Agency for Health Care Administration

Long Range Program Plan

FY 2009-2010 through FY 2013-2014

TABLE OF CONTENTS

Agency for Health Care Administration's
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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 be maintained while moving toward a more consumer-centric system which introduces market forces to boost access to services?

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

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

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

5. **Performance Measures**: How can we use performance and outcome measures as a bases 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 are 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)

Medicaid Key Personnel List

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(Division of Medicaid)

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Health Care Services

(Division of Medicaid)

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

Objective 1. A: 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 2006-2007	FY 2009-2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014
Projected PMPM with 8% growth $328.24	$413.08	$446.13	$481.82	$520.37*	$561.99*
Actual PMPM $269.89	$314.8	$339.98	$367.18	$396.55	$428.27

*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 2013-2014 and to develop measures more in line with program performance goals.

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 2007-2008	FY 2009-2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014
Number of Medicaid outcome measures that are tracked 33	30	20	20	20	20
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	100%	100%	100%	100%	100%

Given the increased emphasis on performance measures, the Medicaid LRPP measures will be submitted for revision with emphasis on improving the measures to more accurately tie in with the overall goals, programs and services in Florida Medicaid. This will necessitate the deletion of 14 obsolete measures, the revision of nine measures, and the addition of 11 new measures for a total of 30 measures by FY 2008-2009. Further revisions planned are deletion of all irrelevant count measures which will bring the total to 20 by FY2009-2010.

Objective 1. C: To slow the growth in long-term care expenditures by $290 million by converting a portion of the institutional care budget to community-based long-term care, by FY 2012-2013.

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 2009-2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014
Current LTC projections $2,423	$2,508	$2,552	$2,596	$2,641	$2,686
Revised LTC projections $2,294	$2,328	$2,345	$2,362	$2,379	$2,396
LTC savings $129	$180	$207	$234	$262	$290

Table excludes Medicare nursing home crossover payments.

Objective 1. D: To increase beneficiaries reported satisfaction with access to specialty care services to 83 percent by FY 2013-2014.

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 2005-06	FY 2009-2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014
Percent of MediPass patients that reported satisfaction with access to specialty care 68%	73%	75%	77%	80%	83%

Objective 1. E: To increase the extent of consumer directed care to four programs/services, to include development of alternative options to Medicaid by FY 2012-2013.

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

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

Baseline/Year FY 2003-2004	FY 2009-2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014
Number of Services programs with consumer directed incentives 1	2	2	3	3	4

Objective 1. F: 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 eight percent by FY 2013-2014.

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

Service Outcome Measure Projection Table 1. F:

Baseline/Year FY 2004-2005	FY 2009-2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014
Percent of physicians enrolled in Medicaid who use hand-held wireless devices to assist in prescribing 2%	4%	5%	6%	7%	8%

Linkage of Agency Goals and Programs to Governor's Priorities

	Governor's Priorities and Goals	Agency Goals and/or Programs
1.	Protecting Our Communities	
2.	Strengthening Florida's Families	
3.	Keeping Florida's Economy Vibrant	
4.	Success for Every Student	
5.	Keeping Floridians Healthy	**Goal 1:** To be a prudent purchaser of quality health care services for low-income Floridians.
6.	Protecting Florida's Natural Resources	

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, 55.4 percent of the cost of most Medicaid services was reimbursed with federal funds in FY 2008-2009, while administrative costs were reimbursed 50 percent. Information technology projects and services such as family planning are reimbursed at higher levels.

In July 2007 U.S. Census Bureau estimated Florida's population to be approximately 18.3 million, making it the fourth most populous state in the nation. Projections indicate that Florida will become the third most populous state by CY 2025; its growth rate is among the fastest in the nation.

As the population grows, so does the need for health care services. As of July 1, 2007, Florida had the highest percentage (17 percent) of elderly residents in the nation. The over 65 population is projected to grow to more than 3.4 million by CY 2010, nearly 18 percent of the state's total population. As the baby–boom generation reaches retirement age the demand for health care 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. Medicaid is currently working with community stakeholders and the Florida legislature to improve performance of Medicaid programs. As part of that effort, the Agency is re-designing its performance monitoring tools in order to be better able to track performance and outcomes (Objective 1B). Medicaid hopes to maintain or improve the level of quality in its programs by FY 2009-2010.

In FY 2007-2008, Medicaid served nearly 3.0 million beneficiaries and processed 150 million claims from approximately 80,000 providers. Medicaid is the second largest single program in the state budget behind public education, requiring more than 23 percent of the state's total budget, and is the largest source of federal funding for the state. While Medicaid caseloads are up almost 48 percent from over a decade ago, there was a slight decline from the FY 2005-2006 level in fiscal years, FY 2006-2007 and FY 2007-2008. However, it is projected to rise slightly above the FY 2005-2006 caseload level in FY 2008-2009. The recent increase reflects external factors such as the economy and eligibility criteria set by State and Federal mandates, and are not within the Medicaid program's control. The average monthly caseload in FY 2008-2009 is projected to be about 2.25 million which is close to the caseload in FY2005-2006. See Figure 1.1 for average monthly caseloads between FY 1995-1996 and FY 2008-2009.

Expenditures in the Medicaid program grew at an average annual rate of 13 percent between Fiscal Year 1999-2000 and Fiscal Year 2004-2005. The primary factors contributing to the expenditure growth were prescription drug costs, increased costs of medical services, long-term care, and enrollment growth. Between FY 2004-2005 and FY 2006-2007, expenditures remained fairly flat, actually dropping slightly in FY 2005-2006 then increasing by 3.5 percent in FY 2006-07 and 3.8 percent by the end of FY 2007-2008. They are expected to increase 3.2 percent in FY 2008-2009. The largest expenditure categories for FY 2008-2009 are Prepaid

Health Plans ($2.4 billion), Nursing Home Care ($2.3 billion), Hospital Inpatient Services ($2.2 billion), Prescription Services ($1.5 billion) and Low Income Pool ($1.0 billion). Figure 1.2 shows the largest expenditure categories by beneficiary type. Figure 1.3 shows Medicaid expenditures by appropriation category.

Figure 1.1

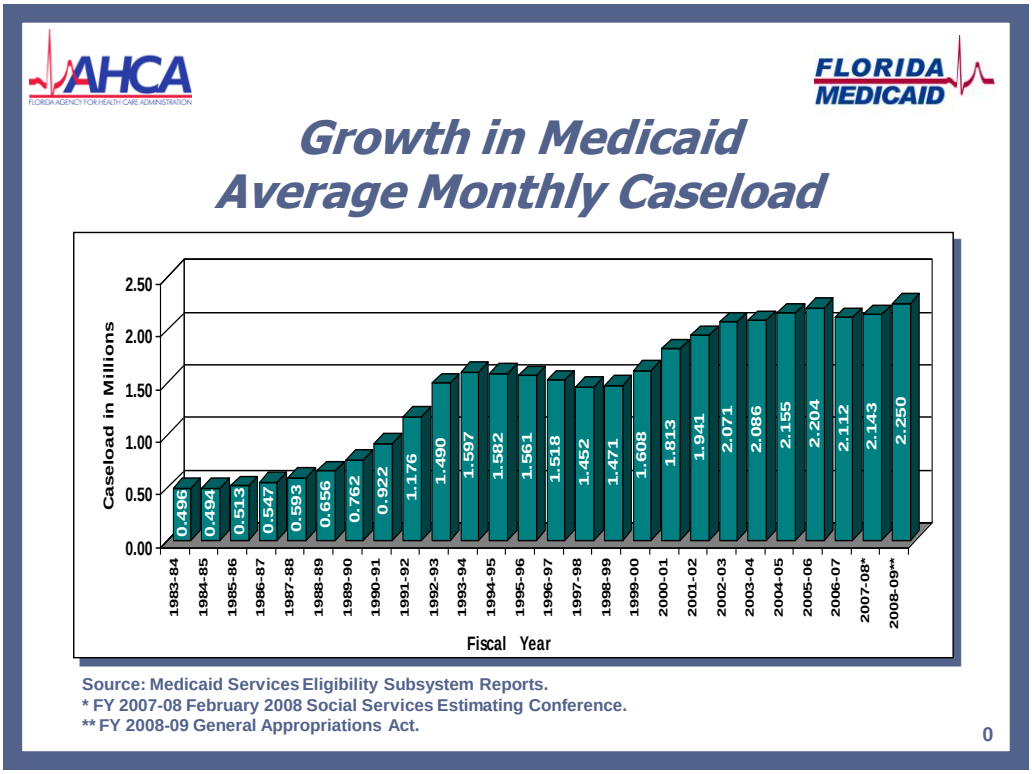


Figure 1.2

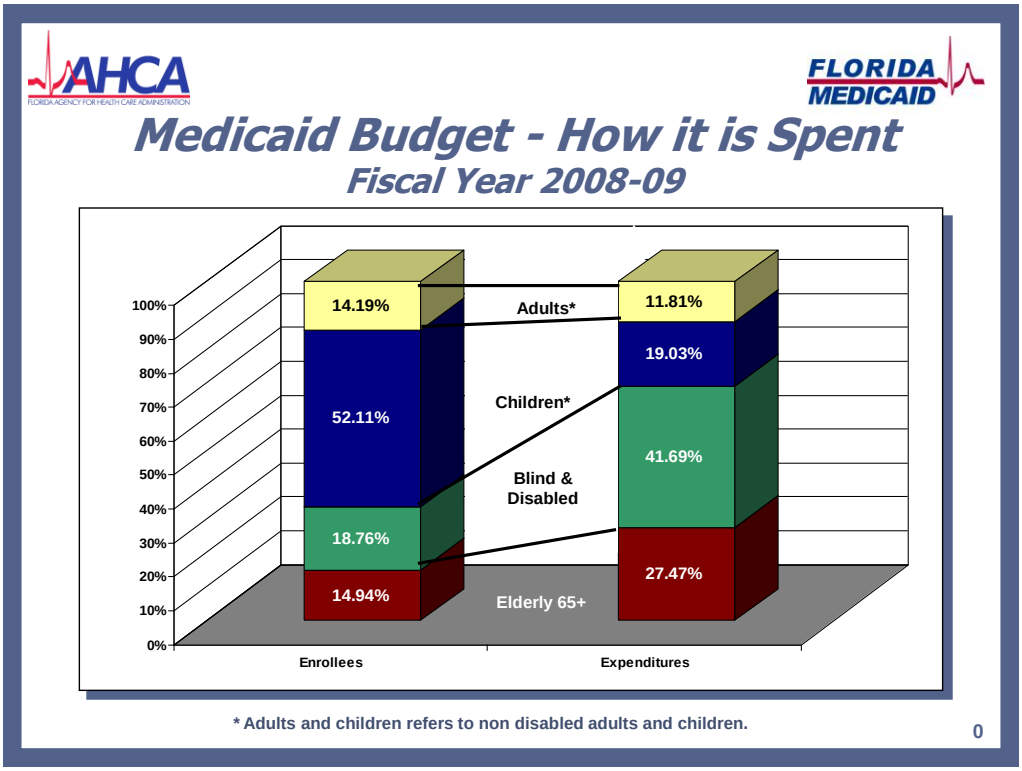
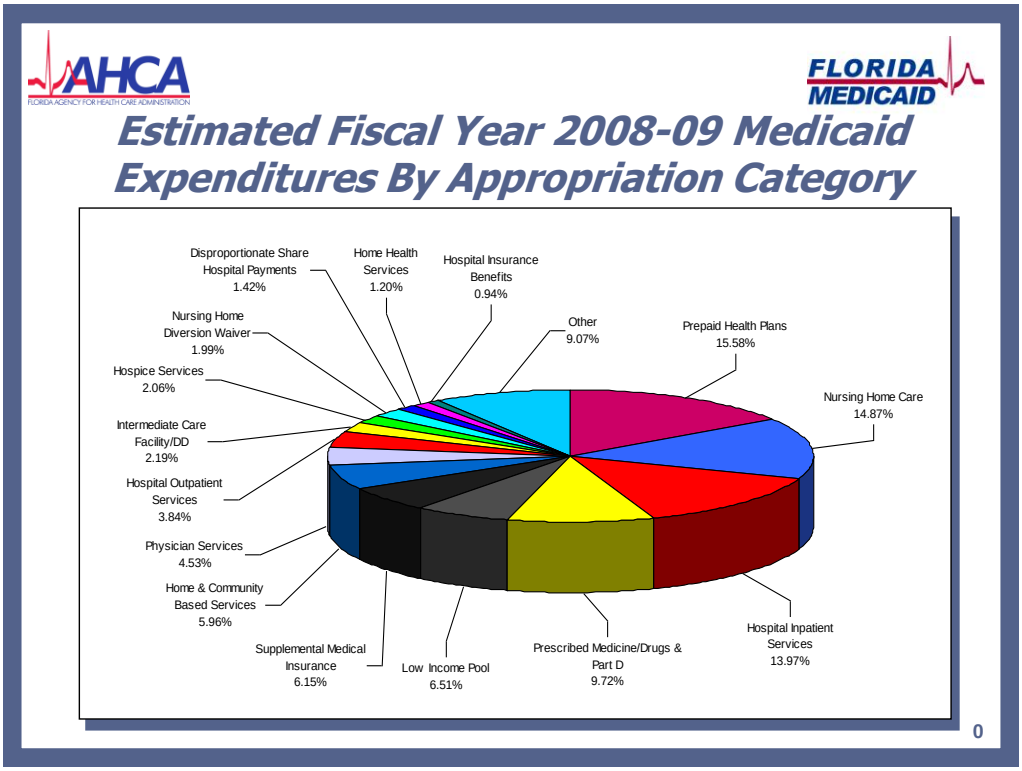


Figure 1.3



Medicaid Pilot

Florida's Medicaid pilot program, created in Section 409.91211, F.S., with the passage of Senate Bill (SB) 838 (View Bill Info) during the CY 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 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 pilot program is designed to enhance and change the Medicaid program by empowering Medicaid beneficiaries to take control of their health care. Beneficiaries will have more choices and will be provided incentives to adopt healthy behaviors. They will also enjoy better health through education and increased health literacy.
The Medicaid pilot program is designed to transform the Medicaid program by empowering Medicaid beneficiaries to take control of their health care by providing more choices for beneficiaries, and improving health through health literacy and incentives and bringing about 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, beneficiaries in the children and families, and the aged and disabled (non-Medicare) eligibility categories were required to enroll in a Medicaid pilot health plan. Some beneficiaries were allowed to voluntarily enroll in a Medicaid pilot health plan, such as those eligible for Medicare and Medicaid, and foster care children. Beneficiaries, who were in the mandatory eligibility groups, were given Medicaid Reform Choice Counseling materials and had 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 pilot health plan on criteria set forth in Section 409.91211, F.S. The first date of enrollment into a Medicaid pilot health plan was September 1, 2006.

The Medicaid pilot Choice Counseling Program is designed to empower eligible beneficiaries to select a Medicaid pilot health plan that best meets their individual health care needs. The Agency established contract standards for the Choice Counseling Program related to the percentage of beneficiaries who must choose their own health plan.. Each quarter, a minimum of 65 percent of the new Medicaid eligibles should voluntarily enroll in a pilot 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 self-selection rate in pilot counties is presented in Figure 1.4 below. The lowest quarterly self-selection rate was 79 percent and the high was 83 percent during the second year of the pilot.

Figure 1.4

New Eligible Self-Selection Rate July 1, 2007 – June 30, 2008	
Voluntary Enrollment Numbers for Newly Eligible Enrollees:	
1st quarter	
Self-Selection Rate	78.56%
2nd quarter	
Self-Selection Rate	80.70%
3rd quarter	
Self-Selection Rate	81.53%
4thquarter	
Self-Selection Rate	83.32%

By the end of FY 2007-2008, 16 Medicaid pilot health plans had been contracted in Broward County. In Duval County, seven plans were contracted and in Baker, Clay, and Nassau counties, two plans were contracted.

Should Florida expand the Medicaid pilot program statewide, the vast majority of Medicaid enrollees will be required to enroll in a Medicaid pilot health plan. When fully implemented, the Medicaid pilot program will be the state's primary delivery system. Only a few Medicaid eligibility beneficiary groups will continue 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 pilot program may be found at: http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml

Source: Medicaid Health Systems Development, Medicaid Program Analysis, Medicaid Choice Counseling 'Florida Medicaid Reform: Quarterly Progress Report' for the four quarters during FY2007-2008.

State Children's Health Insurance Program / KidCare

Because of programmatic changes requiring families to document their income and complete an active renewal process, Florida KidCare enrollment declined between CY 2004 and CY 2006. Enrollment in Florida's State Children's Health Insurance Program (SCHIP) a component of Florida KidCare, was 331,281 in July 2004. In July 2006, SCHIP enrollment was 196,674, a 41 percent decrease.

In CY 2006, the Florida Legislature funded $1 million in matching grants for KidCare community outreach, and provided funding for maximum average monthly caseload of 228,159 children in FY 2006-2007. 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 CY 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 FY 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 of 277,346 children

SCHIP enrollment in June 2008 was 257,137, a 14.5 percent increase from the June 2007 enrollment. The FY 2008-09 Florida Legislature increased funding for a target average monthly caseload of 264,616. The Legislature did not fund the $1 million in matching grants for KidCare community outreach although the KidCare partners continue to conduct outreach campaigns with existing funding. Without the matching grant funds, community organizations will be limited in the amount of KidCare outreach activities they can initiate. The number of KidCare applications received may decrease as a result.

While several of the programmatic changes from CY 2004 have been eliminated, two changes remain in place: 1). They are income documentation and, 2) 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 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.

The Institute for Child Health Policy (www.ichp.edu/) conducted The Florida Children's Health Insurance Study 2007 and found that 548,000 children in Florida were uninsured, or 12.6 percent of all children in the state. Of the uninsured, it is estimated that 77 percent are eligible for Florida KidCare.

Source: Florida KidCare Enrollment Reports, 2004 through 2008; KidCare Appropriations Social Services Estimating Conferences, FY 2006-2007, FY 2007-2008 and FY 2008-2009; Florida Health Insurance Study, 2004; Florida Children's Health Insurance Study 2007. The Florida Children's Health Insurance Study 2007

Prescription Drug Program

The Agency continues to promote innovations that facilitate evidence-based medicine (Objective 1.F.). The Agency initiated a contract with Gold Standard Multimedia (GSM) in FY 2003-2004 to provide hand-held wireless devices (EmPowerRx) to 1000 high volume Medicaid prescribers. In FY 2004-2005, this program was expanded to 3000 EmPowerRx hand-held devices. In addition to supporting e-prescribing via Sprint connectivity, the hand-held devices allow prescribers to view all medications their patients received in the preceding 100 days through the Medicaid Drug Program. To date, the volume of e-prescribing has not met expectations, and remains at approximately 3-4 percent of Medicaid prescriptions. However, the data captured from the hand-held devices indicate that these e-prescribers write fewer duplicate or unnecessary prescriptions than non-e-prescribers, and the savings generated by the EmPowerRx Program more than offsets program expenses. Additionally, the hand-held device provides drug interaction warnings to physicians that serve to reduce adverse drug events and medication errors. The Agency continues to support e-prescribing via the Electronic

Prescribing Advisory Panel that was created by the Legislature in CY 2007. Section 408.0611 F.S. requires the Agency to establish an informational clearinghouse on the Agency's website; collaborate with stakeholders to create the clearinghouse; and report on the progress to the Governor and the Legislature. While working with various stakeholders, the panel is well aware that e-prescribing has lagged behind expectations. Reasons for the slow adoption of technology include: hand-held connectivity limitations in rural areas; hardware / software limitations that limit utility to physicians; desktop application restricts office workflow; and the EmPowerRx product is not integrated with an office electronic medical record system.

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. The Gen Rx service can only be made available via EmPowerRx with e-prescriptions going to the pharmacy of the patient's choice. The balance of the first month's supply and refills are obtained at the pharmacy. The Agency is in the second year of the Transformation Grant, and physician interest in dispensing medication starter packs from their offices has proven to be far below expectations. The initial goal was to have 100 physicians operational in the GenRx Program by the end of the first year, but fewer than 10 physicians are participating. The Centers for Medicare and Medicaid Services (CMS) is aware of the low participation rate, and the Agency will not be applying for Grant extension. The program will end in June 2009.

The Medicaid Drug Program pursues a variety of cost containment measures that are designed 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 2009-2010 through FY 2013-2014. Over the last 12 months, reimbursed prescription costs as well as net cost after rebate have remained stable, and well below increases in the consumer price index for pharmaceuticals. Expansion of the cost containment measures, as described below, will help keep the cost of pharmaceuticals comparatively flat over the next 12 months.

At this time, the Florida Medicaid Drug Program has implemented the following cost containment strategies: (Note: physicians may submit clinical documentation for patients to receive therapies or medications outside the normal parameters that are controlled by the fiscal intermediary).

- In accordance to Food and Drug Administration **(**FDA**)** guidelines, dispense quantity limits, age limits and dosing limits have been implemented at the fiscal intermediary to control excessive utilization. Plan limitations will continue to be developed and implemented as new drugs become available or as the need arises.
- The Preferred Drug List (PDL) has been fully implemented across all therapeutic categories of medications, and the prior authorization processes for non-PDL medications has matured. Human immunodeficiency virus (HIV) medications remain exempt from the PDL. Processes for obtaining rebates from the pharmaceutical companies are operating in a timely manner.
- The new fiscal intermediary has technology which will allow the drug program to reduce paper-based prior authorizations, and convert them to electronic processes. The drug program has implemented a few of these processes, and is exploring ways to implement them on a broader scale.
- The "Lock-In" Program for beneficiaries who have a history of over-utilization of pharmaceuticals has been successful for several years. This will continue unchanged.

- The daily activities of the 12 area pharmacists have been restructured to support outcomes based medical chart reviews; broader interaction with high volume Medicaid prescribers; auditing support for waiver programs; and technical support of e-prescribing.
- The "Medication Therapy Management Program" authorized in the FY 2006-2007 General Appropriations Act (GAA) is being implemented, and started generating data in FY 2008-2009.

Source: Medicaid Pharmacy Services, August 2008
http://ahcaweb/medicaid/pdffiles/pharmacy_services_directory.pdf

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 instead of multiple vendors and contracts 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 CY 2008, the State released a Request for Proposal (RFP) for HIV/AIDS disease management services in August 2008. It is anticipated that a new contract for these services will begin in the spring of CY 2009. The State has also contracted with two specialty pharmacy vendors to provide factor products and disease management to beneficiaries with hemophilia. These program services began on April 1, 2008.

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. The incentives are structured around requirements that providers must supply preventive dental services to 60 percent of their enrolled children.

Other steps the Agency is taking to improve purchasing and access to quality services that are medically necessary include (Objective 1.D.):

- 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;

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

- Reducing costs through selective contracting for some Medicaid services; and

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

Source: Medicaid Health Systems Development, Disease Management Office, August 2008

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 CY 2025. Although studies of the elderly suggest that impairment levels at each age cohort are diminishing, the decline may not be enough to offset the population growth. This, combined with recent court decisions such as the 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 (Objective 1.E.).

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 is ranked 42nd out of 50 states in the total number of 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 2013-2014."

Source: Bureau of Medicaid Services, September 2008

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 in the child welfare system being served by the Department of Children and Families for FY 2007-2008. 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 when funds become available.

The Agency, at the direction of the CY 2007 Florida Legislature, created a four-tiered waiver system of care for beneficiaries with developmental disabilities. Starting in fall 2008 beneficiaries were assigned to the appropriate tier based on identified service needs and historic service utilization.

Finally, the Agency administers the Familial Dysautonomia (FD) Waiver for individuals diagnosed with FD, a rare developmental disability. Consumer and provider enrollment began July 2006. There are currently seven individuals enrolled.

