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
- ☒ Performance Assessment of Output Measure
- ☐ Adjustment of GAA Performance Standards
- ☐ Revision of Measure
- ☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
407,052	337,311	(69,741)	(17.1%)

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

Explanation:

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

Explanation: This measure does not measure program performance and should be deleted in favor of measures more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate.

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

Recommendations:
The Agency is requesting that this output (count) measure be deleted.

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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
92,960	104,615	11,655	12.5%

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

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 does not measure program performance and should be deleted in favor of measures more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations:
The Agency is requesting that this output (count) measure be deleted.

Office of Policy and Budget – July 2007

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 children**

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
6,457,900	7,051,231	593,331	9.2%

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 does not measure program performance and should be deleted in favor of measures more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: The Agency is requesting that this output (count) measure be deleted.

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 children**

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
4,444,636	4,989,964	545,328	12.3%

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 does not measure program performance and should be deleted in favor of measures more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: The Agency is requesting that this output (count) measure be deleted.

Office of Policy and Budget – July 2007

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 hospital inpatient 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
100,808	95,521	(5,287)	(5.2%)

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 does not measure program performance and should be deleted in favor of measures more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: The Agency is requesting that this output (count) measure be deleted.

Office of Policy and Budget – July 2007

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	681,689	(754,471)	(52.5%)

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☒ Previous Estimate Incorrect
☐ Other (Identify)
Explanation: The actual performance result was lower than the approved standard due to 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: This measure does not measure program performance and should be deleted in favor of measures more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations:
The Agency is requesting that this output (count) measure be deleted.

Office of Policy and Budget – July 2007

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	1,384,948	(13,829,345)	(90.9%)

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: Reduction due largely to initiation of Medicare Part D. This measure does not measure program performance and should be deleted in favor of measures more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: The Agency is requesting that this output (count) measure be deleted.

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

Action:

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
3,529	2,933	(596)	(16.89%)

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: This measure does not measure program performance and should be deleted in favor of measures more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate.

Management Efforts to Address Differences/Problems (check all that apply):

- ☐ Training
- ☐ Personnel
- ☐ Technology
- ☒ Other (Identify)

Recommendations:
The Agency is requesting that this output (count) measure be deleted.

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

Action:
☒ Performance Assessment of Outcome Measure ☐ 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
12.6%	10.2%	(2.54%)	(19%)

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: While ambulatory sensitive hospitalizations remain an accepted national standard as part of an overall evaluation of access and preventive care services, the population groups previously defined in the Long-Range Program plan did not accurately address the issue along programmatic lines. The existing measures are therefore being dropped in favor of measures that will more directly reflect program decisions, policies, and services.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: The Agency is requesting that this measure be deleted in favor of a more meaningful measure.

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

Action:
☐ Performance Assessment of Outcome Measure ☐ 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
550,436	681,049	130,613	23.7%

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: This measure does not measure program performance and should be deleted in favor of measures more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: The Agency is requesting that this output (count) measure be deleted.

Office of Policy and Budget – July 2007

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	553,596	(65,791)	(10.6%)

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: This measure does not measure program performance and should be deleted in favor of measures more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: The Agency is requesting that this output (count) measure be deleted.

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

Action:
☒ Performance Assessment of Outcome Measure ☐ 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
13%	7.3%	(5.7%)	(43.8%)

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: While ambulatory sensitive hospitalizations remain an accepted national standard as part of an overall evaluation of access and preventive care services, the population groups previously defined in the Long-Range Program plan did not accurately address the issue along programmatic lines. The existing measures are therefore being dropped in favor of measures that will more directly reflect program decisions, policies, and services.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: The Agency is requesting that this measure be deleted in favor of a more meaningful measure.

Office of Policy and Budget – July 2007

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%	14.50%	0%	0%

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: While ambulatory sensitive hospitalizations remain an accepted national standard as part of an overall evaluation of access and preventive care services, the population groups previously defined in the Long-Range Program plan did not accurately address the issue along programmatic lines. The existing measures are therefore being dropped in favor of measures that will more directly reflect program decisions, policies, and services.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☒ Other (Identify)
Recommendations: The Agency is requesting that this measure be deleted in favor of a more meaningful measure.

Office of Policy and Budget – July 2007

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	1,733,532	(143,508)	(7.6%)

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: This measure does not measure program performance and should be deleted in favor of measures more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: The Agency is requesting that this output (count) measure be deleted.

Office of Policy and Budget – July 2007

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	9,025,368	(371,460)	(3.95%)

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 does not measure program performance and should be deleted in favor of measures more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: The Agency is requesting that this output (count) measure be deleted.

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

Action:

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0%	3.14%	Over	3.14%

Factors Accounting for the Difference:
Internal Factors (check all that apply):

- ☐ Personnel Factors
- ☐ Competing Priorities
- ☐ Previous Estimate Incorrect
- ☐ Staff Capacity
- ☐ Level of Training
- ☒ 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
- ☐ 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: Although this is a legitimate measure of facility performance, it is not a reasonable measure of agency performance.

Management Efforts to Address Differences/Problems (check all that apply):

- ☐ Training
- ☐ Personnel
- ☐ Technology
- ☒ Other (Identify)

Management has repeatedly attempted to have this measure deleted as it does not believe the measure is an appropriate measure of agency performance.

Recommendations: Delete this measure.

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: **Agency for Health Care Administration**
Program: **Health Care Regulation**
Service/Budget Entity: **Health Care Regulation/68700700**
Measure: **Percent of investigations of alleged unlicensed facilities and programs that have been previously issued a cease and desist order that are confirmed as repeated unlicensed activity**

Action:

☒ Performance Assessment of Outcome Measure ☐ 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%	0%	Under	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: The Agency is committed to protecting its customers through the investigation of all reports of unlicensed activity followed by facility closure or facility compliance with applicable standards. As these facilities are closed or brought into compliance, there will be fewer instances of repeat unlicensed activities. A decrease in this measure demonstrates the Agency's commitment to ensuring quality of care and services through compliance with minimum standards.

External Factors (check all that apply):

☐ Resources Unavailable ☐ 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 is not a measure over which the agency has ultimate control.

Management Efforts to Address Differences/Problems (check all that apply):

☐ Training ☐ Technology
☐ Personnel ☐ Other (Identify)

Recommendations: Delete this measure.

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: **Agency for Health Care Administration**
Program: **Health Care Regulation**
Service/Budget Entity: **Health Care Regulation/68700700**
Measure: **Percent of Priority I consumer complaints about licensed facilities and programs that are investigated within 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%	99.63%	Under	0.37%

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, personnel changes, and area office accountability resulted in nearly 100% compliance with 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: Staff turnover and workload. Systems are not set to measure 48 hours, but rather are set to measure full days.

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

Management continues to expand its efforts to obtain and retain qualified staff.

Recommendations: This is a good measure, but the time frame must be revised to match the federal standard of two business days.

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

Action:

☒ Performance Assessment of Outcome Measure ☐ 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
25%	29.60	Over	4.6%

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

External Factors (check all that apply):

☐ Resources Unavailable ☐ 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 is not a measure over which the Agency has control

Management Efforts to Address Differences/Problems (check all that apply):

☐ Training ☐ Technology
☐ Personnel ☐ Other (Identify)

Recommendations: Delete this measure.

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

Action:

☒ Performance Assessment of Outcome Measure ☐ 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
98%	100%	Over	2%

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: Accreditation is an evaluative process in which a healthcare facility undergoes an examination of its policies, procedures and performance by an external organization (accrediting body) to ensure that it is meeting predetermined criteria. The Centers for Medicare and Medicaid Services (CMS) grants authority to a selected group of accrediting organizations to determine, on CMS' behalf, whether a health care facility evaluated by the organization is in compliance with corresponding regulations. The Agency in turn accepts inspections performed by CMS approved accrediting organizations in lieu of State licensure surveys.