Source: Bureau of Medicaid Services, September 2008

List of Potential Policy Changes Affecting the Agency's Legislative Budget Request

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	TASK FORCES AND STUDIES REQUIRED BY FY 2008-2009 LEGISLATION	DIVISION ASSIGNED
1.	HB 370 Page 4 Web Page	**Personal Care Attendant Program-Oversight Group** The oversight group shall include, but need not be limited to, a member of the Florida Association of Centers for Independent Living, a person who is participating in the program, and one representative each from the Department of Revenue, the Department of Children and Family Services, the Division of Vocational Rehabilitation in the Department of Education, the Medicaid program in the Agency for Health Care Administration, the Florida Endowment Foundation for Vocational Rehabilitation, and the Brain and Spinal Cord Injury Program in the Department of Health	Medicaid Services
2.	SB 1092 Page 1-2 Web Page	**Alzheimer's Waiver Evaluation** The Office of Program Policy Analysis and Government Accountability shall conduct an evaluation of comparable Medicaid home and community-based-services waiver programs. The office shall consult with the Agency for Health Care Administration, the Department of Elderly Affairs, appropriate substantive and fiscal legislative committees, and other subject matter experts to determine which waiver programs should be included in the evaluation in order to make reasonable comparisons. The evaluation shall assess whether the waiver programs are more effective at delaying or preventing participants from entering institutional settings and the cost of the waiver programs across groups compared to the regular Medicaid program. The evaluation shall also assess whether specialty home and community-based-services waiver programs are more effective at keeping participants out of institutional settings than the broader home and community-based-services waiver programs and	Medicaid Services

		whether there is a difference in Medicaid expenditures per participant on average between specialty and broad waiver programs. The evaluation shall provide a review of the flexibility provided to states by the federal Deficit Reduction Act of 2005 in regard to home and community-based services and recommend whether this flexibility should be used instead of providing these services under the provisions of current Medicaid home and community-based-services waivers. The evaluation's findings and recommendations shall be submitted to the President of the Senate and the Speaker of the House of Representatives by February 1, 2010.	
5.	SB 2534 Page 6-13 Web Page	**Cover Florida Program** (4) PROGRAM.--The agency and the office shall jointly establish and administer the Cover Florida Health Care Access Program. (b) Guidelines shall be developed to ensure that Cover Florida plans meet minimum standards for quality of care and access to care. The agency shall ensure that the Cover Florida plans follow standardized grievance procedures. (c) Changes in Cover Florida plan benefits, premiums, and policy forms are subject to regulatory oversight by the office and the agency as provided under rules adopted by the Financial Services Commission and the agency. (c) Changes in Cover Florida plan benefits, premiums, and policy forms are subject to regulatory oversight by the office and the agency as provided under rules adopted by the Financial Services Commission and the agency. (5) PLAN PROPOSALS.--The agency and the office shall announce, no later than July 1, 2008, an invitation to negotiate for Cover Florida plan entities to design a Cover Florida plan proposal in which benefits and premiums are specified. (a) The invitation to negotiate shall include guidelines for the review of Cover Florida plan applications, policy forms,	Medicaid Services

		and all associated forms and provide regulatory oversight of Cover Florida plan advertisement and marketing procedures. A plan shall be disapproved or withdrawn if the plan: 1. Contains any ambiguous, inconsistent, or misleading provisions or any exceptions or conditions that deceptively affect or limit the benefits purported to be assumed in the general coverage provided by the plan; 2. Provides benefits that are unreasonable in relation to the premium charged or contains provisions that are unfair or inequitable, that are contrary to the public policy of this state, that encourage misrepresentation, or that result in unfair discrimination in sales practices; 3. Cannot demonstrate that the plan is financially sound and that the applicant is able to underwrite or finance the health care coverage provided; 4. Cannot demonstrate that the applicant and its management are in compliance with the standards required under s. 624.404(3); or 5. Does not guarantee that enrollees may participate in the Cover Florida plan entity's comprehensive network of providers, as determined by the office, the agency, and the contract. (b) The agency and the office may announce an invitation to negotiate for the design of Cover Florida Plus products to companies that offer supplemental insurance, discount medical plan organizations licensed under part II of chapter 636, or prepaid health clinics licensed under part II of chapter 641. (c) The agency and office shall approve at least one Cover Florida plan entity having an existing statewide network of providers and may approve at least one regional network plan in each existing Medicaid area. (10) PROGRAM EVALUATION.--The agency and the office shall: (a) Evaluate the Cover Florida Health Care Access Program and its effect on the entities that seek approval as Cover Florida plans, on the number of enrollees, and on the scope of the health care coverage offered under a Cover Florida plan. (b) Provide	

		an assessment of the Cover Florida plans and their potential applicability in other settings (c) Use Cover Florida plans to gather more information to evaluate low-income, consumer-driven benefit packages. (d) Jointly submit by March 1, 2009, and annually thereafter, a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives which provides the information specified in paragraphs (a)-(c) and recommendations relating to the successful implementation and administration of the program. 15. Provide information on a quarterly basis to the Legislature and the Governor which compares the costs and utilization of the full-pay enrolled population and the Title XXI-subsidized enrolled population in the Florida Kidcare program. The information, at a minimum, must include: a. The monthly enrollment and expenditure for full-pay enrollees in the Medikids and Florida Healthy Kids programs compared to the Title XXI-subsidized enrolled population; and b. The costs and utilization by service of the full-pay enrollees in the Medikids and Florida Healthy Kids programs and the Title XXI-subsidized enrolled population. By February 1, 2009, the Florida Healthy Kids Corporation shall provide a study to the Legislature and the Governor on premium impacts to the subsidized portion of the program from the inclusion of the full-pay program, which shall include recommendations on how to eliminate or mitigate possible impacts to the subsidized premiums.	
8.	SB 2654 Pages 3-4 Web Page	**Medicaid Waiver or State Plan Amendment for Home and Community Based Services** The agency is authorized to seek federal approval through a Medicaid waiver or a state plan amendment for the provision of occupational therapy, speech therapy, physical therapy, behavior analysis, and behavior assistant services to individuals who are 5 years of age and under and have a diagnosed developmental	Medicaid Services

		disability as defined in s. 393.063, autism spectrum disorder as defined in s. 627.6686, or Down syndrome, a genetic disorder caused by the presence of extra chromosomal material on chromosome 21. Causes of the syndrome may include Trisomy 21, Mosaicism, Robertsonian Translocation, and other duplications of a portion of chromosome 21. Coverage for such services shall be limited to $36,000 annually and may not exceed $108,000 in total lifetime benefits. The agency shall submit an annual report beginning on January 1, 2009, to the President of the Senate, the Speaker of the House of Representatives, and the relevant committees of the Senate and the House of Representatives regarding progress on obtaining federal approval and recommendations for the implementation of these home and community-based services. The agency may not implement this subsection without prior legislative approval.	
9.	HB 5001 HB 5001-Appropriations	**Substance Abuse Services** The agency is authorized to work with the Department of Children and Family Services and Florida county governments to develop a local match program to fund these Medicaid specialized substance abuse services using local county funds. The public revenue funds required to match the Medicaid funds for these specialized substance abuse services are limited to those funds that are local public tax revenues and are made available to the state for this purpose. As required by Medicaid policy, participating counties shall make these services available to any qualified Florida Medicaid recipient regardless of county of residence. Payment for these services is contingent upon the local matching funds being provided by participating counties.	Medicaid Services

11.	HB 5085 Page 8 HB 5085 - Health Care	**Administrative Claiming/ Educational Services.** The Agency for Health Care Administration may develop a procurement document and procedure to claim administrative federal matching funds for state provided educational services. The agency shall then competitively procure an entity with appropriate expertise and experience to retrospectively and prospectively maximize federal revenues through administrative claims for federal matching funds for state provided educational services.	Medicaid Program Analysis
12.	HB 7083 Page 40-41 CS/HB 7083 - Health Care Fraud and Abuse	**Assessment of Home Health Services to Dual Eligible Recipients.** The Agency for Health Care Administration shall report to the Legislature by January 1, 2009, on the feasibility and costs of accessing the Medicare system to disallow Medicaid payment for home health services that are paid for under the Medicare prospective payment system for recipients who are dually eligible for Medicaid and Medicare.	Medicaid Program Analysis

Health Care Regulation

(Division of Health Quality Assurance**)**

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Health Care Regulation

(Division of Health Quality Assurance)

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

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 2005-2006	FY 2009-2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014
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 it can be accepted. To accept electronic applications over the Internet, the Agency will need to establish a web based linking program connected to FRAES/LicenseEase and develop/manage software and individual passwords to enable provider use of such programming. Those efforts are currently in process. During the CY 2006 legislative session, the Agency secured passage of the Health Care Licensing Procedures Act (Chapter 408, Part II, Florida Statutes). This uniform licensure statute, enables the Agency to promulgate rules requiring electronic submission of documents. The Agency will use this rule authority to require electronic renewal applications via the Internet (Objective 2.A.). 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; most notably, the Department of Business and Professional Regulation, as well as in the Agency's own Background Screening System. The Agency is making progress more slowly than originally anticipated with its e-gateway programming to implement on-line licensure applications. Pending success of the FY 2009-2010 legislative budget request, it is reasonable to expect the system will be implemented by CY 2010. Consequently, we anticipate a 50 percent e-renewal application rate by FY 2013-2014.

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 2010-2011.

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 2003-2004	FY 2009-2010	FY 2010-2011	FY2011-12	FY 2012-2013	FY 2013-2014
Number of public record requests handled by the Division of Health Quality Assurance 3,723	2,234	1,862	Completed in previous year	Completed in previous year	Completed in previous year
Percentage reduction in the public records requests handled by the Division of Health Quality Assurance	40%	50%	Completed in previous year	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. All three segments of a new automated document management system have been implemented in the Division of Health Quality Assurance. The system is so new that

significant results will not be experienced until FY 2009-2010. In the interim, we have seen a reduction to 2,929 in the numbers of public information requests made to the division. Most such requests continue to come into the long term care services area. On average, responses to public information requests are completed in less than 15 days.

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 2013-2014.

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 2000-2001	FY 2009-2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014
Percentage of Medicaid HMOs that reach the statewide average on the reported HEDIS measures 53.0%	40%	45%	50%	55%	60%

In January 2008, the External Quality Review Organization, Health Services Advisory Group, reported results on 15 HEDIS measures for the CY 2006, reported by the 12 Medicaid HMOs in 2007:

- Evaluation of data based on the Florida Medicaid weighted average of nine measures revealed that on two of the measures, 50 percent or more of all plans reporting reached or exceeded the Florida average.
- On the other seven measures, less than 50 percent of all plans reached or exceeded the Florida average.
- Of 15 measures, five (33.3 percent) fell between the national 10th and 25th percentile:
  - ✓ Six measures (40 percent) fell between the 25th and 50th percentiles
  - ✓ Three measures (20 percent) fell between the 50th and 75th percentiles
  - ✓ One measure (6.7 percent) fell between the 90th and 100th percentiles

Objective 2. D: To increase the numbers of fully operational Health Flex plans to 20 by FY 2013-2014.

Service Outcome Measure 2. D: The numbers of Health Flex plans that are fully operational at the end of FY 2013-2014.

Service Outcome Measure Projection Table 2. D:

Baseline/Year FY 2003-2004	FY 2009-2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014
The number of approved, fully operational Health Flex plans 4	7	10	15	17	20

During the CY 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. One additional plan was approved during FY 2005-06; however, since then, one plan has left the program. In FY 2007-2008, Senate Bill 2534 revised section 408.909, Florida Statutes, to expand coverage of certain employer groups up to 300 percent of the poverty level and extend applicability of Health Flex Plans into CY 2013 from the original ending date of CY 2008. Consequently, we extended the time frame to meet our goal of 20 plans to FY 2013-2014 (Objective 2.D).

As of August 2008, there were only four operational Health Flex plans. Of the four 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 counties where they are located and from other health care providers. Initial perceptions that these plans could be fully funded by member premiums proved incorrect. Last year, the Division indicated this objective would be eliminated this year unless additional Health Flex Plans materialized. During the CY 2008 Legislative session, the law was amended to increase the income level of eligible enrollees from 200 percent of the poverty level to 300 percent. This program change should encourage additional enrollment. In fact, one of the existing plans (American Care) currently restricted to Miami-Dade County, has applied to offer the Health Flex Plan in Polk, Broward, Palm Beach and Hillsborough counties. In addition, the health flex plan program has been extended from July 2008 to July 2013.

Linkage of Agency Goals and Programs to Governor's Priorities

	Governor's Priorities and Goals	Agency Goals and/or Programs
1.	Protecting Our Communities	
2.	Strengthening Florida's Families	
3.	Keeping Florida's Economy Vibrant	.
4.	Success for Every Student	
5.	Keeping Floridians Healthy	**Goal 2**: To maximize the use of Agency resources by increasing the efficiency and effectiveness of Agency operations to achieve required outcomes and eliminate unnecessary health facility regulations.
6.	Protecting Florida's Natural Resources	

Goal 2 links to the Governor's priority of Keeping Floridians Healthy, 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 come an increase in consumers' perceptions 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

The Goal of the Division of Health Quality Assurance is 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.

National Trends Are Mirrored or Enhanced in Florida

In accordance with the Deficit Reduction Act, in mid 2006, the Centers for Medicare and Medicaid Services (CMS) announced it was investigating ways to reduce or eliminate the occurrence of "never events"—serious and costly errors in the provision of health care services that should never happen. "Never events," like surgery on the wrong body part or mismatched blood transfusions, cause serious injury or death to beneficiaries and result in increased cost to the Medicare program to treat the consequences of errors. Never events, at least initially, would be based on those defined by the National Quality Forum as Serious Reportable Adverse Events. The Deficit Reduction Act allowed the CMS, beginning in FY 2008-2009, to adjust payments for hospital acquired infections. On July 31, 2008, CMS announced new Medicare and Medicaid payment and coverage policies to improve safety for hospitalized patients. The Inpatient Prospective Payment System FY 2008-2009 final rule expands the list of selected hospital-acquired conditions that will have Medicare payment implications beginning October 1, 2008. CMS issued a State Medicaid Director letter outlining the authority of State Medicaid Agencies to deny payment for selected hospital acquired conditions. Florida is considering payment measures to curb medical errors with Medicaid payment policies.

Florida is at the forefront of the quest to initiate electronic health records with requests pending for grants for a point of care model electronic health records program.

Florida currently has the largest percentage of population over 65 years of age in the United States. However, the use of hospitals and nursing homes in Florida by those 65+ is among the lowest in the nation and is declining. Growth in Florida's 85+ populations in the 11 Agency–defined areas of the state will mean that the 85+ population in the eight of the 11 areas will more than double by CY 2030. (Mapping the Future: Estimating Florida's Demand for Aging Services 2008-2030, Larson Allen LLP).

In a reversal of the trend to privatize seen in Florida over the eight years of the Bush Administration, a trend toward bringing privatized functions back into state agencies to enable cost savings may be emerging. Recent media articles speak to the decision of the Department of Veterans' Affairs' to drop their PhyAmerica Government Services contract in three nursing homes for nurse aide and food worker staffing. Instead, the facilities will employ state workers in these jobs, hiring those currently working for the contractor in as many cases as possible. According to the Department, using state workers in these jobs is more cost effective, provides better quality care for the residents and the employees get better benefits. Similarly, believing that services will improve with the return to in-house provision, the division has developed a budget request to bring that portion of the call center charged with facility complaint intake back into the Agency.

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 clinical 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. 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 facilities they regulate. To address the nursing shortage in Florida, hospital providers (the primary employers of nurses) offer competitive salaries and sign-on bonuses. 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, which represents an expenditure that is not recoverable. Survey staff members receive offers from health care providers that are often well above—sometimes even double--their current surveyor salaries.

As of July 27, 2008, the field offices where the majority of health quality assurance nurses are employed, had a 12.5 percent vacancy rate for registered nurses as compared to a 9.4 percent vacancy rate for all other types of field office staff. This rate compares favorably with last year's vacancy rate, which was 14.2 percent, possibly reflecting the recent downturn in the economy. Efforts are in process to increase salaries for nurse surveyor positions through a legislative budget request. The CY 2008 Legislative session will be the third year in which this request has been made. Nurse surveyor 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 U.S. 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 $44,000 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 CY 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. The budget request was not successful.

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 2007 was 88.05 percent, down by 0.17 percent from the prior year. As of March 1, 2008, there were 79,214 licensed and 1,367 approved community nursing home beds in Florida. This represents practically no change from the prior year's total available beds. Medicaid occupancy for CY 2007 was 60.62 percent; six-month occupancy was 61.09 percent during the period July 2007 through December 2007. Total occupancy for the second half of that calendar year was down by nearly one percent from 88.50 percent to 87.60 percent.

Overall, Florida's facilities are still improving in some respects. For FY 2007-2008, the most recent year for which complete information is available, conditional days in nursing homes declined to 3,656, down by nearly 69 percent from their high of 11,670 in FY 2000-2001. 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 2007-2008 report, entitled "Nursing Home and Assisted Living Facility: Adverse Incidents and Notices of Intent," specifically notes the following:

July 1, 2007 to June 30, 2008

- 3,928 reported adverse incidents occurring with associated outcomes.
- 17 on-site visits to nursing homes and 12 on-site visits to assisted living facilities specifically in response to adverse incidents requiring investigations. These surveys did not result in findings of any Class I & II deficiencies.
- 70 practitioner cases opened by the Department of Health in response to adverse incident reports resulting in 33 license revocations or suspensions.

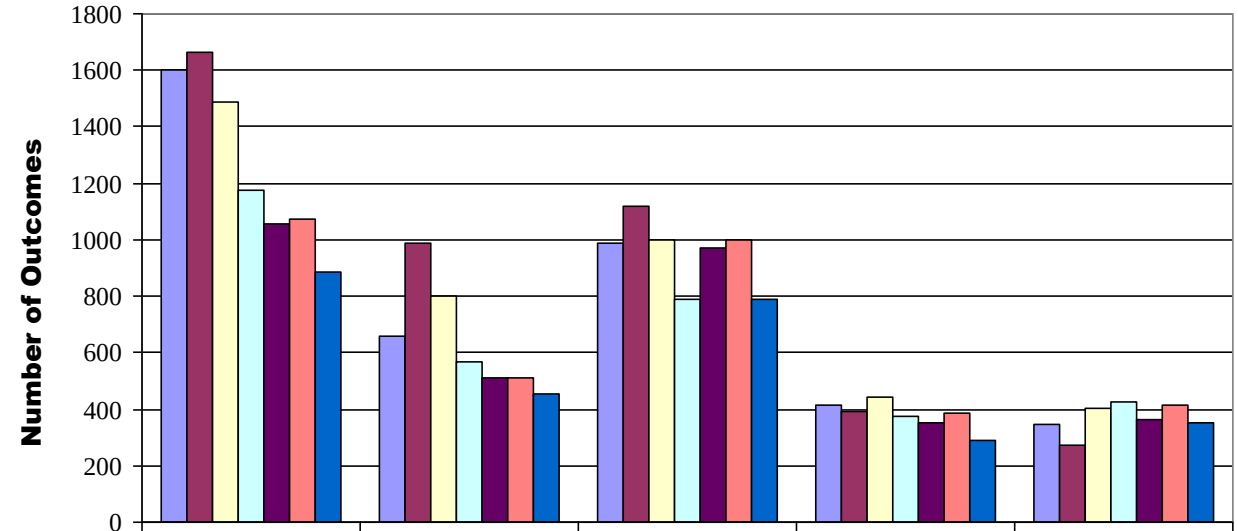
Comments

- 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.

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

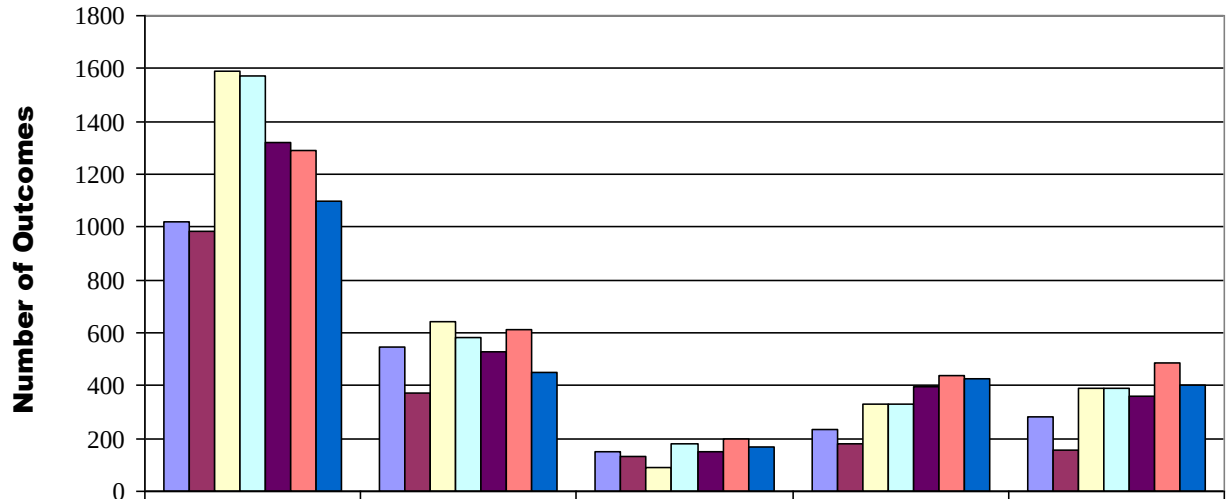
Figures 2.1 and 2.2 show the trends in the top five Nursing Home and Assisted Living Facilities' outcomes over time. Note that, for both nursing homes and assisted living facilities, preventable negative outcomes, such as transfers to higher levels of care, fractures and abuse/neglect have trended downward or remained relatively steady over the years from FY 2001-2002 through FY 2007-2008.

Figure 2.1: Top Five Nursing Home Outcomes Over Time



	Transfer	Fracture	Abuse/Neglect	Elopement	Law Enforcement
FY 01 - 02	1604	659	990	415	346
FY 02 - 03	1664	990	1117	391	275
FY 03 - 04	1489	798	1000	441	405
FY 04 - 05	1177	568	790	374	425
FY 05 - 06	1055	513	972	354	363
FY 06 - 07	1076	511	1001	388	412
FY 07 - 08	883	456	789	289	350

Figure 2.2: Top Five Assisted Living Facility Outcomes Over Time



	Transfer	Fracture	Abuse/Neglect	Elopement	Law Enforcement
FY 01 - 02	1021	545	149	233	285
FY 02 - 03	983	373	134	183	159
FY 03 - 04	1592	641	88	328	391
FY 04 - 05	1573	585	183	328	389
FY 05 - 06	1319	531	148	395	360
FY 06 - 07	1288	610	199	437	486
FY 07 - 08	1096	451	168	429	405

There is a federal side to the nursing home quality assurance program as well. The Government Performance Results Act of 1993 was intended to improve the confidence of the American people in the capability of the Federal Government by systematically holding Federal agencies accountable for achieving program results. To that end, the Act required initiation of a series of pilot programs setting program goals, measuring program performance against those goals and reporting publicly on the outcome. The two goals chosen for nursing homes include the percentage of pressure ulcers in the nursing home population and the percentage of residents in restraints. Florida is making steady progress with both goals. Pressure ulcer incidence is down from 9.7 percent in the third quarter of CY 2003 to 8.3 percent in the second quarter of 2008. Restraint use is down from 9.3 percent in the third quarter of 2003 to 6.5 percent in the second quarter of CY 2008.

Another plus for Florida is that a variation of Florida's nursing home five-star rating system is currently under consideration as an improvement for use on the federal Nursing Home Compare web site maintained by the Centers for Medicare and Medicaid Services.

Certificates of Need

Activity in the Certificate of Need (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 CY 2001 and was extended for another five years in CY 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 CY 2003 and CY 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. A Medicare moratorium on new long term care hospitals through January 1, 2011, has slowed the interest in filing CON applications.

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 wishing 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. Previous attempts to promulgate rules were subjected to challenges; however, when the rules are finalized, there will be no more CON review of adult open heart surgery programs. At this time, the rules are under review at the Division of Administrative Hearings and further progress is pending the decision of the administrative law judge.

Additional revisions to the CON law occurred during the CY 2008 Legislative session, becoming Chapter 2008-29, Laws of Florida. The revised statutes streamline the CON process for new acute care hospitals, particularly with respect to the litigation that generally follows Agency CON decisions. Revisions require a CON application for a new general hospital to contain a detailed description of the project, statement of purpose and need. The project location as well as its service areas must be identified by zip code. The primary service area is defined as the zip code areas comprising 75 percent of the hospital's discharges with the remaining being the secondary service area.

Except for competing applicants, a hospital must submit a detailed written statement of opposition to the Agency and the applicant in order to be eligible to challenge the Agency's decision. The bill provides for an administrative hearing related to a CON application for a general hospital to begin within six months and prohibits granting of a continuance unless there is a finding of extraordinary circumstances by the administrative law judge. If the party appealing the final order is unsuccessful, that party must pay all attorney's fees and costs, up to $1 million. The party appealing a final order must post a bond in the amount of $1 million. The Agency is not liable for any other party's attorney's fees unless the court finds that the Agency violated the Administrative Procedures Act.

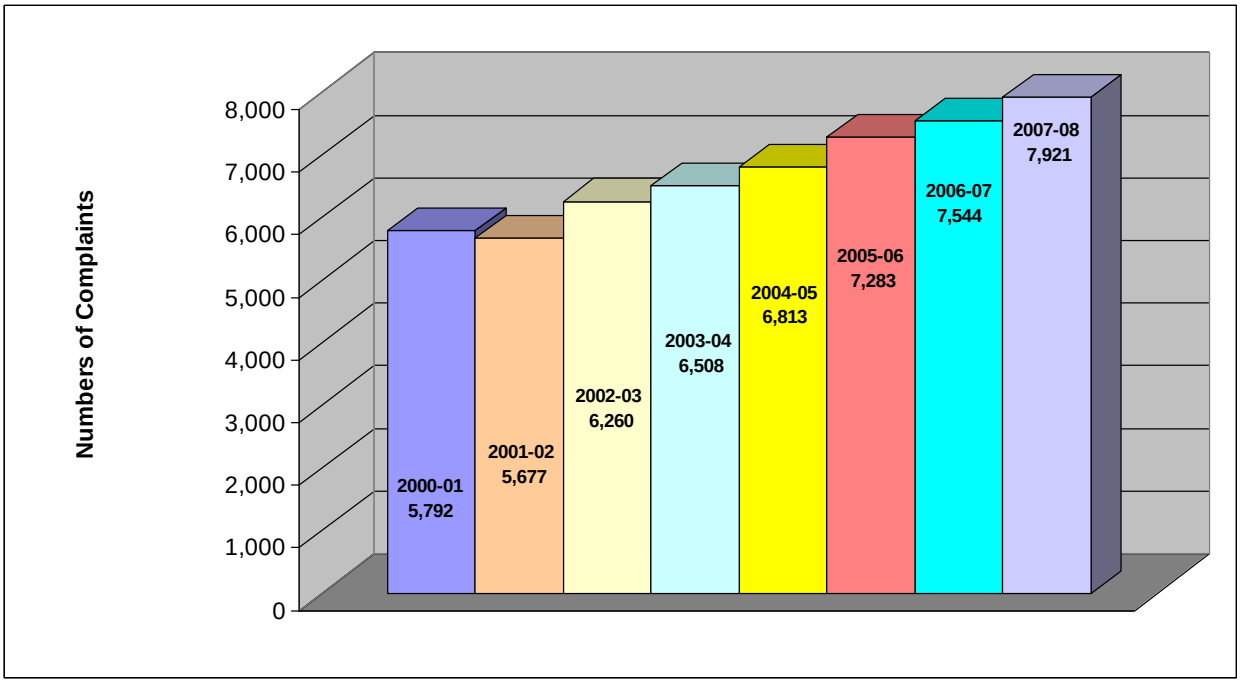
The Agency has considered expansion of CON revisions to other types of projects, but has determined expansion is not feasible until it can determine whether the new law is effective.

Consumerism, Technology, Public Information and Document Management

The 2004 Affordable Health Care for Floridians Act (Chapter 2004-297, Laws of Florida) expanded the notion of "transparency" to the costs and quality indicators for hospitals. The Florida Center for Health Information and Policy Analysis implemented Florida Compare Care in FY 2005-2006, the first time such information had been required by law in any state. Florida Compare Care is now Florida Health Finder—and its improved utility has been remarkable.

Figure 2.3 show that 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 capable of using the Internet to obtain information than in the past. Complaints coming into the Division for review and potential investigation have increased substantially over the past eight years, rising from 5,792 to 7,921. Increasing numbers of complaints place additional resource requirements upon the Agency. Sources of complaints include not only individual consumers, but also other state agencies and the media.

Figure 2.3 NUMBER OF CONSUMER COMPLAINTS AGAINST HEALTH CARE FACILITIES – FY 2000-2001 THROUGH FY 2007-2008



Not all complaints are investigated. Some complaints are out of the Agency's jurisdiction or, while important to complainants, do not represent violations of state or federal statutes and regulations. Florida is one of the best and most efficient investigators of facility complaints. Based on federally maintained statistics, Florida staff requires 16.8 hours, on average to investigate a complaint. This is well below the national average of 19.8 staff hours per complaint. However, complaints are investigated at a cost to the normal survey process since the same staff members are used for both processes and staffing has not been increased despite the increase in the numbers of complaints. The Agency will submit a budget issue in FY 2008-2009 to increase staffing to cover a specialized complaint investigation unit designed through special training in investigative techniques to further reduce the average staff hours per complaint and take the burden off the regular survey staff.

Document Management

As part of its mission to promote accessible, affordable, quality health care, the Agency aims to improve the quality of Florida's health care regardless of the location where such care is provided. The Agency must take advantage of all available technologies to speed the process of licensing facilities, reduce duplication of effort and ensure that monitoring, evaluation and

investigation systems are effective. In the past, the Agency improved the efficiency of operations by consolidating area offices and allowing tele-working. Such consolidation enabled staff and office space reductions; however, it did not 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 2007-2008, the Division received 2,929 public information requests (Objective 2.B).

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 knowledgeable about the value of such records tend to request significant numbers of public records on behalf of their clients.

In the past, the Agency used a contractor to redact and scan documents deemed 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 developed its own document management system, for which third year funding in the amount of $449,251 was obtained in FY 2006-2007. By the time this project was completed in FY 2007-2008, it effectively placed all of the records of the Division of Health Quality Assurance into an electronic format. The system enables the Agency to establish electronic scanning, redaction and storage of documents for easy retrieval and response to public records requests. Beginning in FY 2008-2009, redacted documents were 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.

Public Information

As part of on-going efforts to promote transparency in health care, the Agency now includes health care facilities' and providers' inspection reports on its Web site. The site incorporates regular inspections and complaint investigation reports for health care facilities and providers regulated by the Agency. The inspection reports reflect regulatory violations found during an Agency inspection.

Health care facilities and providers are routinely inspected according to statute to ensure that providers operating in compliance with applicable Florida Statutes, Florida Administrative Code and applicable federal regulations, in a manner that protects the health and safety of their residents or patients. Access these documents at: http://ahcaxnet.fdhc.state.fl.us/dm_web .

In an additional effort to streamline operations, the Agency plans to offer provider facilities the opportunity to renew their licenses online (Objective 2.A). This requires the technology to create an online identity management application as well as new programming. The Agency is still in the planning stages on this initiative.

Disaster Preparedness

In CY 2006, Florida's legislature passed a significant emergency management bill, House Bill 7121 Web Page, 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, Part III of Chapter 252, F.S., formalized some of the details of Agency assistance with emergency response to nursing homes.

Hurricanes that devastated Florida in CY 2004 and CY 2005 led to the development of an on-line tracking system for emergency situations. This system, called the Emergency Status System (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. During CY 2007 and CY 2008, additional modifications were made to this system, one of which will allow analysis of transportation needs when facilities evacuate prior to an anticipated disaster, such as a hurricane. Recent indications are that the system is gaining acceptance in the provider community. Note participation statistics in Figure 2.4 as of August 4, 2008. There were 4,837 facilities eligible to use ESS, of which 2,617 are participating in the program.

Figure 2.4 **ESS Providers / Online Participation**

Provider Type	Percent of Provider Type	Number of Participating Providers of Type		Total Providers of This Type
Hospitals	97.9%	280	of	286
Inpatient Hospices	96.4%	53	of	55
Intermediate Care Facilities/DD	90.3%	93	of	103
Nursing Homes	94.2%	631	of	670
Crisis Stabilization Units	80.9%	55	of	68
Dialysis Facilities	63.8%	196	of	307
Residential Treatment Centers	52.3%	23	of	44
Assisted Living Facilities	39.8%	1,066	of	2,676
Transitional Living Facilities	41.7%	5	of	12
Adult Family Care Homes	23.4%	122	of	502
Homes for Special Services	100.0%	1	of	1
VA Hospitals	28.6%	2	of	7

The Agency has little doubt that, if emergency situations arise in the future, ESS will attract more users, particularly since it has been used not only for hurricane disasters but also for the wildfire situations occurring in early CY 2008 in Florida.

Managed Health Care Operations

Chapter 641, F.S., gives the Agency joint responsibility with the Department of Financial Services, Office of Insurance Regulation (OIR), for regulating managed care organizations. As of December 2007, there were 35 licensed Health Maintenance Organizations (HMOs), down from 38 in 2006. However, as of August 2008, three new applications are pending.

The following statistics are based on data available for these 35 HMOs. Based upon the most recent available Agency and OIR data reports, the enrollment in Florida's HMOs declined from 4.5 million in CY 2001 to 3.5 million in June 2008. WellCare had the largest market share with 541,712 enrollees, including the two Medicaid plans HealthEase and Staywell, followed by Aetna with 536,283 enrollees and Humana with 462,227. HealthEase generally reports separate enrollment figures to the Agency and OIR, although they are wholly owned subsidiaries of the same parent organization.

The decline in enrollment did not negatively affect the profitability of Florida's HMOs. In the 4th quarter of CY 2007, Florida's HMOs reported an overall net income of $640.3 million, up from $626 million in the 4th quarter of CY 2006 (Florida Hospital Association, data brief CY 2008).

As of December 2007, 21 of the HMOs offered commercial managed care, 26 provided a Medicare product and 14 offered Medicaid plans. Eight HMOs offer all three product lines.

There has been an increase in Medicaid HMO enrollment partially reflective of the implementation of the Medicaid Reform Program that required most managed care eligible recipients to move from MediPass enrollment to a managed care organization. Medicaid enrollment increased from 711,255 in December 2006, to 787,344 in July 2008 (Agency internal reports). HealthEase and Staywell, both product lines of WellCare, had the largest market share with 384,437 enrollees or 48.8 percent of the total.

Medicaid HMOs reported operating income of $104.7 million in CY 2007 compared to $95.8 million in CY 2006 for the Medicaid product line only. The consolidated HMO operating income for the 14 Medicaid HMOs over all product lines grew from $107.3 million in CY 2005 to $271.4 million in CY 2007.

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 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 Health Employer Data and Information Set (HEDIS) measures (Objective 2.C). The Florida Center for Health Information and Policy Analysis 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. Beginning in CY 2006, the External Quality Review contractor reviewed the Agency's HEDIS measure and published reports comparing HMOs on these measures. The report contains comparisons to Medicaid national standards as well as Florida specific average scores.

Florida law specifies that subscribers dissatisfied with the care provided by an HMO or 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 2007-2008, this program reviewed more than 526 cases. The availability of the Internet as a research tool has made HMO 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, Maximus, 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, 59 cases in CY 2006, and 15 cases in CY 2007 Initially successful as a review option, it appears that the cases being sent to Maximus are trending sharply downward. Of the 15 cases processed in 2007,

- Five cases were returned to the filing entities because they did not meet the review criteria;
- Two providers submitted incomplete information and the cases were returned;
- One case was withdrawn by Maximus because the case was not within its jurisdiction;
- One case was withdrawn by the filing entity prior to completion of the full review;
- Two cases were settled prior to the full review;
- Two cases completed the review process and a final order was issued; and
- Two cases are pending resolution.

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 are 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. Recent decisions by

UnitedHealth, Staywell, Wellcare and Amerigroup to exit the Medicaid Reform plan in Broward County have been a disappointment to the Agency.

Hospital Emergency Care Issues

Hospital emergency room operations have become a significant source of concern not only for the industry, but also for the Agency. The Florida Hospital Association and the Florida College of Emergency Physicians have 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) 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 CY 2003, emergency room visits in Florida hospitals had increased by 46 percent since CY 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 CY 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 patients' ability to pay.

In 2006, the Agency was involved in litigation about 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 CY 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. In the interim, a Center for Disease Control National Center for Health Statistics report was released indicating that, nationwide, the average waiting time for emergency room services was up by 47 percent over the decade spanning CY 1996 to CY 2006. Average wait time is now 56 minutes as opposed to 38 minutes in CY 1996. Nationally, this is explained partially by the 32 increase in the number of emergency room visits, and partially by the decrease in supply of available emergency rooms.

In CY 2008, the Agency is discussing ways to:

- Promote emergency room diversion and targeted primary care efforts;

- Increase the role and visibility of urgent care centers;

- Allow urgent care centers that meet defined standards to become Medicaid providers; and

- Ensure accurate reporting of available emergency service by adapting the ESS database for use as a potential call coverage tool.

Helping consumers to use lower-cost options will reduce emergency room demand and save the state money. Developing new ways to identify available on-call physicians in a community will help direct patients to the most appropriate place quickly. Since 99 percent of hospitals already use the Agency's Emergency Status System, this seems the best alternative to meet the policy needs**.**

Health Care Clinics

FY 2006-2007 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 5, 2008, the Agency has licensed 2,375 clinics and provided exemption certificates to 6,422 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. 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, 129 licenses have been denied, and 29 clinics have licensure issues in litigation. Nine of the 14 revocations occurred in Miami-Dade County, two were in Broward County, and one each in Duval and Hillsborough counties. Of the 129 denied applications, 84 were in Miami-Dade County, 13 were in Broward County and no other county had more than six denials. The Division of Insurance Fraud arrested 39 healthcare clinic professionals/employees at 24 clinics during FY 2006-2007. Of these 39 individuals, 16 were clinic owners.

New Initiatives to Resolve the Problem of Un-Insurance

One of Governor Crist's major objectives during the CY 2008 Legislative session was to begin resolving the problems associated with lack of health insurance. The Cover Florida Health Care Access Program (Cover Florida) was born with passage of Senate Bill 2534 (Chapter 2008-32, Laws of Florida). Cover Florida is intended to provide low cost (anticipated average of $150 per month) insurance for individuals through private insurers. Cost-effectiveness will be gained by allowing bare bones policies to be issued by unregulated entities not required to follow all the state statutory mandates for insurance coverage. The Invitation to Negotiate to provide such services was issued jointly by the Agency for Health Care Administration and the Office of Insurance Regulation on July 2, 2008. Nine proposals were submitted by August 19, 2008. The Agency received proposals from:

- Blue Cross Blue Shield of Florida
- Universal Health Care
- Florida Health Care Plan
- United Health Care
- Medical Health Plan
- Celtic Insurance Company
- JMH Health Plan
- Total Health Choice
- American Management Advisors- AIG

Now it remains for the Agency to review the proposals and negotiate with these plans to provide affordable health care coverage for the 3.2 million Floridians that could conceivably be covered by this effort.

Chapter 2008-32 also contains the seeds of another program, Florida Health Choices, Inc. Florida Health Choices, Inc., will be established by the Agency to:

- Expand opportunities for Floridians to purchase affordable health insurance and health services
- Preserve the benefits of employment-sponsored insurance while easing the administrative burden for employers who offer these benefits
- Enable individual choice in both the manner and amount of health insurance purchased
- Provide for the purchase of individual, portable health care coverage
- Disseminate information to consumers about the price and quality of health services
- Sponsor a competitive market that stimulates product innovation, quality improvement, and efficiency in the production and delivery of health services

Florida Health Choices is a single centralized market for sale and purchase of products that enable individuals to pay for health care. Products would include health insurance plans, health maintenance organization plans, prepaid services, service contracts, flexible spending accounts, etc. Policies sold as part of the program would not be subject to licensing requirements of the Florida Insurance Code, Chapter 641 or the mandated offerings of Chapter 627 (Part VI) and chapter 641.

Status of CY 2007 Legislation

- Supplemental Social Services Block Grant funding originally appropriated in CY 2006 and re-appropriated in CY 2007 for hospital hurricane damage relief was distributed in CY 2008. Total funds sent to 45 of the original 78 hospital applicants amounted to $13,234,618.38.
- Legislation passed in CY 2007 required the Agency to 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 developed procedures for operating the pilot programs and submitted a report in January 2008 on the success and outcomes achieved by the pilot programs. An

appropriation of $3.5 million was tied to this project. When the full appropriation was not spent during the fiscal year, remaining funds were re-appropriated in CY 2008 to continue the programs.

Legislation for CY 2008

For the Division of Health Quality Assurance, major legislation from the CY 2008 Legislative Session included:

House Bill 7083 Web Page (Chapter 2008-246, Laws of Florida) relating to Health Care Fraud and Abuse, which expands licensure requirements for home health agencies and the Agency's enforcement authority to help combat abuse of the payment systems and blatant fraud in the industry, particularly notable in South Florida. Passage of this bill was on the Agency's top legislative priorities in early CY 2008.

Two bills dealing with Organ and Tissue Donation issues, one of which, SB 2630 Web Page (Chapter 2008-223, Laws of Florida) requires the Agency and the Department of Highway Safety and Motor Vehicles to jointly contract through competitive solicitation for operation of an organ and tissue donor registry and education program.

Senate Bill 2534 Web Page (Chapter 2008-32, Laws of Florida), which creates the Cover Florida Health Care Access Program to provide unsubsidized, low-cost private insurance to uninsured Floridians. This legislation was one of the Governor's top priorities for the 2008 session. The Invitation to Negotiate to obtain companies to negotiate for provision of these services was published July 2, 2008. Nine responses from managed care organizations were received on August 19, 2008. Negotiations will begin in the near future.

Senate Bill 2326 Web Page (Chapter 2008-29, Laws of Florida) which will streamline the Certificate of Need Process for new acute care hospitals, particularly with respect to litigation. This legislation was another of the Agency's top priorities for the CY 2008 session.

List of Potential Policy Changes Affecting the Agency's Legislative Budget Request

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 in play for the FY 2009-2010 legislative session	Inability to manage currently increasing application workload without additional staff
2.	Deregulation of Utilization Review Organizations, homemaker companions and Clinical Laboratories that do only waived testing.	2	LBR in play for the FY 2009-2010 legislative session	Inability to continue regulation without acquisition of additional staff.

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	Deregulation of Utilization Review Organizations, Clinical Laboratories that do only waived testing, and homemaker companions.	Section 395.0199, F.S. Chapter 400, Part III, F.S., Sections 483.031(2), 483.041(10), 483.23(1)(a)(3), 483.106, and 483.172(3) F.S	Homemaker companions and utilization review organization agents would no longer be registered. Waived labs would not receive regulatory processing before receiving certificates of exemption.	Three programs and the fees attendant thereto would also be eliminated.	The statutory sections referenced in column 3 would be modified substantially or eliminated entirely.

List of All Task Forces, Studies in Progress

Number	Bill Cite	Task Forces and Studies Required by FY 2008-09 Legislation	Agency Staff Assigned	Action Required Due Date
1	None			

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

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 2013-2014.

Service Outcome Measure 3. A: The average number of days between receipt of certified patient data and posting that data on the Agency for Health Care Administration's web site *www.FloridaHealthFinder.gov*.

Service Outcome Measure Projection Table 3. A:

Baseline/ Year FY 2005-2006	FY 2009-2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014
Number of days from data receipt to posting on website 485	485	388	310	248	198
Percent decrease in days to post on website 0	0%	20%	20%	20%	20%

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 for faster consumer accessibility to high quality health data information.

The Agency should take advantage of all technologies to speed data processing and public reporting. The Florida Center is working in partnership with the Bureau of Information Technology to determine which technology and process strategies are best to accomplish this objective and will begin development in-house to improve the process.

Objective 3.B: To increase by 10 percent annually through FY 2013-2014 the average daily number of persons who visit *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 2006-2007	FY 2009-2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014
Average number of sessions on web site per day 3,107	3,760	4,136	4,550	5,005	5,506
Annual percent increase in the number of sessions begun per day 10	10%	10%	10%	10%	10%

Objective 3. C: To increase the percentage of prescriptions submitted electronically in Florida at a rate of 75 percent increase per year.

Service Outcome Measure 3. C: The percentage of prescriptions that are sent electronically.

In CY 2007, the Florida Legislature directed the Agency to collect information on the benefits of electronic prescribing (e-prescribing) and e-prescribing software and disseminate that information through the Agency's website in order to facilitate and promote the adoption of electronic prescribing. The Florida Center is also partnering with Medicaid to promote e-prescribing among Medicaid providers. The promotion of e-prescribing requires coordination among physicians, pharmacies, health plans and patients. A key adoption metric is the percentage of e-prescriptions sent to a pharmacy relative to the number of prescriptions that could be submitted electronically. The desired outcome is for this percentage to increase at a rate of 75 percent per year.

Service Outcome Measure Projection Table 3. C:

Baseline/Year FY 2007-2008	FY 2009-2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014
Percentage of Florida prescriptions that are sent electronically 1.7%	5.2%	9.1%	15.9%	27.9%	48.8%
Annual percent of increase in the percentage of electronic prescriptions 75%	75%	75%	75%	75%	75%

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

Governor's Priorities	Agency Goals and Programs
1. Protecting Our Communities	
2. Strengthening Florida's Families	
3. Keeping Florida's Economy Vibrant	
4. Success for Every Student	
5. Keeping Floridians Healthy	**Goal 3:** Increase the availability of transparent health care data and information so consumers may make better informed selection and purchasing decisions.
6. Protecting Florida's National Resources	

Trends and Conditions Statement

The Agency's consumer oriented website, FloridaHealthFinder.gov was developed in support of the Florida Center for Health Information and Policy Analysis's (Florida Center) mission to provide accurate and timely health care information to the public, and to promote well informed decisions and transparency in the health care delivery system. With growing interest in harnessing the power of consumer choice to drive quality and cost effectiveness in health care, data collection systems must have the capacity to handle increased data volumes efficiently and allow dynamic data access.

The Florida Center collects an extensive array of health care information from hospitals, other facilities, and payers in order to fulfill its overall mission related to consumer information and to support public policy research as directed by the Legislature. The Florida Center collects patient data on hospitalizations, ambulatory surgery visits, and emergency department visits.

Collection of Patient Data:

Hospital Inpatient 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 CY 2000 to 2,557,279 records in CY 2008 for an increase of 12.7 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 informed health care decisions.

Ambulatory Patient Data

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 submitted ambulatory patient records increased from 2,278,559 in CY 2000 to 2,947,135 in CY 2007, for an increase of 22.7 percent.

Emergency Department Data

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 CY 2005 and 5,730,442 discharges in CY 2007, resulting in an increase of 11.4 percent.

Comprehensive inpatient rehabilitation data

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 records, rehabilitation care continues to be an important feature in Florida's health care delivery system.

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

The number of comprehensive inpatient rehabilitation discharge records submitted decreased from 18,216 in CY 2000 to 17,234 in CY 2007 for a decrease of 5.4 percent.

As additional resource, Figures 3.1, 3.2, and 3.3 provide a visual comparison for the historic, current and projected volume of data collected.

Figure 3.1 Trends in Number of Patient Record Collection

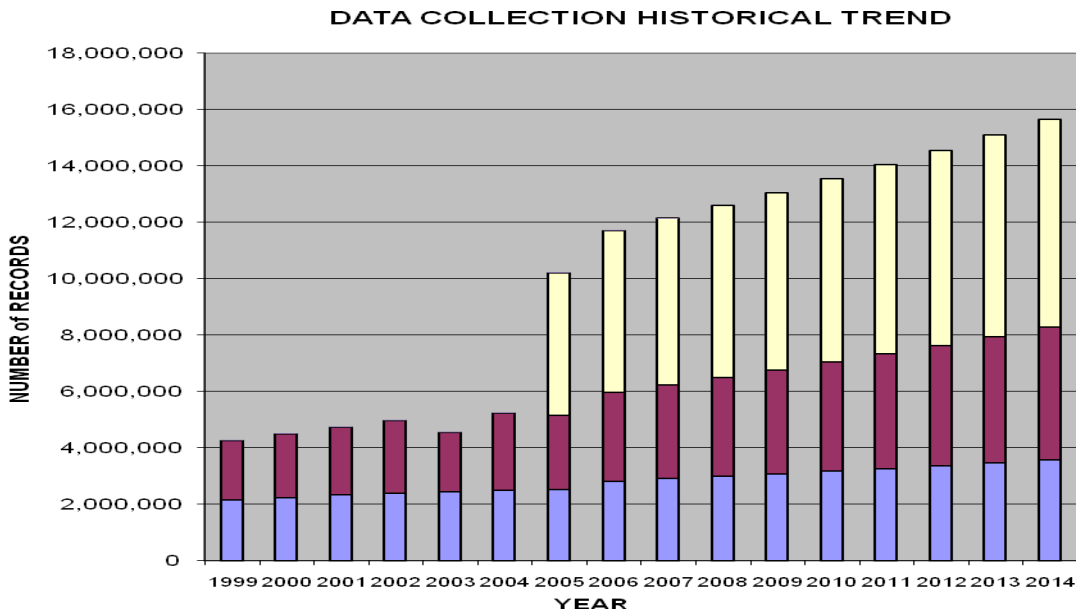

Figure 3.2 Projected Record Collections

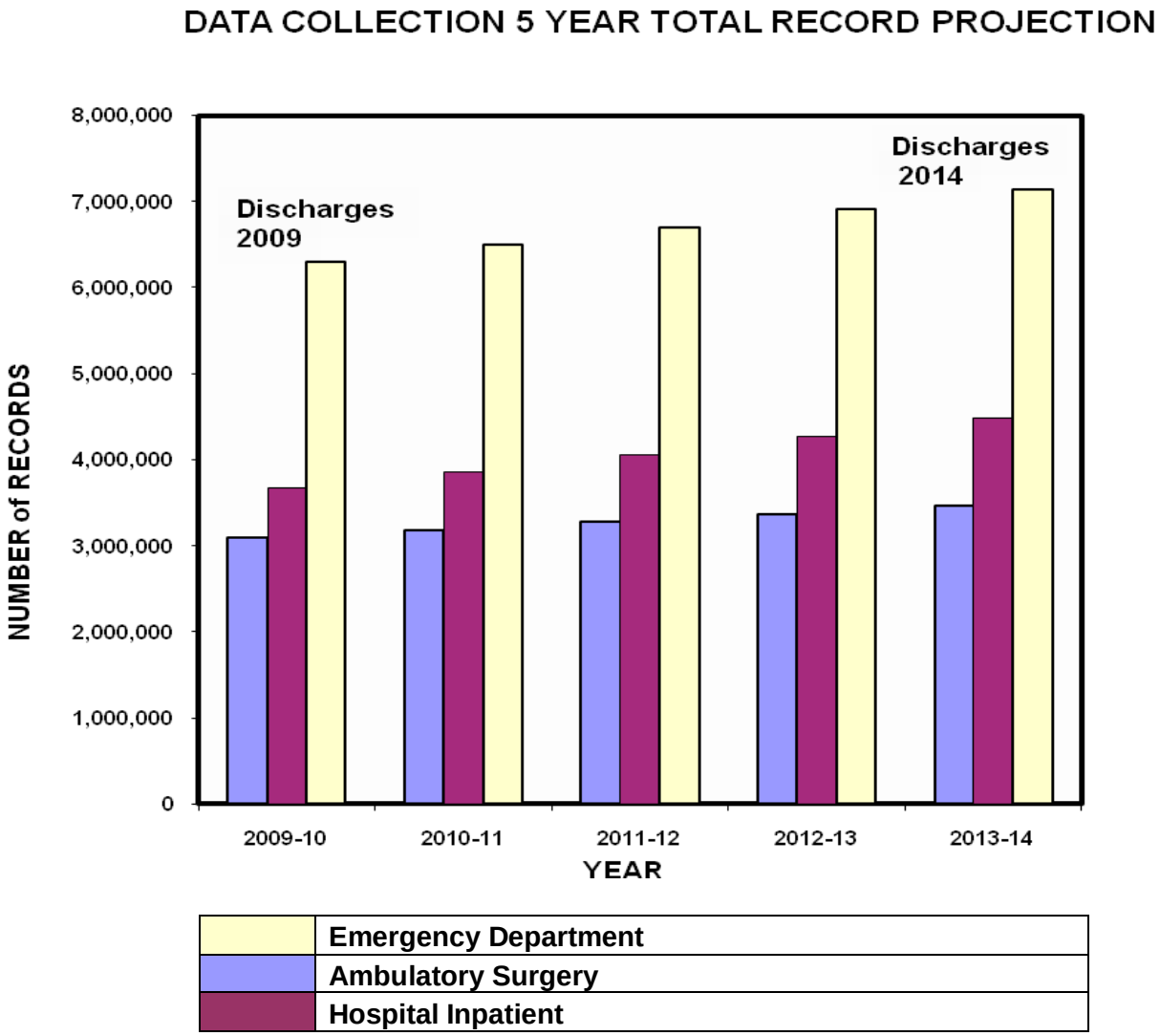

Figure 3.3 Five Years Record Collection Projection

Fiscal Year / Record Type	2009-10	2010-11	2011-12	2012-13	2013-2014
Hospital Inpatient	3,088,073	3,179,789	3,274,228	3,371,472	3,471,604
Ambulatory Surgery	3,671,371	3,860,446	4,059,258	4,268,309	4,488,126
Emergency Department	6,298,356	6,499,903	6,707,899	6,922,551	7,144,072
TOTAL Records	13,057,800	13,540,138	14,041,385	14,562,332	15,103,802

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) limit the release of protected patient health information; therefore, not all reported information is available to the public.