A validation survey assesses whether the review by the accrediting organization has adequately evaluated the facility according to the minimum state 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:

Management Efforts to Address Differences/Problems (check all that apply):

☐ Training ☐ Technology
☐ Personnel ☐ Other (Identify)

Recommendations: Delete this standard. It measures the performance of the accrediting organization, not the performance of the Agency.

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

Action:

☒ Performance Assessment of Outcome Measure ☐ 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%	0.97%	Over	0.97%

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: Please note that it is unreasonable to expect that these facilities will never be cited for deficiencies that pose a serious threat to the health, safety or welfare of the public. Chapter 2001-45, Laws of Florida, amended what is now s. 429.407, F.S., and increased the frequency of Agency monitoring visits for assisted living facilities licensed to provide extended congregate care services from 2 times per year to quarterly and assisted living facilities licensed to provide limited nursing services from once a year to twice a year. However, the same problem exists with ALFs as with nursing homes. Although 0% is an admirable goal, it is not a reasonable 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: The Agency has no control over whether there will be serious deficiencies in health care facilities. We can only site and require correction of these deficiencies.

Management Efforts to Address Differences/Problems (check all that apply):

☐ Training ☐ Technology
☐ Personnel ☐ Other (Identify)

Recommendations: Delete this measure.

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: **Agency for Health Care Administration**
Program: **Health Care Regulation**
Service/Budget Entity: **Health Care Regulation/68700700**
Measure: **Percent of home health 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%	0.16%	Over	0.16%

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: While we believe that 0% serious deficiencies 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: This measure is not one over which the Agency can exercise control. While we can find and require correction of deficiencies, we cannot ensure that none will exist.

Management Efforts to Address Differences/Problems (check all that apply):

☐ Training ☐ Technology
☐ Personnel ☐ Other (Identify)

Recommendations: Delete this measure.

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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%	No Difference	No Difference

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 resulted in compliance with 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: This measure is not one over which the Agency has control. While we can find and require correction of deficiencies, the fact that this measure was met is related more to the number of laboratories in the state (12,000) than to the Agency's ability to ensure that all are deficiency free.

Management Efforts to Address Differences/Problems (check all that apply):

☐ Training ☐ Technology
☐ Personnel ☐ Other (Identify)

Recommendations: Delete this measure.

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

Action:

☒ Performance Assessment of Outcome Measure ☐ 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%	0.26%	Over	0.26%

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: While the agency can find and require correction of deficiencies, it cannot guarantee that no facility will have such deficiencies. This is not a measure of agency performance, it is a measure of ambulatory surgery center performance.

Management Efforts to Address Differences/Problems (check all that apply):

☐ Training ☐ Technology
☐ Personnel ☐ Other (Identify)

Recommendations: Delete this measure.

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

Action:

☒ Performance Assessment of Outcome Measure ☐ 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%	7.14%	Over	7.14%

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: 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: This is not a measure of Agency performance—it is a measure of hospital performance. While the Agency can often find and require correction of deficiencies, it cannot ensure that no such deficiencies will exist.

Management Efforts to Address Differences/Problems (check all that apply):

☐ Training ☐ Technology
☐ Personnel ☐ Other (Identify)

Recommendations: Delete this measure.

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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
6.00%	3.38%	Under	2.62%

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 measure is dependent upon the performance of the hospitals, not the performance of the Agency.

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's ability to meet this standard is entirely dependent upon external factors that the Agency has no control over. This measure is dependent upon the ability of hospitals to identify a "serious incident" and report that incident as required by Florida law.

Management Efforts to Address Differences/Problems (check all that apply):

☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)

Recommendations: Delete this measure

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: **Agency for Health Care Administration**
Program: **Health Care Regulation**
Service/Budget Entity: **Health Care Regulation/68700000**
Measure: **Percent of new Medicaid recipients voluntarily selecting managed care plan**

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
50%	50.93%	+.93%	1%

Factors Accounting for the Difference:
Internal Factors (check all that apply):

- ☐ Personnel Factors
- ☐ Competing Priorities
- ☐ Previous Estimate Incorrect
- ☐ Staff Capacity
- ☐ Level of Training
- ☐ Other (Identify)

Explanation: In compliance

External Factors (check all that apply):

- ☐ Resources Unavailable
- ☐ Legal/Legislative Change
- ☐ Target Population Change
- ☐ This Program/Service Cannot Fix The Problem
- ☐ Current Laws Are Working Against The Agency Mission
- ☐ Technological Problems
- ☐ Natural Disaster
- ☐ Other (Identify)

Explanation:

Management Efforts to Address Differences/Problems (check all that apply):

- ☐ Training
- ☐ Personnel
- ☐ Technology
- ☐ Other (Identify)

Recommendations:

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: **Agency for Health Care Administration**
Program: **Health Care Regulation**
Service/Budget Entity: **Health Care Regulation/68700700**
Measure: **Percent of facility patient dumping complaints investigated.**

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
100%	100%	0	0

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: There was only one such complaint in 2006-07 as compared with 15 such complaints in 2005-06. The single complaint was investigated.

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

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

Recommendations: None.

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

Action:

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
30,000	6,014	(23,986)	80%

Factors Accounting for the Difference:
Internal Factors (check all that apply):

- ☐ Personnel Factors
- ☐ Competing Priorities
- ☐ Previous Estimate Incorrect
- ☐ Staff Capacity
- ☐ Level of Training
- ☐ Other (Identify)

Explanation:

External Factors (check all that apply):

- ☐ Resources Unavailable
- ☐ Legal/Legislative Change
- ☐ Target Population Change
- ☐ This Program/Service Cannot Fix The Problem
- ☐ Current Laws Are Working Against The Agency Mission
- ☐ Technological Problems
- ☐ Natural Disaster
- ☒ Other (Identify)

Explanation: The Agency has no control over the numbers of phone calls that come into the call center for practitioner information. This measure is an artifact of the days when Medical Quality Assurance was part of the Agency for Health Care Administration. Now is it part of the Department of Health. This measure should be deleted.

Management Efforts to Address Differences/Problems (check all that apply):

- ☐ Training
- ☐ Personnel
- ☐ Technology
- ☐ Other (Identify)

Recommendations: Delete this measure.

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

Action:

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
7,550	7,139	Under	411

Factors Accounting for the Difference:
Internal Factors (check all that apply):

- ☐ Personnel Factors
- ☐ Competing Priorities
- ☐ Previous Estimate Incorrect
- ☒ Other (Identify)
- ☐ Staff Capacity
- ☐ Level of Training

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

External Factors (check all that apply):

- ☐ Resources Unavailable
- ☐ Legal/Legislative Change
- ☐ Target Population Change
- ☐ This Program/Service Cannot Fix The Problem
- ☐ Current Laws Are Working Against The Agency Mission
- ☐ Technological Problems
- ☐ Natural Disaster
- ☒ Other (Identify)

Explanation: This is a workload measure not a performance measure. The program has no control over the workload it receives.

Management Efforts to Address Differences/Problems (check all that apply):

- ☐ Training
- ☐ Personnel
- ☐ Technology
- ☐ Other (Identify)

Recommendations: Delete this measure.

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

Action:

☒ Performance Assessment of Outcome Measure ☐ 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
53	27	26 under	49% under

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: High level of staff experience.

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:

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure: Number of construction reviews performed (Plans and Construction)

Action:

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
4,500	4,725	225	5%

Factors Accounting for the Difference:
Internal Factors (check all that apply):

- ☐ Personnel Factors
- ☐ Competing Priorities
- ☐ Previous Estimate Incorrect
- ☐ Staff Capacity
- ☒ Level of Training
- ☐ Other (Identify)

Explanation: Staff is well trained and experienced with both plan and onsite reviews.

External Factors (check all that apply):

- ☐ Resources Unavailable
- ☐ Legal/Legislative Change
- ☐ Target Population Change
- ☐ This Program/Service Cannot Fix The Problem
- ☐ Current Laws Are Working Against The Agency Mission
- ☐ Technological Problems
- ☐ Natural Disaster
- ☒ Other (Identify)

Explanation: The number of plans and construction reviews is heavily dependent upon external factors related to the available funding for health care construction. In lean years, there are fewer requests for new projects.

Management Efforts to Address Differences/Problems (check all that apply):

- ☐ Training
- ☐ Personnel
- ☐ Technology
- ☐ Other (Identify)

Recommendations: Delete this measure. It is market dependant and, while a good measure of workload, is not a credible performance measure.

Office of Policy and Budget – July 2007

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: **Agency for Health Care Administration**
Program: **Health Care Regulation**
Service/Budget Entity: **Health Care Regulation/68700000**
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	451,630	(68,370)	-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: The implementation of Medicaid Reform in Broward and Duval counties in late July 2006 reduced the number of new eligible packets mailed and choice counseling provided by Medicaid Options. Those recipients' choice counseling is now provided by Reform Choice Counseling in a separate contract.

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:

Office of Policy and Budget – July 2007

LRPP Exhibit IV:

Performance Measure Validity and Reliability

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: 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.
- ☒ Requesting Deletion

Proposed Change to Measure:
The Agency is requesting that this measure be deleted in favor of more meaningful measures.

Data Sources and Methodology:

Proposed Standard/Target:

Validity:

Reliability:

Discussion: While ambulatory sensitive hospitalizations remain an accepted national standard as part of an overall evaluation of access and preventive care services, the population groups previously defined in the Long-Range Program plan did not accurately address the issue along programmatic lines. The existing measures are therefore being dropped in favor of measures that will more directly reflect program decisions, policies, and services.

Office of Policy and Budget – July 2007

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Children's Special Health Care (KidCare)/68500100
Measure: Percent 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: The Agency proposes to change the measure to "Percentage of all Title XXI KidCare enrollees eligible for renewal who either renew KidCare coverage or maintain health care coverage from another source."

Also, the Agency recommends changing the proposed standard from 100% to 90% and modifying the data source.

Data Sources and Methodology: Data are obtained from the Florida Healthy Kids Corporation for Title XXI renewals. The Agency obtains the data on a monthly basis. The data reflect the total number of children due for renewal each month and the number of children who complete the renewal process and maintain coverage.

The Institute for Child Health Policy (ICHP) at the University of Florida conducts an annual survey of caregivers in the KidCare program. As part of that annual process, they will also conduct interviews of caregivers for eligible children who do not re-enroll to ascertain their insurance status.

Proposed Standard/Target: 90%

Validity: The validity of this measure is high. The enrollment data come directly from administrative data. For those not re-enrolling, ICHP will interview the caregiver directly to ascertain insurance status.

Reliability: Data are reliable. They come directly from program administrative data and caregiver interviews.

Discussion: Once children are enrolled in a KidCare program, every effort is made to ensure that children eligible for the program remain enrolled. In addition, for those either losing eligibility or failing to renew, the program can educate the caregiver on the importance of maintaining insurance coverage. Prior to the renewal date, the caregiver of a child enrolled in KidCare is mailed a renewal form that must be completed, signed and returned with appropriate income documentation so that continued eligibility can be determined. The caregiver is given approximately 2 months to complete the process.

While this measure should be as close to 100% as possible, there will always be some people who choose not to maintain insurance coverage, or who do not complete the re-enrollment process for reasons outside the control of the KidCare program. While 100% is ideal, it is not a realistic goal.

Office of Policy and Budget – July 2007

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Children's Special Health Care (Kidcare)/68500100
Measure: Percent of children 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.

Proposed Change to Measure: The Agency proposes to change the "Percent of two year old children enrolled in Medicaid with up-to-date immunizations." The measure will include all Medicaid (Title XIX) and MediKids (Title XXI) children of the appropriate age.

The Agency also proposes to change the standard from 85 to 90 percent to match Healthy People 2010 goals and to limit the measure to two year olds who are only enrolled in Medicaid.

Data Sources and Methodology: The Department of Health (DOH), Bureau of Immunization, completes an annual immunization survey of randomly selected two year old children in Florida. The survey provides statewide coverage rates for the basic series of vaccines (4 Diptheria, Tetanus, and Pertussis (DTaP), 3 polio, and 1 Measles, Mumps, and Rubella (MMR) [4/3/1]) by two years of age. It also evaluates the statewide coverage rates for the 4/3/1/3/3 series of 4 DTaP, 3 polio, 1 MMR, 3 Influenza (Hib), and 3 hepatitis B vaccines.

Bureau of Immunization field staff conduct the survey with the assistance of county health departments' personnel, private physicians, and parents. The survey method includes a random sample of birth records selected from a list of all live births occurring among Florida residents for the month of January two years prior to the survey year. Once the survey evaluation is completed, the Department of Health provides Medicaid with a file of the two year old children. This file is matched to eligibility files to determine Medicaid-enrolled recipients. Then, the Department of Health, Bureau of Immunization, determines the coverage rate for Medicaid-enrolled two year old children.

Currently, the Agency has no direct method for matching non-Medicaid children to the DOH survey. The Agency is currently exploring options to match KidCare and CMSN (Children's Medical Services Network) children in the future.

Proposed Standard/Target: 90 percent

Validity: The DOH, Bureau of Immunization field staff conducts surveys with the assistance of county health departments' personnel, private physicians and parents.

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

Discussion: The Healthy People 2010 goal is 90 percent immunization coverage levels for each of the vaccines administered to children by two-years of age. The Department of Health established the Early Childhood Immunization Initiative with a goal of 90 percent by 2007.

Office of Policy and Budget – July 2007

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare 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.
☒ Requesting Deletion

Proposed Change to Measure:
The Agency is requesting that the measure be deleted due to data collection issues.

Data Sources and Methodology:
The American Academy of Pediatrics has a recommended frequency and interval for well-child visits and overall health supervision of children. The Institute for Child Health Policy (ICHP) conducts a telephone interview survey, as part of the annual KidCare Evaluation, with caregivers whose children have been receiving health care coverage through one of the KidCare program components for at least 12 months.

Validity:
Data are self-reported by parents and caregivers who often do not understand what a well-child visit is, or whether they've had one in the previous six months. In addition, for some age groups, the standard is 12 months, yet the measure has only looked at visits during the previous 6 months. The measure is difficult to capture accurately.

Reliability:
Data from the telephone interviews are based on the caregiver's self-reporting which can be unreliable. Various factors can also influence the respondent's answers including their memory and other unknowns such as answering "Yes" to a question which may trigger additional questions that can significantly lengthen the time necessary to complete the survey.

Discussion:
Since the data are unreliable and subject to the caregiver's memory, the Agency is requesting that this performance measurement be deleted.

Office of Policy and Budget – July 2007

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Children's Special Health Care (KidCare)/68500100
Measure: Percent of families with children enrolled in a Title XXI KidCare program 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.

Proposed Change to Measure: The Agency proposes to change the measure to the "Percentage of parents who rate their health plan/provider at least a 7 out of 10 on the annual satisfaction surveys." This is to bring the measure in line with national standards.