In CY 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 Extensible Markup Language (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/hpdunit.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 CY 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 (**ICD-10**) 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 the Agency. 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 in CY 2005 to collect Surgical Infection Prevention (SIP) data on the use of appropriate antibiotics for surgical patients. Although the initial intent was to display the data on the Agency's website, SIP data available from the Centers for Medicaid and Medicare Services (CMS) supplanted the need for separate data collection. Therefore the Florida Center, in conjunction with the Comprehensive Health Information System Advisory Council (CHIS) recommended repeal of SIP rule 59B-15 . The SIP rule repeal became effective June 8, 2008.

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

Reportable procedures are defined as having a primary procedure in any of the following ranges corresponding to Current Procedural Terminology (CPT) codes 10000 through 69999 and 93500 through 93599. These code ranges include surgical procedures, cardiac catheterization and lithotripsy. Facilities with fewer than 200 reportable visits 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) limit the release of protected patient health information; therefore, not all reported information is available to the public.

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

The amended rule, Ch. 59B-9, 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.

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

One of the Florida Center's primary missions is to promote better and more informed decision making on the part of Florida's health care consumers. The primary means of accomplishing this mission is through the promotion of health care transparency, i.e. the publishing of detailed health care data in visible and accessible venues such as the FloridaHealthFinder.gov web site. This can only be achieved through the rapid collection and display of quality data. Achieving the ambitious goal of data turnaround in 198 days, though, will require significant upgrades in both technology and personnel.

The Florida Center's data processing needs require personnel who can handle increasingly large amounts of data while mastering complex skills and a rigorous work pace. Current pay grades do not adequately reflect the demands of the processing positions resulting in significant turnover. Analysts that master these positions find themselves qualified for numerous other positions within the Agency and elsewhere that offer significantly higher wages. Consequently, the Data Collection unit continually operates well below its needed staffing levels as analysts leave for higher paying jobs. This problem is compounded by the lags in worker productivity due to the length of time required to train new staff, during which both the new analyst and the trainer cannot manage a full data processing load.

In the last three years, the Data Collection unit has experienced a 108 percent turnover rate in its data collection positions. This rate includes a three-year turnover rate of 200 percent for the five positions occupying the 2208 and 2303 class codes. Similar class codes within the Agency averaged just fewer than 18 percent over the same three-year time period. Leveraging resources in order to reduce this turnover is essential to increasing the Florida Center's efficiency. To that end, the Florida Center is moving ahead with an LBR to increase the pay grade of most data collection analysts.

The Florida Center's aggressive data turnaround goals also demand that all technological resources be maximized. Future technological needs for data collection can therefore be said to

be driven by the need for system-wide technical enhancements and increased automation. in order to These improvements will help accelerate the Center's capacity to collect, audit and disseminate data, enhance the State's health care database and improve the availability of information for consumer websites.

The Florida Center is currently seeking to upgrade its data collection system to meet these goals, but 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 request for FY 2008-2009 was not funded. In the current year (FY 2008-2009), given state budget realities, the Florida Center is working with the Agency's Bureau of Information Technology to determine the degree to which the system can be upgraded internally without the need for additional state funds.

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 does the Agency standardize usage throughout the state?

Through implementation of health transparency and adoption of electronic health records as statutorily mandated, 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. 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. In January 2000, the Florida Center launched FloridaHealthStat.com. 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.

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 CY 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. FloridaCompareCare.gov 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 (CDC), 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. The redesign work also 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 CY 2006, giving us hands-on information for improving website navigation and content.

In the fall of CY 2007, FloridaHealthStat.com and FloridaCompareCare.gov were combined into one central website, www.FloridaHealthFinder.gov. Recent expansion on the new website has included the addition of the ADAM Health Encyclopedia with thousands of articles and illustrations, some of which contain links to Florida health care data for particular medical conditions or procedures. A new Symptom Navigator allows the user to click on a human form to search for particular symptoms which then takes the user directly to relevant articles in the Health Encyclopedia. When applicable, the diseases and procedures link up to quality outcome and pricing information.

In July 2008 potentially preventable hospital readmissions were added to the website, making Florida the first state in the country to provide this information to the public. This same year an emergency department query tool was added, as well as figures on Medicaid expenditures.

In accordance with legislation that passed in the CY 2008 Legislative session, the website will be expanded to display over 150 medical conditions and procedures. Also a range of charges will be added, in addition to the average charges currently on the website.

From the November 2007 launch of www.FloridaHealthFinder.gov through July 2008, there have been 842,375 visits to the website. Each year the visit numbers have increased as more Floridians learn about the website. See Table 3.B for future projections.

Consumer Services

Providing information through a website allows for quick update and dissemination of information, allowing the Agency to respond quickly to developing health care trends, to address concerns expressed by consumers and 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 the Agency through the website it was quickly learned that many people have questions about health insurance and the need for services due to insufficient insurance coverage or lack thereof. In response additional insurance information was added to the site, including links to the Florida Department of Insurance, as well as information on Medicaid and Medicare. An extensive Medical Help Resources page was added 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. By adding educational information about emergency room care and the Medical Help Resources section, the website provides alternative choices for non-urgent care as well as preventive care.

By responding directly to consumer inquiries sent through the website “Contact Us” link, consumers are referred to the correct information, agency, or private organization where they have found the assistance or information they need. Other state agencies and community-based programs use the website’s list of health care facilities or the Medical Help Resources to assist their clients as well.

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 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.

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. The Florida Center'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.

Consumer Communication Campaign

Since the launch of FloridaHealthStat.com in CY 2000 and FloridaCompareCare.gov in CY 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 developed a communications plan for use in conducting community outreach activities. These activities 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 2007-2008 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 the Agency's consumer website. 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 available resources for educating consumers and will work with appropriate stakeholders to develop and implement further outreach.

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 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 *www.FloridaHealthFinder.gov* website.

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: Data Transparency Steering Committee, Health Plan Workgroup, Health Care Facilities Workgroup, Physicians Data Workgroup, and Public Relations Workgroup.

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

- Launch of the consumer centric health information website making Florida the first state to publicly report hospital infection rates and mortality rates;
- Development of a communications plan for www.FloridaHealthFinder.gov including an action plan and budget needs to implement the plan;
- Development and launch of the health plan comparison tool on www.FloridaHealthFinder.gov;
- Adding pediatric care data to www.FloridaHealthFinder.gov, making Florida the first state to publicly report specific data on pediatric conditions and procedures;
- Display of Potentially Preventable Readmissions that capture readmits clinically relating to the original admission;
- Preparation and research in the current development of the web-based physician comparison tool, to be added in the future~~;~~
- Development and implementation of strategic goals for the enhancement and expansion of the website, and,
- Development and implementation of standards for transparency to ensure consistency and conformity throughout the website.

Recommendations for future development include:

- Staying informed about national transparency initiatives and the State of Florida's status in regards to same;
- Exploring policy development as it relates to transparency;
- Examining rules to determine if current data collection should be expanded;
- Discussing expansion of current measures and inclusion of additional measures;

- Review of current methodologies for public reporting and attendant policy issues;
- Expanding data reporting to possibly include other health care facility types; and

- Review of current regulatory and legislative mandates and authorities and the resulting impact on the Agency, the Advisory Council, their mission, vision and purpose.

Future plans also being discussed are:

- Expanding Hospital Profile pages to include additional specialty services provided in each facility and financial data;

- Continuing to monitor national guidelines for public reporting of hospitals and ASCs quality/outcome measures (i.e. HCAHPS (hospital patient satisfaction surveys), Surgical Infection Prevention/Surgical Care Improvement measures, CMS measures relating to heart attack, heart failure and pneumonia, etc.);

- Continuing to work with 3M on incorporating Potentially Preventable Complications (PPCs) which incorporates Present On Admission (POA) as well as incorporating the appropriate AHRQ Patient Safety Indicators with POA;

- Incorporating AHRQ Pediatric Quality Indicators; and

- Continuing to revise and update the data, display and methodology on the website to improve the consistency of reporting, when applicable, for providers and health plans

Research and Development

The Office of Research and Development is responsible for statutorily required reports and the production of health plan information. The unit transforms the data collected by the Florida Center into information for policymakers, researchers, and the general public.

This Emergency Department Utilization Report fulfills the requirements of s.408.062(1)(i), Florida Statutes, which mandates that the Agency publishes an annual report on the use of emergency department services, including an analysis of the treatment given by patient acuity level and the implications of increasing hospital costs in providing non-urgent care in emergency departments. The Emergency Department Utilization Report describes characteristics of visits to emergency (ED) departments in Florida, and presents data on utilization that may have implications for hospital costs.

The Florida Health Care Expenditures Report examines trends in expenditures for health care services, health care payers, and Health Maintenance Organizations (HMOs). The report focuses on data from the most recent calendar year available (FY 2004-2005), but also shows trends from CY 1992. The Health Care Expenditures report describes payments for services delivered in Florida, including services delivered to nonresidents.

The Florida Health Plan quality data posted on Florida's interactive Health Plan Consumer Website, www.FloridaHealthFinder.gov, fulfills the requirement of s. 408.05(3)(k), Florida Statutes, which mandates that the Agency publicly disclose performance measures for specified Florida health plans.

The State Health Data Directory as required in s.408.05(4)(g), Florida Statutes was developed to assist individuals searching for health data and statistics. Its purpose is to facilitate referrals

to the responsible data administrator for detailed information regarding available data and to promote the efficient use of data for research and public policy purposes. The State Health Data Directory is available on www.FloridaHealthFinder.gov.The directory is updated annually by an e-mail survey of state agencies. Information is current and checked for accuracy as of the date indicated on each database entry.

Copies of reports are available on the Internet at www.FloridaHealthFinder.gov.

Health Plan Performance Data

Since CY 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 s. 641.59(9), Florida Statutes, known as the Health Plan Employer Data & Information Set (HEDIS); and,

- Health plan member satisfaction information, as required under s. 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.

Over the past three years, the quality indicator data have shown that Florida's Commercial HMOs have performed equivalent to the national averages and that the rates have remained stable. The same is true for Medicare HMOs. However, the performance of the Medicaid HMOs has been consistently below the national averages for most indicators, and there is a trend toward poorer performance for some indicators.

The member satisfaction survey data contain the results of an annual statewide survey of a sample of members in each HMO. In CY 2006, the Florida Center began collection of survey data from many of Florida's largest Preferred Provider Organizations (PPO) and indemnity insurance plans. 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.

Over the past three years, the member satisfaction data for Florida's commercial and Medicaid HMOs has been nearly the same as the national data. Satisfaction as measured by most questions has remained steady over this period. Satisfaction with the health plan was higher for the Medicaid plans compared to the commercial plans. Medicaid members were more satisfied with the care their children receive than the care they receive.

A review of the health plan performance data shows that there is room for improvement. This is especially true of the Medicaid HMOs who performed well below those in other states on the quality indicator (HEDIS) data. The Agency has begun to address this finding by reforming the Medicaid program. There is a new emphasis on improving the performance of preventive care and the effectiveness of care.

The Agency has little influence over the performance of commercial or Medicare HMOs, but they are already performing better than the Medicaid plans. However, the posting of performance data for these plans should have a positive effect on their delivery of care as they will strive to improve their performance over time.

Policymakers should review the quality and satisfaction information with an eye to areas that may need improvement. For example, it appears that most plans are providing appropriate screenings for cancer, but they perform poorly in providing prenatal care. These data will allow policymakers to focus efforts on the weak areas while pointing to the strong performing areas as examples of excellence.

Prior to CY 2006, the Florida Center annually published summary results from these two data sets, in the Florida HMO Report, along with "check mark" ratings that ranked each health plan on each summary indicator and survey question. Beginning in CY 2006, these results are posted only to the Agency's website, currently, www.FloridaHealthFinder.gov.

There is a need to better publicize the data that the Agency collects. Consumers and health plan members will make better informed choices if they can view the information displayed on the Agency website. If membership in the poorer plans decreases, while increasing in the well-performing plans, this may provide an incentive for the poor performing plans to improve. The Medicaid program is considering “pay for performance” incentives and penalties based on the plan’s performance, especially on the quality indicator data. If successful in improving plan performance, this approach should be applied, where possible, to all other managed care plans.

Patient Safety

In CY 2007 the Agency’s Adverse Incident Reporting Unit was transferred from the Division of Health Quality Assurance to the Florida Center’s Office of Research and Development. The Agency’s goal in transferring this function from a regulatory unit to a research unit is to use the adverse incident reports to provide health care facilities with quality feedback on best practices and patient safety lessons learned.

Adverse incidents are medical incidents defined in s. 395.0197, Florida Statutes. They include the following: wrong site surgery, wrong patient surgery, wrong surgical procedure, patient death, brain or spinal damage to a patient, and removal of unplanned foreign objects remaining from a surgical procedure. Hospitals and ambulatory surgical centers are required by law to report adverse incidents to the Agency. Reports are confidential.

The Agency publishes aggregate adverse incidents reports quarterly on the risk management website: http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Risk/index.shtml.

The Unit’s new responsibility will be to conduct in-depth analysis on reported incidents, and best practices implemented in response to these incidents. The Office of Research and Development will prepare an annual report summarizing the analyses and performance improvement plans submitted in response to the adverse incidents.

The Florida Center is developing and will propose statutory changes to clarify the definition of adverse incidents, require reporting within 15 days of the incident, and allow more time (an additional 45 days) to provide a root cause analysis and performance improvement plan.

Health Information and Technology

In CY 2004 the Florida Legislature directed the Agency to develop a strategic plan for the adoption and use of electronic health records. In Section 408.062(5), F.S., the legislation

provided that the Agency may develop rules to facilitate the functionality and protect the confidentiality of electronic health records.

This section was subsequently amended in CY 2006 to require that the Agency include in its strategy for the adoption and use of electronic health records the development of an electronic health information network for the sharing of electronic health records among health care facilities, health care providers, and health insurers. The Agency is to report to the Governor and Legislature on legislative recommendations to protect the confidentiality of electronic health records.

In CY 2005, the Agency issued a white paper proposing the Florida Health Information Network (FHIN). The FHIN was originally envisioned as a statewide health information server that would enable health care professionals to access a patient's medical records from any provider database connected to the network over a secure Internet connection. However, many stakeholders supported a more decentralized approach. The Agency focused on the funding of health information exchange pilot projects under the leadership of the Governor's Health Information Infrastructure Advisory Board.

The Governor's Advisory Board developed the Florida Health Information Network Grants Program, including program requirements and evaluation criteria. Beginning in FY 2005-2006, the Board evaluated FHIN Grant Program applications and recommended awards. Grant funding was $1.5 million in FY 2005-2006, $2 million in FY 2006-2007, and $2 million in funding for FY 2007-2008. According to the time limit set in the original Executive Order, the Advisory Board served out its term effective June 30, 2007.

In December 2007, the Agency established the Health Information Exchange Coordinating Committee (HIECC) under the State Consumer Health Information and Policy Advisory Council authorized in Section 408.05(8), F.S. The HIECC will continue the work of the Board by assisting the Agency in promoting the adoption and sharing of electronic health records. The committee includes representatives of hospital and medical associations, regional health information organizations, health plans, rural health and consumer groups.

The Agency works with many professional associations and organizations at the local, state and national level to further health information technology initiatives. These include the Health Information Management and Systems Society (HIMSS), American Health Information Management Association, State Alliance for e-Health, Florida Association of Chief Medical Information Officers, and many other professional groups.

The Florida Legislature broadened the technical assistance responsibilities of the Agency and Florida Center related to health information technology with the passage of House Bill (HB) 7073 in CY 2006. HB 7073 amended Section 408.05(4), F.S., providing that the Agency shall administer grants to advance the development of a health information network. This section also directs the Agency to integrate health care data from state agencies and make the health data available to health care practitioners through a state health information network. The Florida Center within the Agency is to provide technical assistance to support the health information network.

Creation of Health Information Technology Committee

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 was able to move forward in implementing the programs and plans recommended by the Board and health care stakeholders. 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.

To enable the Agency to continue to collaborate with stakeholders and provide guidance to the Agency, it established a Health Information Exchange Coordinating Committee (HIECC) in CY 2007, reporting to the State Consumer Health Information and Policy Advisory Council. The Health Information Technology Committee advises and supports the Agency for Health Care Administration (Agency) to develop and implement a strategy for the establishment of a privacy-protected, secure, and integrated statewide network for the communication of electronic health records among authorized parties.

The Health Information Technology Coordinating Committee is expected to stay informed of developments in the health information technology field and consult with national and international health information technology initiatives and state-level health information exchanges operating within the public and private sector. The Committee will develop recommended technical standards to ensure the interconnectivity of all health care providers and to establish and maintain the security for electronic health information. The Committee will also provide guidance for health information exchanges operating in Florida to ensure the privacy of health information and its availability in the event of an emergency or disaster, including recommendations for a periodic privacy and security risk assessment and for demonstrated interoperability consistent with widely adopted standards or standards accepted by a recognized organization that establishes national standards for electronic information networks.

Electronic Prescribing Activities

In CY 2007, the Florida Legislature passed HB 1155, which directed the Agency to collect information on the benefits of electronic prescribing (e-prescribing) and e-prescribing software and disseminate that information through the Agency's website in order to facilitate and promote the adoption of electronic prescribing. Section 408.0611, F.S. provides that the Agency is to collaborate with stakeholders to create an electronic prescribing clearinghouse and coordinate with private sector e-prescribing initiatives.

Section 408.0611, F.S., provides that the Agency is to coordinate with private sector initiatives in the creation of the website and other activities. The Agency is a member of ePrescribe Florida, a private initiative working to increase electronic prescribing.

The legislation that directed the Agency to create the electronic prescribing clearinghouse also provided that the Agency was to collaborate with private sector electronic prescribing initiatives, Regional Health Information Organizations (RHIOs), and other stakeholder groups described in the legislation. It provides that the Agency will meet with stakeholders at least quarterly to "assess and accelerate the implementation of electronic prescribing." In the fall of CY 2007, the Agency formed the State Electronic Prescribing Advisory Panel and invited representatives of the relevant stakeholder organizations to participate as appointed members of the panel.

The State Electronic Prescribing Advisory Panel represents 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 Agency scheduled the first meeting of the panel to coincide with the initial release of the electronic prescribing website in October, 2007. Members of the panel reviewed the content and features of the clearinghouse website. Members of the panel also presented on the benefits of electronic prescribing and described how the Agency and private sector initiatives such as ePrescribe Florida would coordinate their efforts. Members of the panel discussed metrics that could be used to describe trends in electronic prescribing adoption, usage, and impact on patient care, cost savings, and return on investment.
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 Florida Electronic Prescribing Clearinghouse is a collection of e-prescribing resources maintained by the Agency in its website. The portal provides users a single point of access for e-prescribing activities in Florida. It is not only designed to meet the requirements of Section 408.0611 F.S., but also to provide users important information on new developments and trends in the e-prescribing field with an overall goal of promoting the adoption of and improving the quality and effectiveness of e-prescribing in the state. It is expected that the evolution of the clearinghouse will be supported by recommendations from stakeholders and the State Electronic Prescribing Advisory Panel. The Florida Electronic Prescribing Clearinghouse is located at: www.fhin.net/eprescribe.

The Florida Electronic Prescribing Clearinghouse website describes e-prescribing software, summarizes research on e-prescribing and direct physicians to e-prescribing resources at the state and national level. Specifically, the website contains:

- 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 Florida Legislature also directed the Agency to prepare an annual report on the progress of electronic prescribing implementation in Florida beginning with a first report to be issued in January 2008. The Florida 2007 Electronic Prescribing Report

(http://ahca.myflorida.com/dhit/ElectronicPrescribing/Reports.shtml) provides a baseline summary of e-prescribing in Florida based on statistics provided by national e-prescribing companies, a discussion of the barriers to e-prescribing in Florida and recommendations for future steps in CY 2008. It also presents federal and state-level initiatives, in particular the e-prescribing project initiated by Florida Medicaid.

In CY 2003, the Agency implemented a wireless electronic prescribing program for selected high volume Medicaid providers. The Agency's objectives were to have a positive impact on clinical outcomes and over-prescribing by providing preferred drug information and potential drug interaction alerts. The program has been successful in accomplishing these objectives. The participating physicians prescribed less expensive and fewer prescriptions and the program documented the prevention of drug interactions. However, few physicians used the PDA for electronic prescribing which would provide additional quality of care benefits for physicians, pharmacies and beneficiaries (see http://www.fhin.net/eprescribe/Index.shtml). Currently, physicians may use a PDA or desktop personal computer to retrieve a 90 day medication history for patients and send electronic prescriptions. During the first quarter CY 2008, 759 physicians used the Florida Medicaid e-prescribing program to send prescriptions.

Offering financial incentives to Medicaid providers would benefit Florida Medicaid beneficiaries by encouraging the greater use of the system functionalities that support patient care and the sharing of electronic medication history records among care providers. The Florida Medicaid Wireless Handheld Pilot Project, using the eMPOWERx electronic prescribing application has demonstrated consistent savings to the Medicaid program from each provider who uses the eMPOWERx e-prescribing program.

Based on data from the 21 month period from July 2006 to March 2008, physicians in the pilot program saved Medicaid an average of $48 per patient and a total of $2,841,390 each month in prescription payments. The eMPOWERx program also provides alerts for drug interactions. During the same 21 month period, the program issued an average of 892 alerts for a drug interaction, for a projected savings of $208,933 per month in Medicaid claims. The savings to Medicaid from the eMPOWERx program are attributable to utilization and cost avoidance through the reduced number of prescriptions written and hospitalizations avoided.

Privacy and Security Project

Florida is participating in a national collaboration of states to study and make recommendations regarding privacy and security practices affecting interoperable health information exchanges. The Health Information and Security Privacy Collaboration Project (HISPC) 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 Technology (ONC).