Data Sources and Methodology:
To assess KidCare program satisfaction, the Institute for Child Health Policy (ICHP) conducts a telephone interview survey, as part of the annual KidCare Evaluation, with caregivers whose children have been receiving health care coverage through one of the KidCare program components for at least 12 consecutive months. The survey population includes children receiving the following coverage: Medicaid enrolled with an HMO, Medicaid enrolled with a MediPass provider, and the Title XXI programs, MediKids, Healthy Kids and Children's Medical Services Network. The Consumer Assessment of Healthcare Providers and Services (CAHPS) is used to address aspects of care in the 6 months preceding the interview. The survey addresses obtaining routine care and specialized services, general health care experiences, health plan customer service and dental care.

For this measure, the standard reflects the percentage of caregivers who rate their plan 7 or higher on a 10-point scale. This is a nationally recognized measure and standard developed and reported by the Agency for Health Care Research and Quality, a federal HHS department responsible for state and national health policy research.

Proposed Standard/Target: 90%

Validity:
The CAHPS survey is a nationally recognized, validated survey instrument with national standards for this measure. The validity is high.

Reliability:
The CAHPS is a well-documented, nationally recognized survey with proven reliability. Reliability is high.

Discussion:
The ICHP should be required to include this measurement in each annual evaluation.

Office of Policy and Budget – July 2007

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare 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.
☒ Requesting Deletion

Proposed Change to Measure:
The Agency is requesting that this output (count) measure be deleted.

Data Sources and Methodology:

Validity:

Reliability:

Discussion:
This measure that has previously been reported in the Long-Range Program Plan does not measure program performance and should be deleted in favor of measures that are more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the numbers such as caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by state and federal mandate.

Office of Policy and Budget – July 2007

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Children's Special Health Care (KidCare)/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.
- ☒ Requesting Deletion

Proposed Change to Measure:
The Agency is requesting that this output (count) measure be deleted.

Data Sources and Methodology:

Validity:

Reliability:

Discussion:
This measure that has previously been reported in the Long-Range Program Plan does not measure program performance and should be deleted in favor of measures that are more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the numbers such as caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by state and federal mandate.

Office of Policy and Budget – July 2007

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare 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.
- ☒ Requesting Deletion

Proposed Change to Measure:
The Agency is requesting that this output (count) measure be deleted.

Data Sources and Methodology:

Validity:

Reliability:

Discussion:
This measure that has previously been reported in the Long-Range Program Plan does not measure program performance and should be deleted in favor of measures that are more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the numbers such as caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by state and federal mandate.

Office of Policy and Budget – July 2007

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare 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.
☒ Requesting Deletion

Proposed Change to Measure:
The Agency is requesting that this output (count) measure be deleted.

Data Sources and Methodology:

Validity:

Reliability:

Discussion:
This measure that has previously been reported in the Long-Range Program Plan does not measure program performance and should be deleted in favor of measures that are more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the numbers such as caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by state and federal mandate.

Office of Policy and Budget – July 2007

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.

Proposed Change to Measure:
The Agency is proposing that actual costs be used rather than projected budget to calculate the 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. Actual rather than projected budget will be used to calculate the measure.

Proposed Standard/Target: 2%, based on historical data for this measure

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 2007

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.

Proposed Change to Measure: Reduces the standard from 15 days to 7.

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**.**

With the more widespread use of electronic claims reporting, and based on recent program performance, a decrease in the target processing time is warranted.

Proposed Standard/Target: 7 days

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 SAS 70 Audit. The claims adjudication process assigns a unique claim identifier number to each claim and records the receipt date, adjudication date, and payment date for tracking and reporting purposes.

Office of Policy and Budget – July 2007

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.
☒ Requesting Deletion

Proposed Change to Measure:
The Agency is requesting that this output (count) measure be deleted.

Data Sources and Methodology:

Validity:

Reliability:

Discussion:
This measure that has previously been reported in the Long-Range Program Plan does not measure program performance and should be deleted in favor of measures that are more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the numbers such as caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate.

Office of Policy and Budget – July 2007

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 that are 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.
☒ Requesting Deletion

Proposed Change to Measure:
The Agency is requesting that this measure be deleted in favor of more meaningful measures.

Data Sources and Methodology:

Proposed Standard/Target:

Validity:

Reliability:

Discussion:
While ambulatory sensitive hospitalizations remain an accepted national standard as part of an overall evaluation of access and preventive care services, the population groups previously defined in the Long-Range Program plan did not accurately address the issue along programmatic lines. The existing measures are therefore being dropped in favor of measures that will more directly reflect program decisions, policies, and services.

Office of Policy and Budget – July 2007

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure: Percent of all Medicaid 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.

Proposed Change to Measure: A change in the standard/target to 90 percent from 86 percent to reflect the anticipated improvement to prenatal care associated with better coordination of care through Reform, and increased access to family planning services through the Family Planning Waiver.

Data Sources and Methodology: 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). This is a nationally recognized standard based on the Adequacy of Prenatal Care Utilization (APNCU) Index developed by the Department of Maternal and Child Health at the University of North Carolina.

The data source is the Medicaid Maternal and Child Health Status Indicators Report produced under contract annually for the Agency. The data and report are researched and compiled by a partnership between the Maternal Child Health and Education Research and Data Center (MCHERDC) at the University of Florida, and The Lawton and Rhea Chiles Center for Health Mothers and Babies (Chiles Center) at the University of South Florida. 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.

This measure includes all Medicaid women, regardless of eligibility status or program. The MCHERDC works closely with several state agencies including the Department of Health and the Department of Children and Families to obtain prenatal, birth, and postnatal data. 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, Centers for Disease Control and Prevention, and other experts.

Proposed Standard/Target (if known): 90 percent

Validity: The Validity of this measure is high. Over 50 percent of women who give birth in Florida 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 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.

It should be noted, that due to the time involved in closing out claims, compiling data from multiple sources, creating a comprehensive database, and analyzing/reporting the data, data from the MCHERDC and Chiles Center is lagged two years (i.e., is reported for the calendar year two years prior to the current LRPP reporting period).

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. The system is considered accurate. It forms the basis on which claims for Medicaid services are paid. A source of potential error is the matching of the two files. Currently, a match between social security numbers is used. If a social security number is missing from a file, the file is omitted from the analysis. If a case is missing a value needed for the calculation the record is omitted from the analysis. Gestational age is computed based on the clinical estimate as listed on the birth certificate. If this is not present, the date of last menses as indicated on the birth certificate is used to estimate gestational age. If neither are present, the conception is computed as 270 days prior to delivery date.

Office of Policy and Budget- July 2007

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.

Proposed Change to Measure: Establish an appropriate rate that reflects state and/or national trends while controlling for factors unique to the Medicaid population.

Data Sources and Methodology:
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.

The data source is the Medicaid Maternal and Child Health Status Indicators Report produced under contract annually for the Agency. The data and report are researched and compiled through a partnership with the Maternal Child Health and Education Research and Data Center (MCHERDC) at the University of Florida, and The Lawton and Rhea Chiles Center for Health Mothers and Babies (Chiles Center) at the University of South Florida.

Proposed Standard/Target: To be determined

Validity:
The validity is high. 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, Centers for Disease Control and Prevention, 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. The system is considered accurate. It forms the basis on which claims for Medicaid services are paid.

Discussion:
The non-Medicaid statewide neonatal mortality rate has traditionally been between 4 and 6 percent, with Medicaid rates about 2 percent higher than the statewide average. The target measure should reflect the statewide average when controlling for such factors as overall health status, socio-economic factors, and so on. Research continues to identify and validate a reliable method for setting a realistic target for this measure.

Office of Policy and Budget – July 2007

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 women 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.

Proposed Change to Measure:
No change is requested. While the Healthy Start program targets at least 24 months between pregnancies for improved pregnancy outcomes, Florida Medicaid has been well above that target for several years. In order to reflect this historical trend of higher performance, the target should remain at established levels.