In May 2006, the Agency for Health Care Administration (Agency) was awarded a contract by RTI International, Inc., to participate in the nationwide Health Information Security and Privacy Collaboration (HISPC) Project. During this first contractual period, the Agency completed an analysis of barriers to health information exchange and produced an implementation plan for addressing these issues through an extensive round of meetings by stakeholder groups.

Florida's participation in the HISPC Project of FY 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 Agency received an extension of the contract in July 2007 that provided support for the Agency to begin to put the Implementation Plan into effect. During the second contract period the Agency convened the Project's Legal Work Group to consider and make legislative recommendations that would ameliorate legal barriers to health information exchange in Florida law. The Agency continued to broaden its outreach to consumer and patient advocacy groups and added consumer representation to the Legal Work Group.

The Legal Work Group identified priority recommendations for legislation to address specific barriers to health information exchange in Florida law including reconciling hospital, clinical laboratory and medical practice statutes related to release of health records. Each of these suggested changes to statute addresses a specific barrier to health information exchange in Florida law. The project produced a report, *Analysis of Florida Statutes Related to Health Information Exchange,* containing the priority recommendations of the Legal Work Group.

In addition, the Agency developed a risk self-assessment tool based on the National Institute of Standards and Technology (NIST) 800-53 SP security standard. The tool is a stand-alone piece of software that will be placed in the public domain for health information organizations and providers to use as a means to assess their own security strengths and weaknesses.

In CY 2008, Florida received another grant to work in coordination with the Harmonizing State Privacy Law Collaboration (HSPL Collaboration) with the objective of harmonizing state laws to facilitate health information exchange within and across state borders. Florida will reconvene its Legal Working Group (LWG) that has functioned under the Health Information Security and Privacy Collaboration to continue its evaluation of Florida law and the need for reform. The Florida LWG will review the statutory analysis of other States participating in the collaborative to identify barriers and gaps in Florida that were not included in our initial analysis. In addition, the Florida will work with other States to develop priority recommendations and align solutions.

In CY 2008, the Agency also proposed to work in coordination with the Provider Education Toolkit (PET) Collaboration to develop a set of educational tools that can be used in targeted communication campaigns to reach physicians with information about the privacy and security of health information exchange. It is hoped that the messages delivered to physicians will motivate them to take action to work with their local health information exchanges and to consider installing electronic health record systems. The Florida PET team is conducting a baseline assessment of provider interest in health information exchange, will reach out to professional state-level and county-level professional organizations and will determine the cycle

of association conferences and professional meetings to serve as venues for an educational campaign. The Florida PET team is also working on the specific barrier to health information exchange identified as the confusion about HIPAA and Florida state law. The Florida PET team will develop a web-based crosswalk between HIPAA and Florida statutes as an education tool for its physician population. It will also develop a template for other states to create their own HIPAA by state statute crosswalk.

Federal Communication Commission Rural Broadband Pilot Project

The Agency and the Big Bend Regional Healthcare Information Organization (RHIO), with a group of health care stakeholders from the public and private sectors, were awarded a contract 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 tele-health 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.

Personal Health Record Toolkit

In June 2008, the Agency released a consumer guide on personal health records (PHR). The PHR toolkit explains the importance of maintaining personal health records to have available in case of a natural disaster or other emergency. It provides a checklist of content to assist consumers in preparing and using their PHR. The toolkit also provides information on electronic personal health records that may be downloaded or maintained on the Internet. It includes a discussion on desirable functions and security features for an electronic PHR.

The Office of Health Information Technology is responsible for the toolkit and is developing a companion brochure in coordination with the Office of Data Dissemination. The toolkit is located on the Agency's website at: http://www.fhin.net/PHR/index.shtml.

Health Policy

During the CY 2006 Legislative session the Legislature passed HB 7073 that was codified into law in section 408.05 Florida Statute. HB 7073 added policy and analysis as a duty of the Florida Center for Health Information and Policy Analysis. In July 2008 the Florida Center created the Office of Health Policy within the Florida Center.

The Office of Health Policy will provide policy coordination and policy leadership within the Florida Center. The Office of Health Policy will be responsible for building, developing and leveraging the intellectual capital of the Florida Center to strengthen the knowledge of consumers as they interact with the healthcare system. Some of the duties the Office of Policy will be responsible for include:

- Develop and promote statewide health information technology policy in partnership with the Office of Health Information and Technology;
- Coordinate Florida Center Legislative Budget Requests (LBRs) and legislative policy proposals from their development to their final legislative approval, including drafting and internal and external review, presentation and discussion;
- Provide policy support to the Florida Center internal policies, bill drafting and rule development;
- Co-chair the internal Health Information Technology committee;
- Coordinate Florida Center policies across units; and
- Track relevant state and federal data standards, transparency, health facility, and health plan legislation.

List of Potential Policy Changes Affecting the Agency's Legislative Budget Request

Number	Potential Policy Changes	Reference LRPP Goals	The Legislative Budget Requests (LBR) Affected	Impact on Policy if LBR Request not Approved
1.	Create electronic prescribing adoption incentives.	3	Medicaid Electronic Prescribing	Continued inefficiencies and medical errors.
2.	Improve efficiency of patient data collection and dissemination systems.	3	Data Collection and Dissemination Upgrade	Growing lag in the receipt and processing of data for consumer information and public policy.
3.	Enhance and expand FloridaHealthFinder.gov website facility information.	3	Florida Health Finder Enhancements	Inefficient facility data collection and dissemination.

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	Describe Substantive Legislative Action Required to Support Changes
1.	Analyze and report patient safety best practices.	Amend ss. 395.0197 395.3025 408.05 641.55, F.S.	N/A	The Agency shall analyze and provide data to hospitals to facilitate patient safety.	Streamline current adverse incident reporting system.
2.	Adopt clear and concise standards for electronic health information exchange.	ss. 408.062 (5), F.S.	N/A	The Agency shall adopt rules to create a uniform patient authorization form.	Establish specific statutory authorization for uniform patient authorization form.

List of All Task Forces and Studies in Progress

Number	Bill Cite	Task Forces and Studies Required by FY 2008-09 Legislation	Division Assigned
1.	Subcontract Number 7-312-0211557	The Agency is a state subcontractor in the federally-funded Health Information Security and Privacy Collaboration (HISPC) that will develop recommendations for ensuring the privacy and security of electronic health records. Deliverables include an analytical framework for comparing federal and state laws and provider education toolkit.	Florida Center for Health Information and Policy Analysis
2.	Contract Number HHSA 290 2007 10042	The Agency is contracted to conduct a study of the feasibility of adding hospital clinical laboratory data to patient data reporting. The study will evaluate how the data can be used to improve the measurement of inpatient severity of illness.	Florida Center for Health Information and Policy Analysis
3	2008 SB 1488 Line 230	The Agency shall publish on its website undiscounted charges for no fewer than 150 of the most commonly performed adult and pediatric procedures, including outpatient, inpatient, diagnostic, and preventative procedures.	Florida Center for Health Information and Policy Analysis
4	2008 HB 5001 Line 172A	From the funds in Specific Appropriation 172A, $100,000 in non-recurring general revenue funds is provided for grants to health-related institutions and organizations seeking assistance to deploy outpatient clinic information technology emphasizing case management.	Florida Center for Health Information and Policy Analysis
5.	2007 HB 1155 Lines 190-207 ss. 408.0611 (3) F.S.	By October 1, 2007 the Agency shall provide on its website information regarding 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; convene quarterly meetings of the stakeholders to assess and accelerate the implementation of electronic prescribing.	Florida Center for Health Information and Policy Analysis

Number	Bill Cite	Ongoing Task Forces and Studies Required by Legislation	Division Assigned
6.	2007 HB 1155 Lines 208-213 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
7.	2006 HB 7073 Line 149-168 408.05 (3)(k) F.S.	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 Agency shall update the plan and report on the status of its implementation annually thereafter.	Florida Center for Health Information and Policy Analysis
8.	2006 HB 7073 Lines 484-496 408.062 (1)(h) F.S.	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 for 100 of the most frequently prescribed medicines. The data collected shall be reported for each drug by pharmacy and by metropolitan statistical area or region and updated quarterly.	Florida Center for Health Information and Policy Analysis
9.	2006 HB-7073 Lines 313-314 408.05 (1) (d) F.S.	The Florida Center shall be responsible for publishing and disseminating an annual report on the center's activities.	Florida Center for Health Information and Policy Analysis
10.	2006 HB-7073 Lines 478-524 408.062 (1)(j) F.S.	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.	Florida Center for Health Information and Policy Analysis

Number	Bill Cite	Ongoing Task Forces and Studies Required by Legislation	Division Assigned
11	2006 HB-7073 Lines 508-512 408.062 (1)(j) F.S.	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.	Florida Center for Health Information and Policy Analysis
12.	2006 HB-7073 Lines 541-551 408.062 (5) F.S.	Directs the Agency to develop and implement a strategy for the adoption and use of electronic health records. Requires the Agency to report on legislative recommendations to protect the confidentiality of electronic health records.	Florida Center for Health Information and Policy Analysis
13.	2004 HB-1629 408.062 (1)(i) F.S.	The Agency shall monitor and assess 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 with the first report due January 1, 2006.	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 2010-2011 and to increase by nine percent annually through FY 2013-2014, 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 2003-2004	FY 2009-2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014
Actual Collections $16,674,293	$25,494,497	$27,534,057	$30,012,122	$32,713,213	$35,657,402
Percent of projection increase	8%	8%	9%	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 and Programs to the Governor's Priorities

	Governor's Priorities and Goals	Agency Goals and/or Programs
1.	Protecting Our Communities	**Goal 4**: To combat fraud, waste and abuse in the Florida Medicaid Program
2.	Strengthening Florida's Families	
3.	Keeping Florida's Economy Vibrant	.
4.	Success for Every Student	
5.	Keeping Floridians Healthy	**Goal 4**: To combat fraud, waste and abuse in the Florida Medicaid Program
6.	Protecting Florida's Natural Resources	

Trends and Conditions Statement

Section 409.913, F. S., and Section 42, Code of Federal Regulations mandate the Agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate. Primary responsibility for investigations and maintaining integrity of the state's Medicaid program is the Agency's Bureau of Medicaid Program Integrity (MPI) located in the Agency's Office of the Inspector General (OIG).

As part of its oversight responsibility, the Agency for Health Care Administration and the Medicaid Fraud Control Unit of the Department of Legal Affairs annually submit a joint report to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The report describes the number of cases opened and investigated each year; the sources of the cases opened; the disposition of the cases closed each year; the amount of overpayments alleged in preliminary and final audit letters; the number and amount of fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement agreements or by other means; the amount of final Agency determinations of overpayments; the amount deducted from federal claiming as a result of overpayments; the amount of overpayments recovered each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was opened until the overpayment is paid in full; the amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report also documents actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse.

The Agency will continue to work with local, state and federal law enforcement and prosecutorial agencies to stop criminals, reduce fraud and protect the integrity of the Florida Medicaid program from abuse. Current staffing levels may not be adequate to meet all the anticipated challenges we will encounter during the next five years covered by this Long Range Program Plan (LRPP). Additional staff will increase overpayments recouped and enhance return on investment.

The Agency's Office of the Inspector General, Bureau of Medicaid Program Integrity (OIG/MPI) continues to ensure the Medicaid program is managed in accordance with state and federal mandates. To this regard they participated in the recent contract selection of a replacement Medicaid Fiscal Agent and were involved in the development and installation of an improved Florida Medicaid Management Information System (FMMIS). The Medicaid Fiscal Agent contract went live on July 1, 2008. The new contract requires the Fiscal Agent to make technical resources available to OIG/MPI that may be used to produce statistical information from complex Decision Support System (DSS) algorithms. These algorithms will permit the Agency to identify violations of unbundling services, exceeding hour or age limit threshold, etc. On November 1, 2008, the FMMIS DSS system was populated with a complete history of paid claims data.

All states and the Centers for Medicare and Medicaid Services (CMS) share responsibility for protecting the integrity of the Medicaid program. States are responsible for ensuring proper payment and recovering misspent funds. CMS has a role in facilitating states' program integrity efforts and seeing that states have the necessary processes in place to prevent and detect improper payments. The Agency's Office of the Inspector General, Bureau of Medicaid Program Integrity (OIG/MPI) continues to work with CMS as one of eight states participating in a Medicaid federal audit program http://www.gao.gov/new.items/d04707.pdf. Eight states (Florida, Illinois, Louisiana, New Jersey, New York, North Carolina, Texas, and Wisconsin) are participating in this program.

Through this program, CMS facilitates the sharing of health benefit and claims information between state Medicaid and federal Medicare programs. For example, it arranged for Medicaid officials to gain access to confidential provider information contained in Medicare's restricted fraud alerts (a warning against emerging schemes), provider suspension notices, and databases. One of the Medicare-Medicaid information-sharing activities is a data match pilot that received funding from several sources. The purpose of this state-operated pilot is to identify improper billing and utilization patterns by matching Medicare and Medicaid claims information on providers and beneficiaries. Such matching is important, as fraudulent schemes can cross program boundaries.

On February 8, 2006, President George W. Bush signed the Deficit Reduction Act of 2005. In this legislation Congress directed CMS to establish the Medicaid Integrity Program (MIP) (CMS' website). The Act is based on four key principles:

- National leadership in Medicaid program integrity;
- Accountability for the program's own activities and those of its contractors and the states;
- Collaboration with internal and external partners and stakeholders; and,
- Flexibility to address the ever-changing nature of Medicaid fraud.

As part of its MIP initiative CMS's subcontractors are reviewing Florida's Medicaid claims history data and planning to do on-site audits throughout the state. The Agency hopes this combined cooperation between state and federal organizations will assist it in identifying more fraud prevention and monetary recovery opportunities and assist it in identifying areas where state policy need to be strengthened.

The Agency's Office of the Inspector General and the Bureau of Medicaid Program Integrity (OIG/MPI) continues to work closely with Florida's Medicaid Fraud Control Unit (MFCU) in the State Attorney General's Office. As a result of this cooperation the United States Department of Health and Human Services named Florida one of only three states that referred more than 100 fraud cases to their states' Attorney General's office in FY 2005-2006. Florida led the nation with 197 referrals. In FY 2007-2008, the Agency referred 218 providers to MFCU for investigation and an additional 52 providers were referred for informational purposes.

The Agency's Office of the Inspector General, Bureau of Medicaid Program Integrity (OIG) continues to be involved as Medicaid Reform progresses by providing investigative oversight and monitoring program compliance to prevent and combat fraud and abuse.

- The Bureau of Medicaid Program Integrity Case Management Unit's discovery and detection units continue their efforts to monitor the Florida's Medicaid Program. In accordance with s. 20.055 (7) F.S., the Office of the Inspector General's Annual Report to the Secretary details its efforts to combat Medicaid fraud and abuse. The Fraud and Abuse FY 2006-2007 Annual Report to the Legislature was issued in December, 2007. The FY 2007-2008 report should be available for release in December, 2008. Figure 4.1 show that OIG/MPI reported recoveries in FY 2006-2007 resulted in the recovery of $34.6 million in overpayments, an increase of 24 percent from the previous fiscal year.

Figure 4.1 Medicaid Program Integrity Recovery of Overpayments (millions)

Activity	FY 2004-2005	FY 2005-2006	FY 2006-2007
MPI Audits	$11.6	$16.3	$18.9
Reversals	1.5	0.9	0.7
Claims Adjustments	7.4	10.8	15.0
Total	$20.5	$28.0	$34.6

List of Potential Policy Changes Affecting the Agency's Legislative Budget Request

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 Potential Policy Changes that Would Require Legislative Action

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 and Studies in Progress

Number	Bill Cite	Task Forces and Studies Required by FY 2008-09 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 2013-2014, 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 2006-2007	FY 2009-2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014
Number of correspondence pieces tracked by the Agency's Correspondence Unit 6,234	6,962	7,102	7,244	7,389	7,536
Annual percent of increase 2%	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 2006-2007	FY 2009-2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014
Number of public record requests tracked through the Agency 3,215	4,708	4,802	4,899	4,997	5,096
Annual percent of increase 2%	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 2003-2004	FY 2009-2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014
Number of constituent and legislative inquiries handled by the Legislative Affairs Office 489	529	540	550	561	573
Annual percent of increase 2%	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 2006-2007	FY 2009-2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014
Number of legislative bills tracked and analyzed 277	305	312	318	325	331
Annual percent of increase 2%	2%	2%	2%	2%	2%

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

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

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

Baseline/Year FY 2007-2008	FY 2009-2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014
Number of phone contacts received by the Agency's Communication Office from media representatives 935	954	973	992	1,012	1,032
Annual percent of increase 2%	2%	2%	2%	2%	2%

During FY 2007-2008 the Media Office began using a tracking database system for incoming calls from media representatives as well as follow-up activities. This data input allowed us to

form a more accurate baseline without the potential for duplicate entries. 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 2007-2008	FY 2009-2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014
Number of design and production jobs completed by Agency's Multimedia Unit 793	809	825	842	858	857
Annual percent of increase 2%	2%	2%	2%	2%	2%

The FY 2007-2008 baseline was selected as it models outputs for a standard year not associated with increased activity associated with the Medicaid Demonstration Project. 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.	Protecting Our Communities	**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.	Strengthening Florida's Families	**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.	Keeping Florida's Economy Vibrant	
4.	Success for Every Student	
5.	Keeping Floridians Healthy	**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 be an ongoing state and federal issue as more people age and the demands for health care services and information increase. These increases will require more contact between the Agency and the public, the media, and state and federal legislators. These trends indicate 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 public, the media, stakeholders, and legislators.

Without the coordination of the Agency's activities and objectives, 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 affecting the state's health care system. The Agency's Legislative Affairs Office 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 advance the Governor's health care agenda during the legislative session, the Legislative Affairs Office educates new legislators about the Agency's statutory roles and responsibilities.

Since health care issues are expected to remain state and national priorities, the Agency must prepare for the increasing need to respond to inquiries from the 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. As a result, 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.

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

Most of the Agency's contacts with the public, with members of the news media, and with legislators are conducted on a personal level. 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.

It is important to note that personal contact is not reflected in the service outcome measure descriptions of this document. Legislative constituent inquiries are direct calls received by the

Agency. These calls are easily captured by the Agency from a quantitative standpoint; yet do not provide an accurate picture of the majority interactions of the Legislative Affairs and Communication Offices. During a typical day of legislative session, the Agency Legislative Affairs Office interacts with numerous legislators, legislator's offices and legislative committee staff. These interactions are not tracked and the numbers of these interactions are dependent on 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. Similarly for the Communications Office, staff may interact with multiple reporters at press conferences, events or committee hearings, or work on media inquiries referred to them.

As described, personal contact makes up 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 measures 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. Internally, we will keep a constant and "plain language" flow of current information to all Agency members allowing them to provide input throughout the process. We will accomplish this by holding Legislative and Plain Language Seminars for new and current employees, conducting Agency-wide teleconferences and creating clear and concise informational documents.

Externally, we will continue to restructure our areas of responsibility, promoting transparency and assisting our audiences in a timely manner. We will also take steps to ensure that the Agency’s goals and objectives are effectively communicated to all decision makers.

List of Potential Policy Changes Affecting the Agency's Legislative Budget Request

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 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 Number	Proviso Language	Division
1	None		

Exhibits:

Exhibit I:

Agency Workforce Plan (Not Required)

Exhibit II:

Performance Measures and Standards

Approved Performance Measures (Words)	Approved Prior Year Standards FY 2007-08 (Numbers)	Prior Year Actual FY 2007-08 (Numbers)	Approved Standards for FY 2008-09 (Numbers)	Requested FY 2009-10 Standard (Numbers)
Department: AGENCY FOR HEALTH CARE ADMINISTRATION		**Department No: 68000000**		
Program: Administration and Support		**Code: 68200000**		
Administrative costs as a percent of total agency costs	0.11%	0.06%	0.11%	0.14%
Administrative positions as a percent of total agency positions	11.45%	11.42%	11.45%	11.22%
Program: Health Care Services		**Code: 68500000**		
Service/Budget Entity: Children's Special Health Care		**Code: 68500100**		
Percent of hospitalizations for conditions preventable by good ambulatory care	7.7%	Unknown	7.7%	Delete
Percent of eligible uninsured children receiving health benefits coverage	100%	Unknown	100%	Revise measure and Standard
Percent of children enrolled with up-to-date immunizations	85%	Unknown	85%	Revise measure and Standard
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%	Unknown	97%	Delete
Percent of families satisfied with the care provided under the program	95%	87.9%	95%	90.0%
Total number of uninsured children enrolled in Kidcare	228,159	224,575	228,159	Delete Standard
Number of uninsured children enrolled in Medikids	21,000	24,288	21,000	Delete
Number of uninsured children enrolled in Children's Medical Services Network	10,053	13,862	10,053	Delete

Approved Performance Measures (Words)	Approved Prior Year Standards FY 2007-08 (Numbers)	Prior Year Actual FY 2007-08 (Numbers)	Approved Standards for FY 2008-09 (Numbers)	Requested FY 2009-10 Standard (Numbers)
Program: Health Care Services		**Code: 68500000**		
Service/Budget Entity: Executive Direction and Support Services		**Code: 68500200**		
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	8.9	15	7
Number of Medicaid claims received	145,101,035	135,418,100	145,101,035	Delete Standard
Percent of new Medicaid recipients voluntarily selecting managed care plan	50%	53.4%	50%	50.0%
Number of new enrollees provided with choice counseling	520,000	501,168	520,000	Delete
Program: Health Care Services		**Code: 68500000**		
Service/Budget Entity: Medicaid Services to Individuals		**Code: 68501400**		
Percent of hospitalizations that are preventable by good ambulatory care	11%	25.7%	11%	Delete
Percent of women receiving adequate prenatal care	86%	80.2%	86%	90.0%
Neonatal mortality rate per 1000	4.7	6.1	4.7	5.0
Average number of months between pregnancies for those receiving family planning services	35	39.3	35	35
Percent of eligible children who received all required components of EPSDT screen	64%	68%	64%	80.0%
Number of children ages 1-20 enrolled in Medicaid	1,590,866	1,503,938	1,590,866	Delete Standard
Number of children receiving EPSDT services	407,052	314,922	407,052	Delete Standard
Number of hospital inpatient services provided to children	92,960	92,665	92,960	Delete Standard
Number of physician services provided to children	6,457,900	6,556,917	6,457,900	Delete Standard
Number of prescribed drugs provided to children	4,444,636	4,879,278	4,444,636	Delete Standard
Number of hospital inpatient services provided to elders	100,808	91,792	100,808	Delete Standard

Approved Performance Measures (Words)	Approved Prior Year Standards FY 2007-08 (Numbers)	Prior Year Actual FY 2007-08 (Numbers)	Approved Standards for FY 2008-09 (Numbers)	Requested FY 2009-10 Standard (Numbers)
Number of physician services provided to elders	1,436,160	698,765	1,436,160	Delete Standard
Number of prescribed drugs provided to elders	15,214,293	1,342,218	15,214,293	Delete Standard
Number of uninsured children enrolled in the Medicaid Expansion	1,227	2,393	1,227	Delete Standard

Program: Health Care Services	**Code: 68500000**
Service/Budget Entity: Medicaid Long Term Care	**Code: 68501500**

Percent of hospitalizations for conditions preventable with good ambulatory care	12.60%	20.1%	12.60%	Delete
Number of case months (home and community-based services)	550,436	559,020	550,436	Delete
Number of case months services purchased (Nursing Home)	619,387	516,900	619,387	Delete

Program: Health Care Services	**Code: 68500000**
Service/Budget Entity: Medicaid Prepaid Health Plan	**Code: 68501600**

Percent of hospitalizations for conditions preventable by good ambulatory care	13%	29%	13%	Delete
Percent of women and child hospitalizations for conditions preventable with good ambulatory care	16.00%	31.1%	16.00%	Delete
Number of case months services purchased (elderly and disabled)	1,877,040	1,755,708	1,877,040	Delete
Number of case months services purchased (families)	9,850,224	8,926,008	9,850,224	Delete

Approved Performance Measures (Words)	Approved Prior Year Standards FY 2007-08 (Numbers)	Prior Year Actual FY 2007-08 (Numbers)	Approved Standards for FY 2008-09 (Numbers)	Requested FY 2009-10 Standard (Numbers)
Program: Program: Health Care Regulation		**Code: 68700700**		
Service/Budget Entity: Health Care Regulation		**Code: 68700700**		
Percent of nursing home facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0%	2.80%	0%	2.0%
Percent of investigations of alleged unlicensed facilities and programs that have been previously issued a cease and desist order that are confirmed as repeated unlicensed activity	4%	0%	4%	4.0%
Percent of Priority I consumer complaints about licensed facilities and programs that are investigated within ~~48 hours~~ two business days.	100%	96.70%	100%	100.0%
Percent of accredited hospitals and ambulatory surgical centers cited for not complying with life safety, licensure, or emergency access standards	25%	28.90%	25%	25.0%
Percent of validation surveys that are consistent with findings noted during the accreditation survey	98%	100%	98%	98.0%
Percent of assisted living facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0%	1.00%	0%	2.0%
Percent of home health facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0%	0.00%	0%	2.0%
Percent of clinical laboratories with deficiencies that pose a serious threat ~~for not complying with life safety, licensure, or emergency access standards~~ to the health, safety, or welfare of the public	0%	0.07%	0%	2.0%
Percent of ambulatory surgical centers with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0%	1.00%	0%	2.0%
Percent of hospitals with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0%	6.70%	0%	2.0%