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 which contains Medicaid eligibility, birth certificate, death certificate, Healthy Start 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. University of Florida 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.

Proposed Standard/Target: 35 months between pregnancies

Validity:
The validity is high for women who have maintained Medicaid coverage between pregnancies since it is based on claims data and birth records.

Reliability:
The reliability is considered high. Although the potential for inaccuracies on the birth certificate exist, they are not serious enough to jeopardize comparisons between programs or over time.

Office of Policy and Budget – July 2007

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Child Health Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure: Percent of eligible children who received a Child Health Check-Up

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 the Measure: The Agency is requesting that the standard be changed to 80 percent to reflect national standards. Child Health Check-Up service is Medicaid's comprehensive and preventive child health screening for individuals under the age of 21. This measure identifies the percentage of eligible children receiving a check-up within the 12-month federal reporting period. The data provides information to assess the utilization of the Child Health Check-Up service. The current Child Health Check-Up participation rate is 59 percent. The federal (Centers for Medicare and Medicaid Services [CMS]) state goal is to achieve 80 percent participation (Source: State Medicaid Manual, Part 5, Transmittal No. 7, November 1993, Section 5360). Continuing to improve Child Health Check-Up's participation rate increases access to services, which increases the early identification of medical conditions before they become serious and disabling; thereby decreasing future costly treatment services.

Data Sources and Methodology: The data source is the Medicaid Claims History File from the Florida Medicaid Management Information System (FMMIS), and utilization data submitted by the Medicaid Health Maintenance Organizations (HMOs). The data is based on specific procedure codes for a 12-month period and includes straight counts and percentages. This data may be obtained from the FMMIS Annual CHCUP Participation Report (CMS-416). The CMS-416 Reports submitted by states to CMS are entered on the federal CMS website under Medicaid, EPSDT.

Proposed Standard/Target: 80 percent

Validity: This measure is a required measure by the federal Centers for Medicare and Medicaid Services (CMS) and is considered a critical element of quality. The Child Health Check-Up service is designed to ensure that health problems are detected early so that future problems can be averted. Child Health Check-Up policy adheres to federal policy and the recommendations of the American Academy of Pediatrics.

While 80 percent is the target that Medicaid will strive to achieve, it is unlikely that participation rates will reach levels that high without a further increase in funding for screening and preventive services.

Reliability: As of March 1998, CMS updated the annual reporting requirements to more accurately reflect health screenings (Child Health Check-Ups). The updated 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 of Pediatrics. Medicaid verifies the FMMIS data, as well as audits of the HMO utilization reports.

Discussion:
The percentage of eligibles screened has a direct correlation to the fee levels for Child Health Check-Ups. For example, in 1995, the fee increased from $30 to $64.82 and the participation rates increased from 32 percent to 64 percent.

Office of Policy and Budget – July 2007

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.
☒ Requesting Deletion

Proposed Change to Measure:
The Agency is requesting that this output (count) measure be deleted.

Data Sources and Methodology:

Validity:

Reliability:

Discussion:
This measure that has previously been reported in the Long-Range Program Plan does not measure program performance and should be deleted in favor of measures that are more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the numbers such as caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate.

Office of Policy and Budget – July 2007

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- Also listed as "Number of children receiving Child Health Check-Up Services"
Action (check one):

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

Proposed Change to Measure:
The Agency is requesting that this output (count) measure be deleted.

Data Sources and Methodology:

Validity:

Reliability:

Discussion:
This measure that has previously been reported in the Long-Range Program Plan does not measure program performance and should be deleted in favor of measures that are more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the numbers such as caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate.

Office of Policy and Budget – July 2007

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.
☒ Requesting Deletion

Proposed Change to Measure:
The Agency is requesting that this output (count) measure be deleted.

Data Sources and Methodology:

Validity:

Reliability:

Discussion:
This measure that has previously been reported in the Long-Range Program Plan does not measure program performance and should be deleted in favor of measures that are more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the numbers such as caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate.

Office of Policy and Budget – July 2007

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.
☒ Requesting Deletion

Proposed Change to Measure:
The Agency is requesting that this output (count) measure be deleted.

Data Sources and Methodology:

Validity:

Reliability:

Discussion:
This measure that has previously been reported in the Long-Range Program Plan does not measure program performance and should be deleted in favor of measures that are more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the numbers such as caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate.

Office of Policy and Budget – July 2007

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.
☒ Requesting Deletion

Proposed Change to Measure:
The Agency is requesting that this output (count) measure be deleted.

Data Sources and Methodology:

Validity:

Reliability:

Discussion:
This measure that has previously been reported in the Long-Range Program Plan does not measure program performance and should be deleted in favor of measures that are more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the numbers such as caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate.

Office of Policy and Budget – July 2007

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.
☒ Requesting Deletion

Proposed Change to Measure:
The Agency is requesting that this output (count) measure be deleted.

Data Sources and Methodology:

Validity:

Reliability:

Discussion:
This measure that has previously been reported in the Long-Range Program Plan does not measure program *performance* and should be deleted in favor of measures that are more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the numbers such as caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate.

Office of Policy and Budget – July 2007

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.
☒ Requesting Deletion

Proposed Change to Measure:
The Agency is requesting that this output (count) measure be deleted.

Data Sources and Methodology:

Validity:

Reliability:

Discussion:
This measure that has previously been reported in the Long-Range Program Plan does not measure program performance and should be deleted in favor of measures that are more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the numbers such as caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate.

Office of Policy and Budget – July 2007

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.
☒ Requesting Deletion

Proposed Change to Measure:
The Agency is requesting that this output (count) measure be deleted.

Data Sources and Methodology:

Validity:

Reliability:

Discussion:
This measure that has previously been reported in the Long-Range Program Plan does not measure program performance and should be deleted in favor of measures that are more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the numbers such as caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate.

Office of Policy and Budget – July 2007

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.
☒ Requesting Deletion

Proposed Change to Measure:
The Agency is requesting that this output (count) measure be deleted.

Data Sources and Methodology:

Validity:

Reliability:

Discussion:
This measure that has previously been reported in the Long-Range Program Plan does not measure program *performance* and should be deleted in favor of measures that are more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the numbers such as caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate.

Office of Policy and Budget – July 2007

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 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.
- ☒ Requesting Deletion

Proposed Change to Measure:
The Agency is requesting that this measure be deleted in favor of more meaningful measures.

Data Sources and Methodology:

Proposed Standard/Target:

Validity:

Reliability:

Discussion:
While ambulatory sensitive hospitalizations remain an accepted national standard as part of an overall evaluation of access and preventive care services, the population groups previously defined in the Long-Range Program plan did not accurately address the issue along programmatic lines. The existing measures are therefore being dropped in favor of measures that will more directly reflect program decisions, policies, and services.

Office of Policy and Budget – July 2007

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.
- ☒ Requesting Deletion

Proposed Change to Measure:
The Agency is requesting that this output (count) measure be deleted.

Data Sources and Methodology:

Validity:

Reliability:

Discussion:
This measure that has previously been reported in the Long-Range Program Plan does not measure program performance and should be deleted in favor of measures that are more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the numbers such as caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by state and federal mandate.

Office of Policy and Budget – July 2007

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 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.
☒ Requesting Deletion

Proposed Change to Measure:
The Agency is requesting that this output (count) measure be deleted.

Data Sources and Methodology:

Validity:

Reliability:

Discussion:
This measure that has previously been reported in the Long-Range Program Plan does not measure program performance and should be deleted in favor of measures that are more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the numbers such as caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by State and Federal mandate.

Office of Policy and Budget – July 2007

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 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.
☒ Requesting Deletion

Proposed Change to Measure:
The Agency is requesting that this measure be deleted in favor of more meaningful measures.