Approved Performance Measures (Words)	Approved Prior Year Standards FY 2007-08 (Numbers)	Prior Year Actual FY 2007-08 (Numbers)	Approved Standards for FY 2008-09 (Numbers)	Requested FY 2009-10 Standard (Numbers)
Percent of hospitals that fail to report serious incidents (agency identified)	6%	2.67%	6%	6.0%
Percent of complaints of HMO patient dumping received that are investigated*	100%	0%	100%	0.0%
Percent of complaints of facility patient dumping received that are investigated	100%	100%	100%	100%
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	12,048	30,000	12,000
Total number of full facility quality-of-care surveys conducted	7,550	6,872	7,550	7,550
Average processing time (in days) for Subscriber Assistance Program cases.	53	22	53	53
Number of construction reviews performed (plans and construction)	4,500	5,270	4,500	4,500

LRPP Exhibit IIa - Proposed Performance Measures and Standards

Requested Performance Measures (Words)	Requested Prior Year Standards FY 2007-08 (Numbers)	Prior Year Actual FY 2007-08 (Numbers)	Requested Standards for FY 2008-09 (Numbers)
Budget Entity: Children's Special Health Care (Title XXI)			**Code: 68500100**
Percentage of all Title XXI KidCare enrollees eligible for renewal who either renew KidCare coverage or maintain health care coverage from another source	90%	91.9%	90%
Percent of two year old children enrolled in KidCare (Title XXI) with up-to-date immunizations	90%	85.7%*	90%
Percent of families with children enrolled in a Title XXI KidCare program satisfied with the care provided under the program	90%	87.9%	90%
Budget Entity: Executive Director / Support Services			**Code: 68500200**
Percent of new Medicaid beneficiaries voluntarily selecting managed care plan	50%	53.4%	50%
Percent of newly eligible beneficiaries in Medicaid Reform making a voluntary plan choice	80%*	81.0%	80%*
Budget Entity: Medicaid Services - Individuals			**Code: 68501400**
Percent of all Medicaid women receiving adequate prenatal care.	90%	80.2%	90%
Neonatal mortality rate per 1000	5.0	6.1	5.0
Average number of months between pregnancies for women enrolled in Medicaid.	35	39.3	35
Percent of eligible children who received a Child Health Check-Up	80%	68%	80%
Percent of hospitalizations of beneficiaries for conditions preventable by good ambulatory care: CMSN enrollees (Title XIX and Title XXI)	25%	28.5%	25%
Percent of hospitalizations of beneficiaries for conditions preventable by good ambulatory care: Ages 1 to 20 enrolled in Fee for Service Provider Service Networks	25%	30.9%	25%

Requested Performance Measures (Words)	Requested Prior Year Standards FY 2007-08 (Numbers)	Prior Year Actual FY 2007-08 (Numbers)	Requested Standards for FY 2008-09 (Numbers)
Percent of hospitalizations of beneficiaries for conditions preventable by good ambulatory care: Ages 21 and over enrolled in Fee for Service Provider Service Networks	25%	21.3%	25%
Percent of hospitalizations of beneficiaries for conditions preventable by good ambulatory care: Ages 1 to 20 in MediPass or Fee for Service	25%	36.9%	25%
Percent of hospitalizations of beneficiaries for conditions preventable by good ambulatory care: Ages 21 or over in MediPass or Fee for Service	25%	23.0%	25%
Percent of two year old children enrolled in Medicaid with up-to-date immunizations	90%	85.7%*	90%
Percent of hospitalizations of beneficiaries for conditions preventable by good ambulatory care: Ages 1-20 in full service capitated plans	25%	41.2%	25%
Percent of hospitalizations of beneficiaries for conditions preventable by good ambulatory care: Ages 21 and over in full service capitated plans	25%	23.6%	25%
Budget Entity: Medicaid Long Term Care			**Code: 68501500**
Percent of hospitalizations of beneficiaries for conditions preventable by good ambulatory care: Institutional Care and Waiver Programs	25%	21.7%	25%

*Reflects the statewide percentage for all two-year old children. Methodology for calculating separate Medicaid and Title XXI immunization rates is still under development.

Requested Performance Measures (Words)	Requested Prior Year Standards FY 2007-08 (Numbers)	Prior Year Actual FY 2007-08 (Numbers)	Requested Standards for FY 2008-09 (Numbers)
Budget Entity: Health Care Regulation			**Code: 6868700700**
Percent of nursing home facilities with deficiencies posing a serious threat to the health, safety or welfare of the public against which the agency has taken administrative action.	90%	88.0%	90%
Percent of Priority I consumer complaints about licensed facilities and programs that are investigated within two business days.**	90%	96.7%	90%
Percent of assisted living facilities with deficiencies posing a serious threat to the health, safety or welfare of the public against which the agency has taken administrative action.	90%	100.0%	90%
Percent of home health agencies with deficiencies posing a serious threat to the health, safety or welfare of the public against which the agency has taken administrative action.***	90%	N/A	90%
Percent of licenses that are issued or denied within 60 days following receipt of a complete application.	90%	90.4%	90%
Percent of HMO complaints that are investigated and resolved within 10 business days of receipt.	90%	81.5%	90%
Percent of plans and construction reviews completed within 60 days of receipt or scheduled date.	90%	97.8%	90%
Percent of hospital emergency access violations that result in sanctions against the hospital.	90%	68.0%	90%

**This measure is not new. We simply changed the wording to two business days from 48 hours to match the federal standard and comply with our database capabilities to measure days, but not hours. We requested a change to 90%, but that has not yet been approved.

***Three were no serious deficiencies, consequently, there were no administrative actions for serious deficiencies.

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%	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: See explanation below.

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 to preventive care services, the population groups defined in the Long-Range Program plan, including this measure, do not accurately address the issue along programmatic lines.

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 2008

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
100%	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: As written this indicator cannot be measured.

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: As written this indicator cannot be measured.

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 in favor of a more meaningful measure.

Office of Policy and Budget – July 2008

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, Medicaid 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 WorkingAgainst 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 asked to be deleted in favor of a more accurate and meaningful measure several years ago. The contract for collecting the estimates was changed in anticipation of the change to a more meaningful measure. This information is no longer available.

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 2008

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
97%	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: Due to limitations in the collection and coding of medical services, this indicator cannot be accurately measured.

External Factors (check all that apply):

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

Explanation: There is no reliable way to determine whether children and providers are adhering to the standards without comprehensive chart review. In practice, this measure relied on caregiver surveys, relying on their recall, to determine if there had been at least one well-child visit in the previous 6-months. This does not capture the intended measure, nor is it clear whether the responder understands what a well-child visit entails.

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

☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)

Recommendations: Due to confusion and lack of a truly representative way to measure this variable, it is recommended that it be dropped in favor of other measures more representative of program performance.

Office of Policy and Budget – July 2008

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
95%	87.9%	(7.1%)	(7.5%)

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: N/A – see below

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 Medicaid is the primary payer for Title XXI services, they do not manage provider networks. Chief complaint among caregivers is lack of access to specialists, either in getting an appointment or a referral. One in four reported delays in getting routine care.

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 standard to 90% to reflect national standards. In addition, the Agency will continue to explore several avenues for ways of expanding access to care.

Office of Policy and Budget – July 2008

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
228,159	224,575	(3,584)	(1.6%)

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: Enrollment is not a factor of Medicaid performance. Standards are only estimates of expected enrollment.

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. 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 the standard for this output (count) measure be deleted since it has no meaning.

Office of Policy and Budget – July 2008

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
195,867	185,334	(10,533)	(5.4%)

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: See below

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 2008

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
21,000	24,288	3,288	15.7%

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: See below

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 2008

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	13,862	3,809	37.9%

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: See below

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 2008

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: N/A; difference is negligible.

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: AHCA is requesting that the standard for this measure be changed to 2% to reflect the possibility for growth necessary to better meet the needs of Floridians. This standard will remain the same from year-to-year and not fluctuate based on historical numbers as in previous LRPP reports.

Office of Policy and Budget – July 2008

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
☐ 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
15	8.9	(6.1)	(40.7%)

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: Increasing numbers of electronically submitted claims as well as technology systems development have increased capability

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

Explanation:

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

Recommendations: The Agency would like to change this standard to 7 days to reflect the improvements in processing and technology.

Office of Policy and Budget – July 2008

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
- ☒ 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
145,101,035	135,418,100	(9,682,935)	(6.7%)

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: Actual numbers less than projected

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. 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 the standard for this output (count) measure be deleted since it is meaningless.

Office of Policy and Budget – July 2008

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%	25.7%	15%	133%

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: None, see explanation below

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 2008

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%	80.2%	(-5.8%)	(6.7%)

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: Medicaid is not provided an outreach budget and must work through other agencies to encourage and educate women on the benefits of early entry into prenatal care. The SOBRA program is designed to make prenatal care more accessible.

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: Education and outreach efforts through Medicaid's partners in the health care community need 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.

Office of Policy and Budget – July 2008

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	6.1	1.4	29.8%

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: None, see below

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: Information 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 programs should be explored. Medicaid Reform as it expands and the emphasis on healthy behaviors may impact this measure favorably.

Office of Policy and Budget – July 2008

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 ☐ 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
35	39.3	4.3	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: Family Planning Waiver and family planning counseling and 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:

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

Recommendations: Existing efforts to provide family planning services to eligible women should continue.

Office of Policy and Budget – July 2008

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%	68%	4%	(6.3%)

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☒ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect
☐ Other (Identify)
Explanation: The Agency continues to stress the importance of regular, periodic check-ups to providers and beneficiaries.

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: Patient education needs to continue 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 could 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 2008

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
1,590,866	1,503,938	(86,928)	(5.5%)

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

Explanation: The target for this measure represents estimate a planning conference estimate and is not an actual target for an output variable that is outside the Agency's control.

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. 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 the standard for this output (count) measure be deleted since it is meaningless.

Office of Policy and Budget – July 2008

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	314,922	(92,130)	(22.6%)

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: None, see below

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix The Problem
☐ CurrentLaws 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 2008

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	92,665	(295)	(0.03%)

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 target for this measure represents estimate a planning conference estimate and is not an actual target for an output variable that is outside the Agency's control.

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. 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 the standard for this output (count) measure be deleted since it is meaningless.

Office of Policy and Budget – July 2008

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
☒ 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
6,457,900	6,556,917	99,017	1.5%

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: The target for this measure represents estimate a planning conference estimate and is not an actual target for an output variable that is outside the Agency's control.

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

Explanation:
This measure does not measure program performance. 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 the standard for this output (count) measure be deleted since it is meaningless.

Office of Policy and Budget – July 2008

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	4,879,278	434,642	9.8%

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: The target for this measure represents estimate a planning conference estimate and is not an actual target for an output variable that is outside the Agency's control.

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. 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 the standard for this output (count) measure be deleted since it is meaningless.

Office of Policy and Budget – July 2008

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
☒ 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
100,808	91,792	(9,016)	(8.9%)

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: The target for this measure represents estimate a planning conference estimate and is not an actual target for an output variable that is outside the Agency's control.

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. 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 the standard for this output (count) measure be deleted since it is meaningless.

Office of Policy and Budget – July 2008

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	698,765	(737,395)	(51.3%)

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: The target for this measure represents estimate a planning conference estimate and is not an actual target for an output variable that is outside the Agency's control.

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. 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 the standard for this output (count) measure be deleted since it is meaningless.

Office of Policy and Budget – July 2008

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	1,342,218	(13,872,075)	(91.2%)

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: The target for this measure represents estimate a planning conference estimate and is not an actual target for an output variable that is outside the Agency's control.

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 number of prescribed drugs dropped 2 years ago due to the implementation of Medicare Part D. This measure does not measure program performance. 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 the standard for this output (count) measure be deleted since it is meaningless.

Office of Policy and Budget – July 2008

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
1,227	2,393	1,166	95%

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: The target for this measure represents estimate a planning conference estimate and is not an actual target for an output variable that is outside the Agency's control.

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

Explanation:
This measure does not measure program performance. 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 the standard for this output (count) measure be deleted since it is meaningless.

Office of Policy and Budget – July 2008

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
12.6%	20.1%	7.5%	59.5%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☐ Other (Identify)
☐ Staff Capacity
☐ Level of Training
Explanation: None, see below

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. Since neither the methodology nor the population are relevant to Medicaid program areas, 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 2008

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
550,436	559,020	8,584	1.6%

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: The target for this measure represents estimate a planning conference estimate and is not an actual target for an output variable that is outside the Agency's control.

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. 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 the standard for this output (count) measure be deleted since it is meaningless.

Office of Policy and Budget – July 2008

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 month's 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	516,900	(102,487)	(16.5%)

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 target for this measure represents estimate a planning conference estimate and is not an actual target for an output variable that is outside the Agency's control.

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. 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 the standard for this output (count) measure be deleted since it is meaningless.

Office of Policy and Budget – July 2008

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
13%	29%	16%	124.6%

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: None, see below

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. Since neither the methodology nor the population are relevant to Medicaid program areas, 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 2008

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
16%	31.1%	15.1%	94.4%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☐ Other (Identify)
☐ Staff Capacity
☐ Level of Training
Explanation: None, see below

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. Since neither the methodology nor the population are relevant to Medicaid program areas, 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 2008

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
1,877,040	1,755,708	(121,332)	(6.5%)

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

Explanation: The target for this measure represents estimate a planning conference estimate and is not an actual target for an output variable that is outside the Agency's control.

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 the budget entity to which it used to apply has been deleted by the legislature. The measure should therefore be deleted.

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 2008

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
9,850,224	8,926,008	(924,216)	(9.4%)

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 target for this measure represents estimate a planning conference estimate and is not an actual target for an output variable that is outside the Agency's control.

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 the budget entity to which it used to apply has been deleted by the legislature. The measure should therefore be deleted.

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 2008

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0%	2.8%	2.8% Over	2.8% Over

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

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

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

Explanation: 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 management does not believe the measure is an appropriate measure of Agency performance

Recommendations: Delete this measure.

Office of Policy and Budget – July 2008

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
4%	0%	4% Under	100% Under

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

Explanation: The Agency is committed to protecting its customers through the investigation of all reports of unlicensed activity followed by facility closure or facility compliance with applicable standards. As these facilities are closed or brought into compliance, there will be fewer instances of repeat unlicensed activities. A decrease in this measure demonstrates the Agency's commitment to ensuring quality of care and services through compliance with minimum standards. However, it is not a measure over which the Agency can exercise control.

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 not a measure over which the Agency has ultimate control.

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 2008

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

Action:
☒ Performance Assessment of Outcome Measure
☐ 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%	96.70%	3.30% Under	.330% Under

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

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: None

Office of Policy and Budget – July 2008

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
25%	28.90%	3.90% Over	15.6% Over

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

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

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

Explanation: This is not a measure over which the Agency can exercise control.

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 2008

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%	100.0%	2.0% Over	2.04% Over

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. Of 5 such surveys conducted this year, all met the evaluation criteria.

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 standard measures the performance of the accrediting organization, not the performance of the Agency.

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 2008

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0%	1.0%	1.0% Over	1.0%

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: 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 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 4 times per year and assisted living facilities licensed to provided limited nursing services from once per year to twice per year. However, the same problem exists with assisted living facilities as with nursing homes. Although 0% is an admirable goal, it is not a reasonable expectation.

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 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
☐ Personnel
☐ Technology
☒ Other (Identify)

Recommendations: Delete this measure.

Office of Policy and Budget – July 2008

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

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

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 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
☐ Personnel
☐ Technology
☐ Other (Identify)

Recommendations: Delete this measure

Office of Policy and Budget – July 2008

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0%	0.07%	0.07% Over	0.07% Over

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

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

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 is not one over which the Agency has control. While we can find and require correction of deficiencies, we cannot insure that facilities will be deficiency-free.

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 2008

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0%	1.0%	1.0% Over	1.0%

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: 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: 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
☐ Personnel
☐ Technology
☐ Other (Identify)

Recommendations: Delete this measure.

Office of Policy and Budget – July 2008

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0%	6.70%	6.70% Over	6.70% Over

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

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

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

Explanation: 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
☐ Personnel
☐ Technology
☐ Other (Identify)

Recommendations: Delete this measure.

Office of Policy and Budget – July 2008

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%	2.67%	3.33% Under	55.5%

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: This measure depends 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. The Agency hires staff who are knowledgeable of hospital risk management issues and are available to provide consultation to hospitals (when requested) relating to the required reporting of "serious incidents."

Office of Policy and Budget – July 2008

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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%	0*	0*	0*

*There have been no such complaints for the past 5 years.

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:
We have not received any complaint of HMO patient dumping.

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:
We have not received any complaints of HMO patient dumping.

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

Recommendations:
This measure should be eliminated as it is no longer relevant. The Agency has not received any new complaints of patient dumping in at least 5 years.

Office of Policy and Budget – July 2008

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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%	100%	0	0

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:
The number of complaints received regarding patient dumping is dependent on a patient's perception of the care received (or lack of care) at a hospital, nursing home, home health agency or assisted living facility. It would be very rare that such an allegation would not be investigated.

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: Not applicable.

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

Recommendations: None.

Office of Policy and Budget – July 2008

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

Action:
☐ Performance Assessment of Outcome Measure
☐ 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	12,048	(17,952)	59.84% Under

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:
The number of calls received fell short of the expected total. This is an ongoing trend and has been for several years. This measure is based upon factors not within the Agency's control.

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 is an artifact of the days when Medical Quality Assurance was part of the Agency for Health Care Administration. Now, it is part of the Department of Health. This measure should be deleted as it bears little relationship to the Agency's current regulatory mandates.

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

Recommendations: Delete this measure. The difference in the approved estimate and actual is not perceived as a problem. The number of complaints the public submits against practitioners cannot be anticipated. The difference is not attributable to any problem with taking the complaints, but rather is determined by circumstances of the complainants. There is no need to correct collection systems.

Office of Policy and Budget – July 2008

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
7,550	6,872	678 Under	8.98% 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: The Agency has no control over the numbers of facilities that either desire licensure or that no longer wishes to be licensed and discontinue operations. The total number of surveys conducted each year will fluctuate with the total number of licensed facilities.

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

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

Recommendations: Delete this measure. It measures workload, but not performance.

Office of Policy and Budget – July 2008

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Quality Assurance
Service/Budget Entity: Health Care Regulation/68700700
Measure: Average days to close a case

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	22	31 Under	58.49% 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:
Existing staff have a high level of experience and are able to tackle their cases efficiently and effectively. This is an exceptionally positive outcome, since staff efficiency permits case closure in less time than originally allocated.

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: N/A

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

Recommendations: None

Office of Policy and Budget – July 2008

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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
4,500	5,270	770	17.11%

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:

Staff members are experienced and efficient at their jobs.

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 number of plans and construction reviews is heavily dependent upon external factors related to the funding available in the marketplace for health care facility construction. In lean years, there are fewer requests for new projects. When more plans are received, staff makes every effort to review those items that are received.

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

Recommendations: Delete this measure. It is market dependant and, while a good measure of workload, is not a credible measure of performance. This measure is also available as a unit cost measure.

Office of Policy and Budget – July 2008

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 2008

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 2008

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 splitting and changing this measure to two measures-- "Percent of two year old children enrolled in Medicaid with up-to-date immunizations" and "Percent of two year old children enrolled in KidCare with up-to-date immunizations." The data would be extracted from the Department of Health (DOH), Bureau of Immunization annual immunization survey.

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 or KidCare

Data Sources and Methodology: 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 Diphtheria, 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. The Agency is currently exploring options to match KidCare 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, providing statistically accurate estimates for immunization rates within the state. Immunizations are widely recognized as a desirable preventive care measure to ensure the health and well-being of children. Two-year olds are being used here due to the availability of the survey data from DOH and are indicative of efforts to provide appropriate primary care (i.e., immunizations according to well-child guidelines) to children. Waiting until they enroll in kindergarten, which has been done in the past, does not accurately measure preventive care service access since children are required to obtain immunizations to enroll in school.

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.

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 2008

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) are 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 with children enrolled in KidCare 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 2008

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 have the "standard" removed from the reporting requirements.

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. While indicative of the size and scope of the KidCare 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. For this reason, even if the count continues to be reported, the "standard" for this measure is meaningless and should be deleted.

Office of Policy and Budget – July 2008

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 is a subset of the overall KidCare count. While indicative of the size and scope of part of the KidCare 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. Breaking the overall count into its various components is not a performance measure and has no practical value and should be deleted.

Office of Policy and Budget – July 2008

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 is a subset of the overall KidCare count. While indicative of the size and scope of part of the KidCare 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. Breaking the overall count into its various components is not a performance measure and has no practical value and should be deleted.

Office of Policy and Budget – July 2008

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 is a subset of the overall KidCare count. While indicative of the size and scope of part of the KidCare 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. Breaking the overall count into its various components is not a performance measure and has no practical value and should be deleted.

Office of Policy and Budget – July 2008

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 2008

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 2008

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 have the "standard" removed from the reporting requirements.

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. 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. For this reason, even if the count continues to be reported, the "standard" for this measure is meaningless and should be deleted.

Office of Policy and Budget – July 2008

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 2008

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 2008

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: 5.0 per 1,000

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 per 1,000 live births, with Medicaid rates about 2 per 1,000 live births 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.

Office of Policy and Budget – July 2008

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, and Healthy Start data related to women giving birth in Florida for each year since 1991. Medicaid extracts claims each 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:
This is a valid measure for the effectiveness of family planning services. Lengths between pregnancies of at least 24 months are encouraged by Healthy Start and are preferable due to the demonstrated benefits for growth and healthy development of young children.

Reliability:
The reliability is considered high is high for women who have maintained Medicaid coverage between pregnancies since it is based on claims data and birth records. 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 2008

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. 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).

Data Sources and Methodology: 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 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. 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.

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 2008

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 have the "standard" removed from the reporting requirements.

Data Sources and Methodology:

Validity:
This measure does not include Medicaid children under age 1. Further, Medicaid is primarily targeted at children ages 0 to 18. This is not a valid measure for the number of children receiving Medicaid services.

Reliability:

Discussion:

This measure that has previously been reported in the Long-Range Program Plan does not measure program performance. 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. For this reason, even if the count continues to be reported, the "standard" for this measure is meaningless and should be deleted.

Office of Policy and Budget – July 2008

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: This measure has been calculated as the number of children receiving at least 1 EPSDT service in the previous 6 months. This does not measure adherence to EPSDT guidelines, and is problematic due to the lack of standardization in coding these services in the claims database. Since there is another measure reported in the LRPP that adheres to federal reporting requirements, it is recommended that we keep that measure and delete this one.

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 other 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 2008

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 have the "standard" removed from the reporting requirements.

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. 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. For this reason, even if the count continues to be reported, the "standard" for this measure is meaningless and should be deleted.

Office of Policy and Budget – July 2008

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 have the "standard" removed from the reporting requirements.

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. 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. For this reason, even if the count continues to be reported, the "standard" for this measure is meaningless and should be deleted.

Office of Policy and Budget – July 2008

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):

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 have the "standard" removed from the reporting requirements.

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. 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. For this reason, even if the count continues to be reported, the "standard" for this measure is meaningless and should be deleted.

Office of Policy and Budget – July 2008

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):

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 have the "standard" removed from the reporting requirements.

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. 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. For this reason, even if the count continues to be reported, the "standard" for this measure is meaningless and should be deleted.

Office of Policy and Budget – July 2008

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 have the "standard" removed from the reporting requirements.

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. 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. For this reason, even if the count continues to be reported, the "standard" for this measure is meaningless and should be deleted.

Office of Policy and Budget – July 2008

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):

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 have the "standard" removed from the reporting requirements.

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. 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. For this reason, even if the count continues to be reported, the "standard" for this measure is meaningless and should be deleted.

Office of Policy and Budget – July 2008

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):

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 have the "standard" removed from the reporting requirements.

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. 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. For this reason, even if the count continues to be reported, the "standard" for this measure is meaningless and should be deleted.

Office of Policy and Budget – July 2008

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 2008

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:

The number HCBS Waiver recipients (slots) is determined legislatively and enrollment is therefore capped. The count of case months for this variable has no relevant meaning and should be deleted.

Office of Policy and Budget – July 2008

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 have the "standard" removed from the reporting requirements.

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. 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. For this reason, even if the count continues to be reported, the "standard" for this measure is meaningless and should be deleted.

Office of Policy and Budget – July 2008

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 2008

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 2008

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:

The Medicaid Prepaid Health Plan budget entity was eliminated in the GAA (HB5001). Counts for these services in this budget entity are therefore no longer relevant and should be deleted.