Data Sources and Methodology:

Proposed Standard/Target:

Validity:

Reliability:

Discussion:
While ambulatory sensitive hospitalizations remain an accepted national standard as part of an overall evaluation of access and preventive care services, the population groups previously defined in the Long-Range Program plan did not accurately address the issue along programmatic lines. The existing measures are therefore being dropped in favor of measures that will more directly reflect program decisions, policies, and services.

Office of Policy and Budget – July 2007

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 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.
☒ Requesting Deletion

Proposed Change to Measure:
The Agency is requesting that this measure be deleted in favor of more meaningful measures.

Data Sources and Methodology:

Proposed Standard/Target:

Validity:

Reliability:

Discussion:
While ambulatory sensitive hospitalizations remain an accepted national standard as part of an overall evaluation of access and preventive care services, the population groups previously defined in the Long-Range Program plan did not accurately address the issue along programmatic lines. The existing measures are therefore being dropped in favor of measures that will more directly reflect program decisions, policies, and services.

Office of Policy and Budget – July 2007

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.
☒ Requesting Deletion

Proposed Change to Measure:
The Agency is requesting that this output (count) measure be deleted.

Data Sources and Methodology:

Validity:

Reliability:

Discussion:
This measure that has previously been reported in the Long-Range Program Plan does not measure program performance and should be deleted in favor of measures that are more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the numbers such as caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by state and federal mandate.

Office of Policy and Budget – July 2007

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.
☒ Requesting Deletion

Proposed Change to Measure:
The Agency is requesting that this output (count) measure be deleted.

Data Sources and Methodology:

Validity:

Reliability:

Discussion:
This measure that has previously been reported in the Long-Range Program Plan does not measure program performance and should be deleted in favor of measures that are more reflective of program efforts and services. While indicative of the size and scope of the Medicaid program, the numbers such as caseload and enrollment counts are not measures that can be affected by anything Medicaid does or has control over. These numbers are impacted solely by external factors such as overall population age and health, the state of the economy, availability of alternative access to care, and eligibility policy that is established by state and federal mandate.

Office of Policy and Budget – July 2007

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure: Percent of 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 deficiency data are maintained in the federal Automated Survey Processing Environment (ASPEN) and centrally collected. The number of facilities is obtained from Florida Regulatory and Enforcement System (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:
Data maintained in ASPEN and FRAES 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, 2007

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: **Agency for Health Care Administration**
Program: **Health Care Regulation**
Service/Budget Entity: **Health Care Regulation/68700700**
Measure: **Percent of 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 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 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 of these data are questionable.

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:
Centralized collection of data combined with management review of supporting data should ensure accurate and consistent reporting, resulting in reliability for the measure. However, we believe that this condition is impossible to measure accurately. Cease and desist orders are not issued by all units for unlicensed activity, nor are they issued for all facility types. Unlicensed facilities may emerge under different names and ownership and not be identifiable as repeated unlicensed activity. Also, there is no further action other than another cease and desist order than can be taken by the agency. Unlicensed activity is a crime and should be reported to law enforcement authorities.

Office of Policy and Budget – July, 2007

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure: Percent of Priority 1 consumer complaints about licensed facilities and programs that are investigated within 48 hours

Action (check one):
☒ Requesting revision to approved performance measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☐ Backup for performance measure for 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. The system measures days, not hours. To comply with system constraints as well as with federal standards, the Agency is requesting revision of the standard to state "2 business days" rather than "48 hours."

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:
Data maintained in FRAES 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, 2007

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure: Percent of 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, 2007

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure: Percent of 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 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 state accreditation validation surveys conducted for hospitals and ambulatory surgical centers that are consistent with findings noted during the accreditation survey divided by the total number of validation surveys performed during the period. A state validation survey is performed, at minimum, on a 5% sample of accredited hospitals and ambulatory surgical centers that have received their accreditation survey. This measure does not include federal accreditation validation surveys.

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

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

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

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

Office of Policy and Budget – July, 2007

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure: Percent of 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 deficiency data are maintained in the federal Automated Survey Processing Environment (ASPEN) and centrally collected. The number of facilities is obtained from Florida Regulatory and Enforcement System (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:
Data maintained in ASPEN and FRAES 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, 2007

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure: Percent of 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 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 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:
Data maintained in FRAES 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, 2007

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure: Percent of 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. 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:
Data maintained in FRAES 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, 2007

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure: Percent of 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. 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:
Data maintained in FRAES 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, 2007

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure: Percent of 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. 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:
Data maintained in FRAES 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, 2007

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: **Agency for Health Care Administration**
Program: **Health Care Regulation**
Service/Budget Entity: **Health Care Regulation/68700700**
Measure: **Percent of 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.

Data Sources and Methodology: Data Sources: Risk management surveys, complaint investigations, and Code 15 investigations.

Methodology: The number of hospitals that were cited for failure to report an adverse incident divided by the total number of hospitals that were surveyed (including risk management surveys, complaint investigations and Code 15 investigations).

When accurately reported, this measures the hospitals' ability to identify and report serious incidents—but it does not measure the Agency's performance.

Validity: The Agency's ability to meet this standard is entirely dependent upon external factors that the Agency has no control over. This measure is dependent upon the ability of hospitals to identify a "serious incident" and report that incident as required by Florida law.

Reliability: The Agency's ability to meet this standard is entirely dependent upon external factors that the Agency has no control over. This measure is dependent upon the ability of hospitals to identify a "serious incident" and report that incident as required by Florida law.

Office of Policy and Budget – July, 2007

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: **Agency for Health Care Administration**
Program: **Health Care Regulation**
Service/Budget Entity: **Health Care Regulation/68700700**
Measure: **Percent of complaints of HMO patient dumping received that are investigated.**
Action (check one):

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

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 no patient complaints related to health plan "dumping" in Fiscal Years 2003/04 through 2006/07.

Validity:
The purpose of the Agency's activities is to determine whether the patient allegation of dumping is justified. Site visits and the evaluation of individual patient records are the only valid measures to confirm such 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 by replicated by other observers—therefore the measure is reliable.

Office of Policy and Budget – July, 2007

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: **Agency for Health Care Administration**
Program: **Health Care Regulation**
Service/Budget Entity: **Health Care Regulation/68700700**
Measure: **Percent of complaints of facility 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.

Data Sources and Methodology:
The Florida Regulatory and Enforcement System/LicenseEase (FRAES/LE) 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 Medicare and Medicaid Patient Dumping, respectively. FRAES/LE 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/LE database and investigated by field operations survey staff. A complaint is a valid transaction that begins with either a call to the call center or correspondence to one of the facility units in the Agency. All such complaints are entered into FRAES/LE to be investigated. Complaints received by the call center are entered into FRAES/LE by the call center staff at the time of the call. Written complaints are tracked through CorrFlow, the Agency's correspondence tracking system. They are entered into the FRAES/LE database 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/LE 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 FRAES/LE.

Office of Policy and Budget – July, 2007

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Data Sources and Methodology:
Call center staff members input data by call as they respond to phone calls. Calls are tracking 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 issues 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.

Office of Policy and Budget – July, 2007

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: **Agency for Health Care Administration**
Program: **Health Care Regulation**
Service/Budget Entity: **Health Care Regulation/68700700**
Measure: **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, 2007

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Data Sources and Methodology:
An Excel spreadsheet is 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) and (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:
Data entry into the data base is checked regularly to assure that all data meets a "cross-check" standard. The database is maintained by the unit manager and designated staff.

Office of Policy and Budget – July, 2007

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Data Sources and Methodology:
All plans and construction projects are tracked on the Office of Plans and Construction Tracking (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 of reviews. The Agency 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 constriction 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, 2007

Exhibit V:

Identification of Associated Activity Contributing to Performance Measures

LRPP Exhibit V: Identification of Associated Activity Contributing to Performance Measures			
Measure Number	**Approved Performance Measures for FY 2007-08 (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 Purchase Children's Medical Services Network Services ACT5120 Purchase Children's Medical Services Network Services ACT5130

4	Percent of eligible uninsured children receiving health benefits coverage		Purchase MediKids Program Services ACT5110 Purchase Children's Medical Services Network Services ACT5120 Purchase Children's Medical Services Network Services ACT5130
5	Percent of children enrolled with up-to-date immunizations		Purchase MediKids Program Services ACT5110 Purchase Children's Medical Services Network Services ACT5120 Purchase Children's Medical Services Network 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 Purchase Children's Medical Services Network Services ACT5120 Purchase Children's Medical Services Network Services ACT5130
7	Percent of families satisfied with the care provided under the program		Purchase MediKids Program Services ACT5110 Purchase Children's Medical Services Network Services ACT5120 Purchase Children's Medical Services Network Services ACT5130
8	Total number of uninsured children enrolled in Kidcare		Purchase MediKids Program Services ACT5110 Purchase Children's Medical Services Network Services ACT5120 Purchase Children's Medical Services Network Services ACT5130

9	Number of uninsured children enrolled in Florida Healthy Kids		Purchase MediKids Program Services ACT5110 Purchase Children's Medical Services Network Services ACT5120 Purchase Children's Medical Services Network Services ACT5130
10	Number of Title uninsured children enrolled in Medikids		Purchase MediKids Program Services ACT5110 Purchase Children's Medical Services Network Services ACT5120 Purchase Children's Medical Services Network Services ACT5130
11	Number of uninsured children enrolled in Children's Medical Services Network		Purchase MediKids Program Services ACT5110 Purchase Children's Medical Services Network Services ACT5120 Purchase Children's Medical Services Network Services ACT5130
	Executive Direction/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

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 Hospital Inpatient ACT4210 Hospital Inpatient ACT4510 Hospital Inpatient ACT4710
16	Percent of women receiving adequate prenatal care		Prescribed Medicines ACT4220 Physician Services ACT4230 Early Periodic Screening Diagnosis & Treatment ACT4260 Patient Transportation ACT4270
17	Neonatal mortality rate per 1000		Hospital Inpatient ACT4210 Physician Services ACT4220 Early Periodic Screening Diagnosis & Treatment ACT4260
18	Average number of months between pregnancies for those receiving family planning services		Physician Services ACT4230 Case Management ACT4280

19	Percent of eligible children who received all required components of EPSDT screen		Prescribed Medicines ACT4220
			Physician Services ACT4230
			Early Periodic Screening Diagnosis & Treatment ACT4260
			Therapeutic Services for Children ACT4310
20	Number of children ages 1-20 enrolled in Medicaid		Purchase MediKids Program Services ACT5110
			Purchase Children's Medical Services Network Services ACT5120
			Purchase Children's Medical Services Network Services ACT5130
21	Number of children receiving EPSDT services		Physician Services ACT4230
			Early Periodic Screening Diagnosis & Treatment ACT4260
			School Based Services ACT4310
			Clinic Services ACT4330
22	Number of hospital inpatient services provided to children		Hospital Inpatient ACT4210
			Therapeutic Services for Children ACT4310
23	Number of physician services provided to children		Physician Services ACT4230
			Therapeutic Services for Children ACT4310

24	Number of prescribed drugs provided to children		Prescribed Medicines 4220
			School Based Services ACT4320
25	Number of hospital inpatient services provided to elders		Hospital Inpatient -Elderly and Disabled/fee for service ACT4010
			Prescribed Medicines- Elderly and Disabled/fee for service ACT4020
			Physician Services-Elderly and Disabled/fee for service ACT4030
			Hospital Insurance Benefit-Elderly and Disabled /Fee for service ACT4140
26	Number of physician services provided to elders		Physician Services-Elderly and Disabled/fee for service ACT4030
			Supplemental Medical Insurance-Elderly and Disabled/fee for service ACT4050
			Prescribed Medicines- Elderly and Disabled/fee for service ACT4020
27	Number of prescribed drugs provided to elders		Prescribed Medicines- Elderly and Disabled/fee for service ACT4020
28	Number of uninsured children enrolled in the Medicaid Expansion		Purchase MediKids Program Services ACT5110
			Purchase Children's Medical Services Network Services ACT5120
			Purchase Children's Medical Services Network Services ACT5130

	Medicaid Long Term Care - 68501500		
29	Percent of hospitalizations for conditions preventable with good ambulatory care		Nursing Home Care ACT5020 Home and Community Based Services ACT5030 Capitates Nursing Home Diversion Waiver ACT5060
30	Number of case months (home and community-based services)		Home and Community Based Services ACT5030 Capitated Nursing Home Diversion Waiver ACT5060
31	Number of case months services purchased (Nursing Home)		Nursing Home Care ACT5020 Other ACT5070
	Medicaid Prepaid Health Plan - 68501600		
32	Percent of hospitalizations for conditions preventable by good ambulatory care		Prepaid Health Plans Elderly and Disabled ACT1620 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
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

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
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
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
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
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
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 recipients 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
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
50	Number of inquiries to the call center regarding practitioner licensure and disciplinary information		Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT70200
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