Office of Policy and Budget – July 2008

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:

The Medicaid Prepaid Health Plan budget entity was eliminated in the GAA (HB5001). Counts for these services in this budget entity are therefore no longer relevant and should be deleted.

Office of Policy and Budget – July 2008

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Children's Special Health Care (CMSN)/ 68500100
Measure: **New Measure -** Percent of hospitalizations of beneficiaries for conditions preventable by good ambulatory care: CMSN enrollees (Title XIX and Title XXI)

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: This represents a replacement to the existing categories currently measured for ambulatory sensitive hospitalizations.

Data Sources and Methodology:
Inpatient hospital discharge data are used as the primary source of diagnosis and treatment of ambulatory sensitive conditions. Discharge data are matched against Medicaid eligibility files to determine Medicaid status. Data are extracted according to payer and age group. Ambulatory sensitive conditions are identified by ICD-9 diagnosis codes, using the algorithm and methodology outlined by the federal HHS Agency for Healthcare Research and Quality (AHRQ).

Proposed Standard/Target: 25%, based on baseline calculations utilizing the updated AHRQ methodology.

Validity:
Validity of the measure is good. A condition is considered ambulatory sensitive if provision of quality care could reduce or eliminate the need for hospitalization. Some hospitalizations will always occur due to patient non-compliance. However, Medicaid providers are expected to work with patients to increase their likelihood of compliance in addition to providing direct treatment. The measure therefore encompasses not only access to care, but to a certain extent, the providers' ability to educate their patients on the need for appropriate care. The measure is a valid measure of the access to and effectiveness of primary care and preventive treatment programs and is a nationally accepted standard for evaluating preventive care services.

The ambulatory sensitive conditions are identified using the algorithm and methodology outlined by AHRQ. AHRQ is a federal Health and Human Services agency that specifically develops methods and tools to assist governments in the evaluation of their healthcare services, from national to local levels. AHRQ is a highly respected national body that has developed survey tools and evaluation programs in use around the country and maintains a database of findings from other states that utilize their tools.

Reliability:
The reliability of the diagnoses data is high. Hospitals provide the information to AHCA and must certify that it is accurate. The ICD-9 codes are used for billing, hospital report cards etc. so hospitals have incentives to be accurate in their use of these codes. Data to link the patient to payer source is less accurate. Payer source is coded when the patient enters the hospital and may not be known or be incorrectly identified. However, there is no expectation that inaccuracies in payer classification would be related to the reason for hospitalization. Since the measure is based on the ratio of ambulatory sensitive hospitalizations out of all hospitalizations by payer type, the figure should be reliable for the purpose of this measure.

Office of Policy and Budget – July, 2008

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Medicaid Reform Choice Counseling
Service/Budget Entity: Medicaid Director's Office
Measure: **New Measure -** Percent of newly eligible beneficiaries in Medicaid Reform making a voluntary plan choice

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: Voluntary enrollment rate which reflects the number of new eligibles that voluntary choose the managed care plan in which they are enrolled.

Data Sources and Methodology:

The Florida Medicaid Management Information System indicates which Medicaid beneficiaries voluntarily enroll in a Medicaid managed care plan and which beneficiaries are assigned to a Medicaid managed care plan by the state. Each month, the Agency divides the number of beneficiaries that voluntarily choose by the number that were assigned to determine the voluntary enrollment rate. Excluded from this calculation are beneficiaries that lose eligibility for 180 days or less as they are reinstated into their Medicaid managed care plan and are not considered a new eligible.

Proposed Standard/Target: 65% in new Reform areas, 80% after 2 years.

Validity:
The intent of this measure is to report the impact of the Medicaid Reform Choice Counseling on the number of beneficiaries that voluntarily choose their own Medicaid managed care plan. The current contract standard requires that 65 percent of new eligibles voluntarily choose their own Medicaid Reform plan.

Reliability:
The data are highly reliable and are collected and reported monthly by the Agency.

Office of Policy and Budget – July, 2008

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Service to Individuals/68501400
Measure: **New Measure -** Percent of hospitalizations of beneficiaries for conditions preventable by good ambulatory care: Ages 1 to 20 enrolled in Fee for Service Provider Service Networks

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: This represents a replacement to the existing categories currently measured for ambulatory sensitive hospitalizations.

Data Sources and Methodology:
Inpatient hospital discharge data are used as the primary source of diagnosis and treatment of ambulatory sensitive conditions. Discharge data are matched against Medicaid eligibility files to determine Medicaid status. Data are extracted according to payer and age group. Ambulatory sensitive conditions are identified by ICD-9 diagnosis codes, using the algorithm and methodology outlined by the federal HHS Agency for Healthcare Research and Quality (AHRQ).

Provider Service Networks differ from the Fee for Service and MediPass programs in that they contract with a network of providers for comprehensive care for the enrollees. They provide authorization and utilization management to a far greater extent than the MediPass program. Enrollees are divided into Ages 1 to 20 and over 21 age groups because the Medicaid benefit package varies for adults and children. Children under 1 year of age have almost no hospitalizations that fit these criteria. Further, many do not have established Medicaid IDs at the time of hospitalization and cannot be matched to Medicaid eligibility files. These measures therefore concentrate on the children ages 1 to 20 where appropriate. The following groups would be excluded from this measure:

a. SOBRA Pregnant women;
b. Medicaid Recipients domiciled or residing in an institution, including nursing facilities, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an Intermediate Care Facility/Developmentally Disabled (ICF-DD);
c. Medicaid Recipients whose Medicaid eligibility was determined through the medically needy program,
d. Qualified Medicare Beneficiaries ("QMBs"),
e. Special Low Income Medicare Beneficiaries (SLMBs), or Qualified Individuals at Level 1 (QI-1s).
f. Title XXI-funded children with chronic conditions who are enrolled in Children's Medical Services Network,
g. Women eligible for Medicaid due to breast and/or cervical cancer.
h. Individuals eligible under a hospice-related eligibility group.

Proposed Standard/Target: 25%, based on baseline calculations utilizing the updated AHRQ methodology.

Validity:
Validity of the measure is good. A condition is considered ambulatory sensitive if provision of quality care could reduce or eliminate the need for hospitalization. Some hospitalizations will always occur due to patient non-compliance. However, Medicaid providers are expected to work with patients to increase their likelihood of compliance in addition to providing direct treatment. The measure therefore encompasses not only access to care, but to a certain extent, the providers' ability to educate their patients on the need for appropriate care. The measure is a valid measure of the access to and effectiveness of primary care and preventive treatment programs and is a nationally accepted standard for evaluating preventive care services.

The ambulatory sensitive conditions are identified using the algorithm and methodology outlined by AHRQ. AHRQ is a federal Health and Human Services agency that specifically develops methods and tools to assist governments in the evaluation of their healthcare services, from national to local levels. AHRQ is a highly respected national body that has developed survey tools and evaluation programs in use around the country and maintains a database of findings from other states that utilize their tools.

Reliability:
The reliability of the diagnoses data is high. Hospitals provide the information to AHCA and must certify that it is accurate. The ICD-9 codes are used for billing, hospital report cards etc. so hospitals have incentives to be accurate in their use of these codes. Data to link the patient to payer source is less accurate. Payer source is coded when the patient enters the hospital and may not be known or be incorrectly identified. However, there is no expectation that inaccuracies in payer classification would be related to the reason for hospitalization. Since the measure is based on the ratio of ambulatory sensitive hospitalizations out of all hospitalizations by payer type, the figure should be reliable for the purpose of this measure.

Office of Policy and Budget – July, 2008

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Service to Individuals/68501400
Measure: **New Measure -** Percent of hospitalizations of beneficiaries for conditions preventable by good ambulatory care: Ages 21 and Over enrolled in Fee for Service Provider Service Networks

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: This represents a replacement to the existing categories currently measured for ambulatory sensitive hospitalizations.

Data Sources and Methodology:
Inpatient hospital discharge data are used as the primary source of diagnosis and treatment of ambulatory sensitive conditions. Discharge data are matched against Medicaid eligibility files to determine Medicaid status. Data are extracted according to payer and age group. Ambulatory sensitive conditions are identified by ICD-9 diagnosis codes, using the algorithm and methodology outlined by the federal HHS Agency for Healthcare Research and Quality (AHRQ).

Provider Service Networks differ from the Fee for Service and MediPass programs in that they contract with a network of providers for comprehensive care for the enrollees. They provide authorization and utilization management to a far greater extent than the MediPass program. Enrollees are divided into Ages 1 to 20 and over 21 age groups because the Medicaid benefit package varies for adults and children. Children under 1 year of age have almost no hospitalizations that fit these criteria. Further, many do not have established Medicaid IDs at the time of hospitalization and cannot be matched to Medicaid eligibility files. These measures therefore concentrate on the children ages 1 to 20 where appropriate. The following groups would be excluded from this measure:

a. SOBRA Pregnant women;
b. Medicaid Recipients domiciled or residing in an institution, including nursing facilities, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an Intermediate Care Facility/Developmentally Disabled (ICF-DD);
c. Medicaid Recipients whose Medicaid eligibility was determined through the medically needy program,
d. Qualified Medicare Beneficiaries ("QMBs"),
e. Special Low Income Medicare Beneficiaries (SLMBs), or Qualified Individuals at Level 1 (QI-1s).
f. Title XXI-funded children with chronic conditions who are enrolled in Children's Medical Services Network,
g. Women eligible for Medicaid due to breast and/or cervical cancer.
h. Individuals eligible under a hospice-related eligibility group.

Proposed Standard/Target: 25%, based on baseline calculations utilizing the updated AHRQ methodology.

Validity:
Validity of the measure is good. A condition is considered ambulatory sensitive if provision of quality care could reduce or eliminate the need for hospitalization. Some hospitalizations will always occur due to patient non-compliance. However, Medicaid providers are expected to work with patients to increase their likelihood of compliance in addition to providing direct treatment. The measure therefore encompasses not only access to care, but to a certain extent, the providers' ability to educate their patients on the need for appropriate care. The measure is a valid measure of the access to and effectiveness of primary care and preventive treatment programs and is a nationally accepted standard for evaluating preventive care services.

The ambulatory sensitive conditions are identified using the algorithm and methodology outlined by AHRQ. AHRQ is a federal Health and Human Services agency that specifically develops methods and tools to assist governments in the evaluation of their healthcare services, from national to local levels. AHRQ is a highly respected national body that has developed survey tools and evaluation programs in use around the country and maintains a database of findings from other states that utilize their tools.

Reliability:
The reliability of the diagnoses data is high. Hospitals provide the information to AHCA and must certify that it is accurate. The ICD-9 codes are used for billing, hospital report cards etc. so hospitals have incentives to be accurate in their use of these codes. Data to link the patient to payer source is less accurate. Payer source is coded when the patient enters the hospital and may not be known or be incorrectly identified. However, there is no expectation that inaccuracies in payer classification would be related to the reason for hospitalization. Since the measure is based on the ratio of ambulatory sensitive hospitalizations out of all hospitalizations by payer type, the figure should be reliable for the purpose of this measure.

Office of Policy and Budget – July, 2008

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Service to Individuals/68501400
Measure: **New Measure -** Percent of hospitalizations of beneficiaries for conditions preventable by good ambulatory care: Ages 1 to 20 in MediPass or Fee for Service

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: This represents a replacement to the existing categories currently measured for ambulatory sensitive hospitalizations.

Data Sources and Methodology:
Inpatient hospital discharge data are used as the primary source of diagnosis and treatment of ambulatory sensitive conditions. Discharge data are matched against Medicaid eligibility files to determine Medicaid status. Data are extracted according to payer and age group. Ambulatory sensitive conditions are identified by ICD-9 diagnosis codes, using the algorithm and methodology outlined by the federal HHS Agency for Healthcare Research and Quality (AHRQ).

The population includes all enrollees aged 1 to 20 not in capitated managed care plans or Fee-for-Service PSNs. Enrollees are divided into 1-20 and over 21 age groups because the Medicaid benefit package varies for adults and children. Children under 1 year of age have almost no hospitalizations that fit these criteria. Further, many do not have established Medicaid IDs at the time of hospitalization and cannot be matched to Medicaid eligibility files. These measures therefore concentrate on the children ages 1 to 20 where appropriate. The following groups would be excluded from this measure:

a. SOBRA Pregnant women;
b. Medicaid Recipients domiciled or residing in an institution, including nursing facilities, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an Intermediate Care Facility/Developmentally Disabled (ICF-DD);
c. Medicaid Recipients whose Medicaid eligibility was determined through the medically needy program,
d. Qualified Medicare Beneficiaries ("QMBs"),
e. Special Low Income Medicare Beneficiaries (SLMBs), or Qualified Individuals at Level 1 (QI-1s).
f. Title XXI-funded children with chronic conditions who are enrolled in Children's Medical Services Network,
g. Women eligible for Medicaid due to breast and/or cervical cancer.
h. Individuals eligible under a hospice-related eligibility group.

Proposed Standard/Target: 25%, based on baseline calculations utilizing the updated AHRQ methodology.

Validity:
Validity of the measure is good. A condition is considered ambulatory sensitive if provision of quality care could reduce or eliminate the need for hospitalization. Some hospitalizations will always occur due to patient non-compliance. However, Medicaid providers are expected to work with patients to increase their likelihood of compliance in addition to providing direct treatment. The measure therefore encompasses not only access to care, but to a certain extent, the providers' ability to educate their patients on the need for appropriate care. The measure is a valid measure of the access to and effectiveness of primary care and preventive treatment programs and is a nationally accepted standard for evaluating preventive care services.

The ambulatory sensitive conditions are identified using the algorithm and methodology outlined by AHRQ. AHRQ is a federal Health and Human Services agency that specifically develops methods and tools to assist governments in the evaluation of their healthcare services, from national to local levels. AHRQ is a highly respected national body that has developed survey tools and evaluation programs in use around the country and maintains a database of findings from other states that utilize their tools.

Reliability:
The reliability of the diagnoses data is high. Hospitals provide the information to AHCA and must certify that it is accurate. The ICD-9 codes are used for billing, hospital report cards etc. so hospitals have incentives to be accurate in their use of these codes. Data to link the patient to payer source is less accurate. Payer source is coded when the patient enters the hospital and may not be known or be incorrectly identified. However, there is no expectation that inaccuracies in payer classification would be related to the reason for hospitalization. Since the measure is based on the ratio of ambulatory sensitive hospitalizations out of all hospitalizations by payer type, the figure should be reliable for the purpose of this measure.

Office of Policy and Budget – July, 2008

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Service to Individuals/68501400
Measure: **New Measure -** Percent of hospitalizations of beneficiaries for conditions preventable by good ambulatory care: Ages 21 or over in MediPass or Fee for Service

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: This represents a replacement to the existing categories currently measured for ambulatory sensitive hospitalizations.

Data Sources and Methodology:
Inpatient hospital discharge data are used as the primary source of diagnosis and treatment of ambulatory sensitive conditions. Discharge data are matched against Medicaid eligibility files to determine Medicaid status. Data are extracted according to payer and age group. Ambulatory sensitive conditions are identified by ICD-9 diagnosis codes, using the algorithm and methodology outlined by the federal HHS Agency for Healthcare Research and Quality (AHRQ).

The population includes all enrollees aged 21 or older not in capitated managed care plans or Fee-for-Service PSNs. Enrollees are divided into 1-20 and over 21 age groups because the Medicaid benefit package varies for adults and children. Children under 1 year of age have almost no hospitalizations that fit these criteria. Further, many do not have established Medicaid IDs at the time of hospitalization and cannot be matched to Medicaid eligibility files. These measures therefore concentrate on the children ages 1 to 20 where appropriate. The following groups would be excluded from this measure:

a. SOBRA Pregnant women;
b. Medicaid Recipients domiciled or residing in an institution, including nursing facilities, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an Intermediate Care Facility/Developmentally Disabled (ICF-DD);
c. Medicaid Recipients whose Medicaid eligibility was determined through the medically needy program,
d. Qualified Medicare Beneficiaries ("QMBs"),
e. Special Low Income Medicare Beneficiaries (SLMBs), or Qualified Individuals at Level 1 (QI-1s).
f. Title XXI-funded children with chronic conditions who are enrolled in Children's Medical Services Network,
g. Women eligible for Medicaid due to breast and/or cervical cancer.
h. Individuals eligible under a hospice-related eligibility group.

Proposed Standard/Target: 25%, based on baseline calculations utilizing the updated AHRQ methodology.

Validity:
Validity of the measure is good. A condition is considered ambulatory sensitive if provision of quality care could reduce or eliminate the need for hospitalization. Some hospitalizations will always occur due to patient non-compliance. However, Medicaid providers are expected to work with patients to increase their likelihood of compliance in addition to providing direct treatment. The measure therefore encompasses not only access to care, but to a certain extent, the providers' ability to educate their patients on the need for appropriate care. The measure is a valid measure of the access to and effectiveness of primary care and preventive treatment programs and is a nationally accepted standard for evaluating preventive care services.

The ambulatory sensitive conditions are identified using the algorithm and methodology outlined by AHRQ. AHRQ is a federal Health and Human Services agency that specifically develops methods and tools to assist governments in the evaluation of their healthcare services, from national to local levels. AHRQ is a highly respected national body that has developed survey tools and evaluation programs in use around the country and maintains a database of findings from other states that utilize their tools.

Reliability:
The reliability of the diagnoses data is high. Hospitals provide the information to AHCA and must certify that it is accurate. The ICD-9 codes are used for billing, hospital report cards etc. so hospitals have incentives to be accurate in their use of these codes. Data to link the patient to payer source is less accurate. Payer source is coded when the patient enters the hospital and may not be known or be incorrectly identified. However, there is no expectation that inaccuracies in payer classification would be related to the reason for hospitalization. Since the measure is based on the ratio of ambulatory sensitive hospitalizations out of all hospitalizations by payer type, the figure should be reliable for the purpose of this measure.

Office of Policy and Budget – July, 2008

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: **New Measure -** Percent of two year old children enrolled in KidCare (Title XXI) 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:
Change the standard from 85 to 90 percent to match Healthy People 2010 goals, limit the measure to two year olds only, and create a separate indicator (i.e., one each) for Medicaid and the KidCare populations.

Data Sources and Methodology:
The Department of Health, 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 Diphtheria, 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 KidCare-enrolled recipients. Then, the Department of Health, Bureau of Immunization, determines the coverage rate for KidCare-enrolled two year old children.

Proposed Standard/Target: 90 percent

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

Reliability:
Given the extensive testing of the measures, they are quite 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, 2008

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

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: This represents a replacement to the existing categories currently measured for ambulatory sensitive hospitalizations.

Data Sources and Methodology:
Inpatient hospital discharge data are used as the primary source of diagnosis and treatment of ambulatory sensitive conditions. Discharge data are matched against Medicaid eligibility files to determine Medicaid status. Data are extracted according to payer and age group. Ambulatory sensitive conditions are identified by ICD-9 diagnosis codes, using the algorithm and methodology outlined by the federal HHS Agency for Healthcare Research and Quality (AHRQ).

The target group for this measure is Medicaid beneficiaries eligible for full Medicaid benefits who reside in nursing facilities or intermediate care facilities for the developmentally disabled, or who are enrolled in a Home and Community Based waiver program. It includes all ages and beneficiaries who are dually eligible for Medicare and Medicaid. Institutional care is intended to be almost all-inclusive. Thus, the institution is responsible for coordinating care and ensuring appropriate care for its residents. Thus, regardless of which insurer is paying for the institutional care, the quality of care that the facility provides should be measured for Medicaid beneficiaries. In addition, AHCA regulates nursing facilities, and thus has added responsibility for ensuring positive health outcomes for nursing facility residents. Finally, waiver participants should not expect a lower standard of care when moving into the community and the waiver programs are designed to guarantee comparable levels of care.

Proposed Standard/Target: 25%, based on baseline calculations utilizing the updated AHRQ methodology.

Validity:
Validity of the measure is good. A condition is considered ambulatory sensitive if provision of quality care could reduce or eliminate the need for hospitalization. Some hospitalizations will always occur due to patient non-compliance. However, Medicaid providers are expected to work with patients to increase their likelihood of compliance in addition to providing direct treatment. The measure therefore encompasses not only access to care, but to a certain extent, the providers' ability to educate their patients on the need for appropriate care. The measure is a valid measure of the access to and effectiveness of primary care and preventive treatment programs and is a nationally accepted standard for evaluating preventive care services.

The ambulatory sensitive conditions are identified using the algorithm and methodology outlined by AHRQ. AHRQ is a federal Health and Human Services agency that specifically develops methods and tools to assist governments in the evaluation of their healthcare services, from national to local levels. AHRQ is a highly respected national body that has developed survey tools and evaluation programs in use around the country and maintains a database of findings from other states that utilize their tools.

Reliability:
The reliability of the diagnoses data is high. Hospitals provide the information to AHCA and must certify that it is accurate. The ICD-9 codes are used for billing, hospital report cards etc. so hospitals have incentives to be accurate in their use of these codes. Data to link the patient to payer source is less accurate. Payer source is coded when the patient enters the hospital and may not be known or be incorrectly identified. However, there is no expectation that inaccuracies in payer classification would be related to the reason for hospitalization. Since the measure is based on the ratio of ambulatory sensitive hospitalizations out of all hospitalizations by payer type, the figure should be reliable for the purpose of this measure.

Office of Policy and Budget – July, 2008

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Prepaid Health Plans/ 68501600
Measure: **New Measure -** Percent of hospitalizations of beneficiaries for conditions preventable by good ambulatory care: Ages 1-20 in full service capitated plans

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: This represents a replacement to the existing categories currently measured for ambulatory sensitive hospitalizations.

Data Sources and Methodology:
Inpatient hospital discharge data are used as the primary source of diagnosis and treatment of ambulatory sensitive conditions. Discharge data are matched against Medicaid eligibility files to determine Medicaid status. Data are extracted according to payer and age group. Ambulatory sensitive conditions are identified by ICD-9 diagnosis codes, using the algorithm and methodology outlined by the federal HHS Agency for Healthcare Research and Quality (AHRQ).

The population includes all enrollees aged 1 to 20 in capitated managed care plans. Enrollees are divided into 1-20 and over 21 age groups because the Medicaid benefit package varies for adults and children. Children under 1 year of age have almost no hospitalizations that fit these criteria. Further, many do not have established Medicaid IDs at the time of hospitalization and cannot be matched to Medicaid eligibility files. These measures therefore concentrate on the children ages 1 to 20 where appropriate. The following groups would be excluded from this measure:

a. SOBRA Pregnant women;
b. Medicaid Recipients domiciled or residing in an institution, including nursing facilities, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an Intermediate Care Facility/Developmentally Disabled (ICF-DD);
c. Medicaid Recipients whose Medicaid eligibility was determined through the medically needy program,
d. Qualified Medicare Beneficiaries ("QMBs"),
e. Special Low Income Medicare Beneficiaries (SLMBs), or Qualified Individuals at Level 1 (QI-1s).
f. Title XXI-funded children with chronic conditions who are enrolled in Children's Medical Services Network,
g. Women eligible for Medicaid due to breast and/or cervical cancer.
h. Individuals eligible under a hospice-related eligibility group.

Proposed Standard/Target: 25%, based on baseline calculations utilizing the updated AHRQ methodology.

Validity:
Validity of the measure is good. A condition is considered ambulatory sensitive if provision of quality care could reduce or eliminate the need for hospitalization. Some hospitalizations will always occur due to patient non-compliance. However, Medicaid providers are expected to work with patients to increase their likelihood of compliance in addition to providing direct treatment. The measure therefore encompasses not only access to care, but to a certain extent, the providers' ability to educate their patients on the need for appropriate care. The measure is a valid measure of the access to and effectiveness of primary care and preventive treatment programs and is a nationally accepted standard for evaluating preventive care services.

The ambulatory sensitive conditions are identified using the algorithm and methodology outlined by AHRQ. AHRQ is a federal Health and Human Services agency that specifically develops methods and tools to assist governments in the evaluation of their healthcare services, from national to local levels. AHRQ is a highly respected national body that has developed survey tools and evaluation programs in use around the country and maintains a database of findings from other states that utilize their tools.

Reliability:
The reliability of the diagnoses data is high. Hospitals provide the information to AHCA and must certify that it is accurate. The ICD-9 codes are used for billing, hospital report cards etc. so hospitals have incentives to be accurate in their use of these codes. Data to link the patient to payer source is less accurate. Payer source is coded when the patient enters the hospital and may not be known or be incorrectly identified. However, there is no expectation that inaccuracies in payer classification would be related to the reason for hospitalization. Since the measure is based on the ratio of ambulatory sensitive hospitalizations out of all hospitalizations by payer type, the figure should be reliable for the purpose of this measure.

Office of Policy and Budget – July, 2008

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Prepaid Health Plans/ 68501600
Measure: **New Measure -** Percent of hospitalizations of beneficiaries for conditions preventable by good ambulatory care: Ages 21 and over in full service capitated plans

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: This represents a replacement to the existing categories currently measured for ambulatory sensitive hospitalizations.