SECTION I: BUDGET	FISCAL YEAR 2005-06 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.)	777,893,142	0
FINAL BUDGET FOR AGENCY	16,678,207,941	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	1,523,928	601.36	916,422,080	
Prepaid Health Plans - Families * Number of case months Medicaid program services purchased	7,379,316	160.86	1,187,046,812	
Elderly And Disabled/Fee For Service/Medipass - Hospital Inpatient * Number of case months Medicaid program services purchased	6,612,780	204.90	1,354,963,640	
Elderly And Disabled/Fee For Service/Medipass - Prescribed Medicines * Number of case months Medicaid program services purchased	6,612,780	135.69	897,316,553	
Elderly And Disabled/Fee For Service/Medipass - Physician Services * Number of case months Medicaid program services purchased	6,612,780	50.74	335,550,781	
Elderly And Disabled/Fee For Service/Medipass - Hospital Outpatient * Number of case months Medicaid program services purchased	6,612,780	38.55	254,911,241	
Elderly And Disabled/Fee For Service/Medipass - Supplemental Medical Insurance * Number of case months Medicaid program services purchased	4,457,940	174.65	778,575,746	
Elderly And Disabled/Fee For Service/Medipass - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	948,024	10.47	9,924,228	
Elderly And Disabled/Fee For Service/Medipass - Patient Transportation * Number of case months Medicaid program services purchased	6,612,780	8.59	56,783,466	
Elderly And Disabled/Fee For Service/Medipass - Case Management * Number of case months Medicaid program services purchased	6,612,780	13.81	91,337,281	
Elderly And Disabled/Fee For Service/Medipass - Home Health Services * Number of case months Medicaid program services purchased	6,612,780	10.09	66,716,740	
Elderly And Disabled/Fee For Service/Medipass - Therapeutic Services For Children * Number of case months Medicaid program services purchased	948,024	50.48	47,860,539	
Elderly And Disabled/Fee For Service/Medipass - Hospital Insurance Benefit * Number of case months Medicaid program services purchased	4,457,940	24.05	107,209,524	
Elderly And Disabled/Fee For Service/Medipass - Hospice * Number of case months Medicaid program services purchased	6,612,780	21.04	139,136,964	
Elderly And Disabled/Fee For Service/Medipass - Private Duty Nursing * Number of case months Medicaid program services purchased	948,024	112.71	106,847,250	
Elderly And Disabled/Fee For Service/Medipass - Other * Number of case months Medicaid program services purchased	6,612,780	77.49	512,451,526	
Women And Children/Fee For Service/Medipass - Hospital Inpatient * Number of case months Medicaid program services purchased	16,133,304	58.92	950,633,951	
Women And Children/Fee For Service/Medipass - Prescribed Medicines * Number of case months Medicaid program services purchased	16,133,304	18.10	291,993,366	
Women And Children/Fee For Service / Medipass - Physician Services * Number of case months Medicaid program services purchased	16,133,304	26.81	432,469,572	
Women And Children/Fee For Service / Medipass - Hospital Outpatient * Number of case months Medicaid program services purchased	16,133,304	20.50	330,792,091	
Women And Children/Fee For Service / Medipass - Supplemental Medical Insurance * Number of case months Medicaid program services purchased	12,084	11,773.79	142,274,512	
Women And Children/Fee For Service / Medipass - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	7,009,164	16.97	118,948,404	
Women And Children/Fee For Service / Medipass - Patient Transportation * Number of case months Medicaid program services purchased	16,133,304	3.84	62,023,523	
Women And Children/Fee For Service / Medipass - Case Management * Number of case months Medicaid program services purchased	16,133,304	0.69	11,116,606	
Women And Children/Fee For Service / Medipass - Home Health Services * Number of case months Medicaid program services purchased	7,009,164	17.20	120,525,626	
Women And Children/Fee For Service / Medipass - Therapeutic Services For Children * Number of case months Medicaid program services purchased	7,009,164	20.41	143,027,765	
Women And Children/Fee For Service / Medipass - Clinic Services * Number of case months and Medicaid program services purchased	16,133,304	5.42	87,436,824	
Women And Children/Fee For Service / Medipass - Other * Number of case months Medicaid program services purchased	16,133,304	21.38	344,934,714	
Medically Needy - Hospital Inpatient * Number of case months Medicaid program services purchased	214,272	823.60	176,475,389	
Medically Needy - Prescribed Medicines * Number of case months Medicaid program services purchased	214,272	596.23	127,755,329	
Medically Needy - Physician Services * Number of case months Medicaid program services purchased	214,272	216.66	46,423,287	
Medically Needy - Hospital Outpatient * Number of case months Medicaid program services purchased	214,272	239.95	51,415,488	
Medically Needy - Supplemental Medical Insurance * Number of case months Medicaid program services purchased	58,536	82.23	4,813,452	
Medically Needy - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	30,480	16.98	517,561	
Medically Needy - Patient Transportation * Number of case months Medicaid program services purchased	214,272	9.58	2,052,842	
Medically Needy - Case Management * Number of case months Medicaid program services purchased	214,272	7.63	1,634,183	
Medically Needy - Home Health Services * Number of case months Medicaid program services purchased	214,272	8.22	1,761,035	
Medically Needy - Therapeutic Services For Children * Number of case months Medicaid program services purchased	30,480	3.13	95,492	
Medically Needy - Other * Number of case months Medicaid program services purchased	214,272	4,789.92	1,026,346,269	
Refugees - Hospital Inpatient * Number of case months Medicaid program services purchased	119,964	20.83	2,498,780	
Refugees - Prescribed Medicines * Number of case months Medicaid program services purchased	119,964	3,227.56	387,191,212	
Refugees - Physician Services * Number of case months Medicaid program services purchased	119,964	29.83	3,578,969	
Refugees - Hospital Outpatient * Number of case months Medicaid program services purchased	119,964	11.00	1,319,837	
Refugees - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	119,964	0.90	108,437	
Refugees - Patient Transportation * Number of case months Medicaid program services purchased	119,964	0.66	79,653	
Refugees - Case Management * Number of case months Medicaid program services purchased	119,964	0.06	7,516	
Refugees - Home Health Services * Number of case months Medicaid program services purchased	119,964	1.37	164,942	
Refugees - Therapeutic Services For Children * Number of case months Medicaid program services purchased	8,556	2.67	22,828	
Refugees - Other * Number of case months Medicaid program services purchased	119,964	22.28	2,673,105	
Nursing Home Care *	628,443	3,998.25	2,512,674,147	
Home And Community Based Services *	652,081	1,575.31	1,027,226,677	
Intermediate Care Facilities For The Developmentally Disabled - Sunland Centers *	10,498	11,304.29	118,672,427	
Mental Health Disproportionate Share Program *	1,342	45,453.57	60,998,691	
Long Term Care - Other *	227,721	2,322.06	528,782,502	
Purchase Medikids Program Services * Number of case months	286,765	105.29	30,194,528	
Purchase Children's Medical Services Network Services * Number of case months	150,585	577.17	86,912,916	
Purchase Florida Healthy Kids Corporation Services * Number of case months	2,564,371	88.51	226,960,762	
Certificate Of Need/Financial Analysis * Number of certificate of need (CON) requests/financial reviews conducted	2,501	669.33	1,673,994	
Health Facility Regulation (compliance, Licensure, Complaints) - Tallahassee * Number of licensure applications	22,872	609.07	13,930,562	
Facility Field Operations (compliance, Complaints) - Field Offices Survey Staff * Number of surveys and complaint investigations	68,706	573.49	39,402,155	
Health Standards And Quality * Number of transactions	2,185,841	2.00	4,370,922	
Plans And Construction * Number of reviews performed	4,725	1,161.94	5,490,155	
Managed Health Care *	622	7,145.95	4,444,779	
Organ And Tissue Donor * Number of donor designations	1,509,179	0.17	256,970	
Background Screening * Number of requests for screenings	58,953	13.93	821,226	
Subscriber Assistance Panel * Number of cases	408	2,177.70	888,502	
Health Facilities And Practitioner Regulation - Medicaid Choice Counseling * Number of new enrollees provided choice counseling	487,089	15.11	7,361,242	
TOTAL			16,589,808,007	

SECTION III: RECONCILIATION TO BUDGET	
PASS THROUGHS	
TRANSFER - STATE AGENCIES	
AID TO LOCAL GOVERNMENTS	
PAYMENT OF PENSIONS, BENEFITS AND CLAIMS	
OTHER	188,185,389
REVERSIONS	82,792,504
TOTAL BUDGET FOR AGENCY (Total Activities + Pass Throughs + Reversions) - Should equal Section I above. (4)	16,678,207,981

EXHIBIT 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

FFY: Federal Fiscal Year (October through September)

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

ITN: Invitation to Negotiate

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.

Medicaid Reform: A demonstration waiver program created in Section 409.91211, F.S., with the passage of Senate Bill (SB) 838. It began in two counties (Broward and Duval) on July 1, 2006, and was expanded to Baker, Clay, and Nassau counties on July 1, 2007. The Medicaid Reform program is designed to transform the Medicaid program by empowering Medicaid beneficiaries to take control of their health care, provide more choices for beneficiaries, and enhance their health status through increased health literacy and incentives to engage in healthy behaviors. See http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml for more information.

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

MediKids: Part of the KidCare program, MediKids offers coverage to families with incomes over 200 percent of the federal poverty level.

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/PB: 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 Care Access Network (PCAN): Federally Qualified Health Care Centers , some of which provide a full range of services, including hospitalization, and others that provide only primary and preventive care.

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.

RFP: Request for Proposal

SFY: State Fiscal Year (July through June)

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

Severity Level G: Federal citations of deficiencies are used to indicate noncompliance with regulations in a Medicare/Medicaid certified health care facility. Deficiencies in nursing homes are described by scope and severity. Scope defines the number of residents potentially affected by a deficient practice. Severity indicates how serious the impact of the deficiency is on the residents. Severity is measured as levels A through L, with A being the least severe and L the most severe. A severity of G or above is considered a serious deficiency.

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

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

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 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)