Data Sources and Methodology:
Inpatient hospital discharge data are used as the primary source of diagnosis and treatment of ambulatory sensitive conditions. Discharge data are matched against Medicaid eligibility files to determine Medicaid status. Data are extracted according to payer and age group. Ambulatory sensitive conditions are identified by ICD-9 diagnosis codes, using the algorithm and methodology outlined by the federal HHS Agency for Healthcare Research and Quality (AHRQ).

This population would include all eligibles 21 years of age and older in capitated managed care plans. Enrollees are divided into under and over 21 age groups because the Medicaid benefit package varies for adults and children. Children under 1 year of age have almost no hospitalizations that fit these criteria. Further, many do not have established Medicaid IDs at the time of hospitalization and cannot be matched to Medicaid eligibility files. These measures therefore concentrate on the children ages 1 to 20 where appropriate. The following groups would be excluded from this measure:

a. SOBRA Pregnant women;
b. Medicaid Recipients domiciled or residing in an institution, including nursing facilities, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an Intermediate Care Facility/Developmentally Disabled (ICF-DD);
c. Medicaid Recipients whose Medicaid eligibility was determined through the medically needy program,
d. Qualified Medicare Beneficiaries ("QMBs"),
e. Special Low Income Medicare Beneficiaries (SLMBs), or Qualified Individuals at Level 1 (QI-1s).
f. Title XXI-funded children with chronic conditions who are enrolled in Children's Medical Services Network,
g. Women eligible for Medicaid due to breast and/or cervical cancer.
h. Individuals eligible under a hospice-related eligibility group.

Proposed Standard/Target: 25%, based on baseline calculations utilizing the updated AHRQ methodology.

Validity:
Validity of the measure is good. A condition is considered ambulatory sensitive if provision of quality care could reduce or eliminate the need for hospitalization. Some hospitalizations will always occur due to patient non-compliance. However, Medicaid providers are expected to work with patients to increase their likelihood of compliance in addition to providing direct treatment. The measure therefore encompasses not only access to care, but to a certain extent, the providers' ability to educate their patients on the need for appropriate care. The measure is a valid measure of the access to and effectiveness of primary care and preventive treatment programs and is a nationally accepted standard for evaluating preventive care services.

The ambulatory sensitive conditions are identified using the algorithm and methodology outlined by AHRQ. AHRQ is a federal Health and Human Services agency that specifically develops methods and tools to assist governments in the evaluation of their healthcare services, from national to local levels. AHRQ is a highly respected national body that has developed survey tools and evaluation programs in use around the country and maintains a database of findings from other states that utilize their tools.

Reliability:
The reliability of the diagnoses data is high. Hospitals provide the information to AHCA and must certify that it is accurate. The ICD-9 codes are used for billing, hospital report cards etc. so hospitals have incentives to be accurate in their use of these codes. Data to link the patient to payer source is less accurate. Payer source is coded when the patient enters the hospital and may not be known or be incorrectly identified. However, there is no expectation that inaccuracies in payer classification would be related to the reason for hospitalization. Since the measure is based on the ratio of ambulatory sensitive hospitalizations out of all hospitalizations by payer type, the figure should be reliable for the purpose of this measure.

Office of Policy and Budget – July, 2008

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.—deletion requested.
☐ 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 enables the Agency to determine how well the facilities are doing, but is not a realistic measure of how well the Agency is doing. The facilities have ultimate control over reducing the percentage of deficiencies 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, 2008

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—deletion requested.
☐ 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, 2008

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 2 business days.**

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, 2008

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—deletion requested.
☐ 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, 2008

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—deletion requested.
☐ 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, 2008

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 the 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, 2008

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—deletion requested.
☐ 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 the facilities are doing, but is not a realistic measure of how well the Agency is doing. The facilities have ultimate control over reducing the percentage of deficiencies 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, 2008

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 to the health, safety and welfare of the public.**

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 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 clinical laboratories. The data are pulled from FRAES and reviewed by the Facility Data Analysis staff for quality control purposes. The number of facilities is obtained from FRAES.

Validity:
The Agency is committed to acting decisively and pursuing more aggressive penalties for poorly performing facilities. Data collected for this outcome enables the Agency to determine how well the facilities are doing, but is not a realistic measure of how well the Agency is doing. The facilities have ultimate control over reducing the percentage of deficiencies 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, 2008

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—deletion requested.
☐ 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 ambulatory surgical centers. 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 the facilities are doing, but is not a realistic measure of how well the Agency is doing. The facilities have ultimate control over reducing the percentage of deficiencies 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, 2008

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—deletion requested.
☐ 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 hospitals. 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 the facilities are doing, but is not a realistic measure of how well the Agency is doing. The facilities have ultimate control over reducing the percentage of deficiencies 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, 2008

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—deletion requested.
☐ 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 over which the Agency has no control. 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 over which the Agency has no control. 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, 2008

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 Health 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." Whenever such complaints are received, they are investigated.

The Agency has received no patient complaints related to health plan dumping from Fiscal Years 2003/04 through 2007/08.

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 policies and procedures. The source of the data can be independently verified and the review can be replicated by other observers—therefore it is reliable.

Office of Policy and Budget – July 2008

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, 2008

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—deletion requested.
☐ 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, 2008

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 Agency to calculate the percentages of various outcomes related to facility compliance with standards of safety and quality established by state and federal regulations.

Reliability:
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, 2008

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, 2008

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, 2008

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: **New Measure -** Percent of nursing home facilities with deficiencies posing a serious threat to the health, safety or welfare of the public against which the agency has taken administrative action.

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:
ASPEN (Automated Survey Processing Environment) Central Office is a Windows-based program that provides centralized facility and survey management. The Florida Regulatory and Enforcement System/LicenseEase (FRAES/LE) database is used to obtain the legal information about the problem at hand. ASPEN is used to calculate the number of nursing homes that have had surveys in the system with state deficiencies cited as a Class 1. If a facility has a Class 1 deficiency, this indicates that Immediate Jeopardy has been cited for one or more residents' lives within the facility. The percent of nursing homes that have been cited with deficiencies posing a serious threat to one or more residents and that the Agency has taken legal action on is calculated by (1) calculating the number of nursing homes (from FRAES/LE); (2) calculating the number of nursing homes with class 1 citations (from ASPEN); (3) joining the ASPEN data from (2) with legal data from FRAES/LE to calculate the number of nursing homes that have had a Class 1 deficiency with legal action taken; and (4) the percentage is calculated by dividing the result from (3) by (2) and then multiplying by 100%.

Validity:
The measure is based upon survey results entered into the ASPEN database and licensure and legal activity results entered into the FRAES/LE database. A Class 1 deficiency is considered a priority 1 complaint whereby the Agency not only cites a deficiency but charges a fine and may, depending on the circumstances, suspend or revoke the license. The survey results are entered into the ASPEN system by the field office staff and the legal action data is entered into the FRAES/LE system by the General Counsel's staff.

Reliability:
The measure is as reliable as the input of data into the ASPEN and FRAES/LE databases. To the extent that a survey is "missed" for data entry, it will also be missed for tracking purposes. All reports on this data are pulled directly from the joining of the ASPEN and FRAES/LE databases.

Office of Policy and Budget – July, 2008

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: **Revised Measure -** Percent of Priority 1 consumer complaints about licensed facilities and programs that are investigated within 2 business days.

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, 2008

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: **New Measure -** Percent of assisted living facilities with deficiencies posing a serious threat to the health, safety or welfare of the public against which the agency has taken administrative action.

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:
ASPEN (Automated Survey Processing Environment) Central Office is a Windows-based program that provides centralized facility and survey management. The Florida Regulatory and Enforcement System/LicenseEase (FRAES/LE) database is used to obtain the legal information about the problem at hand. ASPEN is used to calculate the number of assisted living facilities that have had surveys in the system with state deficiencies cited as a Class 1. The percent of assisted living facilities that have been cited with deficiencies posing a serious threat to one or more residents and on which the Agency has taken legal action is calculated by (1) calculating the number of assisted living facilities (from FRAES/LE); (2) calculating the number of assisted living facilities with class 1 citations (from ASPEN); (3) joining the ASPEN data from (2) with legal data from FRAES/LE to calculate the number of assisted living facilities that have had a Class 1 deficiency with legal action taken; and (4) the percentage is calculated by dividing the result from (3) by (2) and then multiplying by 100%.

Validity:
The measure is based upon survey results entered into the ASPEN database and licensure and legal activity results entered into the FRAES/LE database. A Class 1 deficiency is considered a priority 1 complaint whereby the Agency not only cites a deficiency but charges a fine and may, depending on the circumstances, suspend or revoke the license. The survey results are entered into the ASPEN system by the field office staff and the legal action data is entered into the FRAES/LE system by the General Counsel's staff.

Reliability:
The measure is as reliable as the input of data into the ASPEN and FRAES/LE databases. To the extent that a survey is "missed" for data entry, it will also be missed for tracking purposes. All reports on this data are pulled directly from the joining of the ASPEN and FRAES/LE databases.

Office of Policy and Budget – July, 2008

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: New Measure: **New Measure -** Percent of home health agencies with deficiencies posing a serious threat to the health, safety or welfare of the public against which the agency has taken administrative action.

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:
ASPEN (Automated Survey Processing Environment) Central Office is a Windows-based program that provides centralized facility and survey management. The Florida Regulatory and Enforcement System/LicenseEase (FRAES/LE) database is used to obtain the legal information about the problem at hand. ASPEN is used to calculate the number of home health agencies that have had surveys in the system with state deficiencies cited as a Class 1. If a facility has a Class 1 deficiency, this indicates that Immediate Jeopardy has been cited for one or more residents' lives within the facility. The percent of home health agencies that have been cited for deficiencies posing a serious threat to one or more residents and on which the Agency has taken legal action is calculated by (1) calculating the number of home health agencies (from FRAES/LE); (2) calculating the number of home health agencies with class 1 citations (from ASPEN); (3) joining the ASPEN data from (2) with legal data from FRAES/LE to calculate the number of home health agencies that have had a Class 1 deficiency with legal action taken; and (4) the percentage is calculated by dividing the result from (3) by (2) and then multiplying by 100%.

Validity:
The measure is based upon survey results entered into the ASPEN database and licensure and legal activity results into the FRAES/LE database. A Class 1 deficiency is considered a priority 1 complaint whereby the Agency not only cites a deficiency but charges a fine and may, depending on the circumstances, suspend or revoke the license. The survey results are entered into the ASPEN system by the field office staff and the legal action data is entered into the FRAES/LE system by the General Counsel's staff.

Reliability:
The measure is as reliable as the input of data into the ASPEN and FRAES/LE databases. To the extent that a survey is "missed" for data entry, it will also be missed for tracking purposes. All reports on this data are pulled directly from the joining of the ASPEN and FRAES/LE databases.

Office of Policy and Budget – July, 2008

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: **New Measure -** Percent of licenses that are issued or denied within 60 days following receipt of a completed application.

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 initial, renewal, and change of ownership applications in which the Agency has approved or denied licensure within 60 days of the date the application is deemed complete, divided by the total number of initial, renewal and change of ownership applications approved or denied during the period. An application is complete when all required documentation is received by the Agency including background screening, and if required, upon successful completion of a survey.

Application transaction data, including the application completion date and application decision date are stored in LicenseEase and specific codes are used to designate various transaction types.

Validity:
When a person or entity applies to the Agency to receive a license under Chapter 408, Florida Statutes, the Agency must approve or deny licensure within 60 days of the date the application is complete. Data collected for this outcome enable the Agency to determine how well it is meeting this requirement.

Reliability:
Data maintained in LicenseEase 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, 2008

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: **New Measure -** Percent of HMO complaints that are investigated and resolved within 10 business days of receipt.

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 consumer issues/complaints received by the Bureau are recorded and tracked in the Consumer Issues Tracking System.

Validity: Each analyst that handles an issue has to enter data into the tracking system. The system prompts the analyst to enter critical data. The system automatically records the dates of entry, updates and closure of an issue. The measure reported is generated by the system automatically from these entries. .

Reliability: Because the system prompts entry or automatically enters data into the system the data reported is reliable.

Office of Policy and Budget – July 2008

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: **New Measure -** Percent of plans and construction reviews completed within 60 days of receipt or scheduled date.

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:
Stage 1, 2 and 3 plan reviews are requested by those planning to build or renovate health care facilities. Such requests come by mail or are hand delivered. Mailed and hand delivered items are logged in when received. Paper reports are used to track receipts as well as closures on submissions. Hand counts are done from these paper reports.

Validity:
Rules for the Office of Plans and Construction in Chapters 59A-3, 4 and 5, Florida Administrative Code, require the office to complete review and either approve or disapprove construction documents within 60 days of receipt of properly executed documents and initial plan review fees. Consequently, this is a valid measure of a portion of the responsibility of the Office of Plans and Construction.

Reliability:
We believe the counts and logs used to track this measure are accurate. However, all systems, whether electronic or manual, are as accurate as the data entry into those systems. The Agency is working to improve an electronic data system called OPCTrack, which tracks projects for the Office of Plans and Construction, to handle this measure. Until those improvements are made, this measure will continue to be tracked manually.

Office of Policy and Budget – July 2008

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: **New Measure -** Percent of hospital emergency access violations that result in sanctions against the hospital.

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:
ASPEN (Automated Survey Processing Environment) Central Office is a Windows-based program that provides centralized facility and survey management. The Florida Regulatory and Enforcement System/LicenseEase (FRAES/LE) database is used to obtain the legal information about the problem at hand. ASPEN is used to calculate the number of hospitals that have had surveys in the system with emergency access violations. Emergency access violations are defined H0030 through H0038. H0040, H0041, H0043 through H0049, H0051, H0054, H0055, H0056 and H0063. The percent of hospitals that have been cited for emergency access violations that result in sanctions against the hospital is calculated by (1) calculating the number of hospitals (from FRAES/LE); (2) calculating the number of hospitals with emergency access violations (from ASPEN); (3) joining the ASPEN data from (2) with legal data from FRAES/LE to calculate the number of hospitals that have had an emergency access violation(s) resulting in sanctions against the hospital; and (4) the percentage is calculated by dividing the result from (3) by (2) and then multiplying by 100%.

Validity:
The measure is based upon survey results entered into the ASPEN database and licensure and legal activity results into the FRAES/LE database. An emergency access violation is considered a priority complaint whereby the Agency not only cites a deficiency but may charge a fine and may, depending on the circumstances, suspend or revoke the license. The survey results are entered into the ASPEN system by the field office staff and the legal action data is entered into the FRAES/LE system by the General Counsel's staff.

Reliability:
The measure is as reliable as the input of data into the ASPEN and FRAES/LE databases. To the extent that a survey is "missed" for data entry, it will also be missed for tracking purposes. All reports on this data are pulled directly from the joining of the ASPEN and FRAES/LE databases.

Office of Policy and Budget – July, 2008

Exhibit V:

Identification of Associated Activity Contributing to Performance Measures

Measure Number	Approved Performance Measures for FY 2008-09 (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

Measure Number	Approved Performance Measures for FY 2008-09 (Words)		Associated Activities Title
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

Measure Number	Approved Performance Measures for FY 2008-09 (Words)		Associated Activities Title
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 Director/Support Services - 68500200		
12	Program administrative costs as a percent of total program costs		Executive Direction ACT0010
13	Average number of days between receipt of clean Medicaid claim and payment		Fiscal Agent Contract ACT5260
4			
14	Number of Medicaid claims received		Fiscal Agent Contract ACT5260
47	Percent of new Medicaid recipients voluntarily selecting managed care plan		Health Facilities and Practitioner Regulation - Medicaid Choice Counseling ACT7150

Measure Number	Approved Performance Measures for FY 2008-09 (Words)		Associated Activities Title
54	Number of new enrollees provided choice counseling		Health Facilities and Practitioner Regulation - Medicaid Choice Counseling ACT7150
	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 ACT 4510 Hospital Inpatient ACT 4710
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

Measure Number	Approved Performance Measures for FY 2008-09 (Words)		Associated Activities Title
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

Measure Number	Approved Performance Measures for FY 2008-09 (Words)		Associated Activities Title
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

Measure Number	Approved Performance Measures for FY 2008-09 (Words)		Associated Activities Title
4	**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 Capitates 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

Measure Number	Approved Performance Measures for FY 2008-09 (Words)		Associated Activities Title
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

Measure Number	Approved Performance Measures for FY 2008-09 (Words)		Associated Activities Title
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

Measure Number	Approved Performance Measures for FY 2008-09 (Words)		Associated Activities Title
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
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 ACT7020

Measure Number	Approved Performance Measures for FY 2008-09 (Words)		Associated Activities Title
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

Exhibit VI:

Agency – Level Unit Cost Summary

AGENCY FOR HEALTH CARE ADMINISTRATION

SECTION I: BUDGET	FISCAL YEAR 2007-08 OPERATING	FIXED CAPITAL OUTLAY
TOTAL ALL FUNDS GENERAL APPROPRIATIONS ACT	16,802,605,680	0
ADJUSTMENTS TO GENERAL APPROPRIATIONS ACT (Supplementals, Vetoes, Budget Amendments, etc.)	(593,927,995)	0
FINAL BUDGET FOR AGENCY	16,208,677,685	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**	1,599,792	678.55	1,101,074,371	
Prepaid Health Plans - Families * **Number of case months Medicaid program services purchased**	7,352,844	154.66	1,153,457,025	
Elderly And Disabled/Fee For Service/Medipass - Hospital Inpatient * **Number of case months Medicaid program services purchased**	422,289	2,843.67	1,218,038,750	
Elderly And Disabled/Fee For Service/Medipass - Prescribed Medicines * **Number of case months Medicaid program services purchased**	422,289	1,773.89	759,816,923	
Elderly And Disabled/Fee For Service/Medipass - Physician Services * **Number of case months Medicaid program services purchased**	422,289	691.20	296,061,688	
Elderly And Disabled/Fee For Service/Medipass - Hospital Outpatient * **Number of case months Medicaid program services purchased**	422,289	531.90	227,831,220	
Elderly And Disabled/Fee For Service/Medipass - Supplemental Medical Insurance * **Number of case months Medicaid program services purchased**	285,735	2,668.49	773,393,073	
Elderly And Disabled/Fee For Service/Medipass - Early Periodic Screening Diagnosis And Treatment * **Number of case months Medicaid program services purchased**	80,344	115.47	9,410,309	
Elderly And Disabled/Fee For Service/Medipass - Patient Transportation * **Number of case months Medicaid program services purchased**	422,289	132.57	56,785,530	
Elderly And Disabled/Fee For Service/Medipass - Case Management * **Number of case months Medicaid program services purchased**	422,289	195.57	83,771,099	
Elderly And Disabled/Fee For Service/Medipass - Home Health Services * **Number of case months Medicaid program services purchased**	422,289	182.19	78,038,087	
Elderly And Disabled/Fee For Service/Medipass - Therapeutic Services For Children * **Number of case months Medicaid program services purchased**	80,344	276.76	22,554,064	
Elderly And Disabled/Fee For Service/Medipass - Hospital Insurance Benefit * **Number of case months Medicaid program services purchased**	258,034	378.28	99,005,889	
Elderly And Disabled/Fee For Service/Medipass - Hospice * **Number of case months Medicaid program services purchased**	422,289	381.34	163,341,417	
Elderly And Disabled/Fee For Service/Medipass - Private Duty Nursing * **Number of case months Medicaid program services purchased**	80,344	1,309.30	106,700,280	
Elderly And Disabled/Fee For Service/Medipass - Other * **Number of case months Medicaid program services purchased**	422,289	1,180.73	505,747,246	
Women And Children/Fee For Service/Medipass - Hospital Inpatient * **Number of case months Medicaid program services purchased**	614,680	1,370.65	854,568,311	
Women And Children/Fee For Service/Medipass - Prescribed Medicines * **Number of case months Medicaid program services purchased**	614,680	396.57	247,249,981	
Women And Children/Fee For Service / Medipass - Physician Services * **Number of case months Medicaid program services purchased**	614,680	612.01	381,574,650	
Women And Children/Fee For Service / Medipass - Hospital Outpatient * **Number of case months Medicaid program services purchased**	614,680	474.20	295,651,009	
Women And Children/Fee For Service / Medipass - Supplemental Medical Insurance * **Number of case months Medicaid program services purchased**	706	197,355.94	141,327,446	
Women And Children/Fee For Service / Medipass - Early Periodic Screening Diagnosis And Treatment * **Number of case months Medicaid program services purchased**	570,017	195.08	112,788,751	
Women And Children/Fee For Service / Medipass - Patient Transportation * **Number of case months Medicaid program services purchased**	614,680	105.83	65,981,780	
Women And Children/Fee For Service / Medipass - Case Management * **Number of case months Medicaid program services purchased**	614,680	16.35	10,195,729	
Women And Children/Fee For Service / Medipass - Home Health Services * **Number of case months Medicaid program services purchased**	614,680	210.81	131,432,963	
Women And Children/Fee For Service / Medipass - Therapeutic Services For Children * **Number of case months Medicaid program services purchased**	614,680	108.11	67,401,190	
Women And Children/Fee For Service / Medipass - Clinic Services * **Number of case months and Medicaid program services purchased**	614,680	152.14	94,857,838	
Women And Children/Fee For Service / Medipass - Other * **Number of case months Medicaid program services purchased**	614,680	605.81	377,707,725	
Medically Needy - Hospital Inpatient * **Number of case months Medicaid program services purchased**	18,607	8,405.62	158,641,794	
Medically Needy - Prescribed Medicines * **Number of case months Medicaid program services purchased**	18,607	5,731.84	108,178,837	
Medically Needy - Physician Services * **Number of case months Medicaid program services purchased**	18,607	2,170.26	40,959,991	
Medically Needy - Hospital Outpatient * **Number of case months Medicaid program services purchased**	18,607	2,434.84	45,953,460	
Medically Needy - Supplemental Medical Insurance * **Number of case months Medicaid program services purchased**	2,520	1,870.61	4,781,409	
Medically Needy - Early Periodic Screening Diagnosis And Treatment * **Number of case months Medicaid program services purchased**	2,647	182.79	490,759	
Medically Needy - Patient Transportation * **Number of case months Medicaid program services purchased**	18,607	108.77	2,052,917	
Medically Needy - Case Management * **Number of case months Medicaid program services purchased**	18,607	79.41	1,498,810	
Medically Needy - Home Health Services * **Number of case months Medicaid program services purchased**	18,607	109.14	2,059,870	
Medically Needy - Therapeutic Services For Children * **Number of case months Medicaid program services purchased**	2,647	16.76	45,000	
Medically Needy - Other * **Number of case months Medicaid program services purchased**	18,607	55,038.14	1,038,751,648	
Refugees - Hospital Inpatient * **Number of case months Medicaid program services purchased**	10,029	314.64	3,200,729	
Refugees - Prescribed Medicines * **Number of case months Medicaid program services purchased**	10,029	42,566.14	433,005,600	
Refugees - Physician Services * **Number of case months Medicaid program services purchased**	10,029	300.68	3,058,664	
Refugees - Hospital Outpatient * **Number of case months Medicaid program services purchased**	10,029	150.63	1,532,333	
Refugees - Early Periodic Screening Diagnosis And Treatment * **Number of case months Medicaid program services purchased**	657	229.89	153,199	
Refugees - Patient Transportation * **Number of case months Medicaid program services purchased**	10,029	2.99	30,429	
Refugees - Case Management * **Number of case months Medicaid program services purchased**	10,029	0.55	5,579	
Refugees - Home Health Services * **Number of case months Medicaid program services purchased**	10,029	9.68	98,514	
Refugees - Therapeutic Services For Children * **Number of case months Medicaid program services purchased**	657	0.44	294	
Refugees - Other * **Number of case months Medicaid program services purchased**	10,029	170.28	1,732,179	
Nursing Home Care * **Number of case months Medicaid program services purchased**	76,868	32,223.38	2,512,396,858	
Home And Community Based Services * **Number of case months Medicaid program services purchased**	63,052	17,137.29	1,096,005,239	
Intermediate Care Facilities For The Developmentally Disabled - Sunland Centers * **Number of case months Medicaid program services purchased**	727	141,332.59	104,219,346	
Mental Health Disproportionate Share Program * **Number of case months Medicaid program services purchased**	612	99,671.06	61,871,711	
Long Term Care - Other * **Number of case months Medicaid program services purchased**	29,232	19,972.33	592,186,927	
Purchase Medikids Program Services * **Number of case months**	27,986	1,765.73	50,123,040	
Purchase Children's Medical Services Network Services * **Number of case months**	15,218	6,818.99	105,256,510	
Purchase Florida Healthy Kids Corporation Services * **Number of case months**	189,608	1,401.10	269,462,299	
Certificate Of Need/Financial Analysis * **Number of certificate of need (CON) requests/financial reviews conducted**	1,100	1,969.53	2,197,489	
Health Facility Regulation (compliance, Licensure, Complaints) - Tallahassee * **Number of licensure/certification applications**	35,651	518.97	18,766,562	
Facility Field Operations (compliance, Complaints) - Field Offices Survey Staff * **Number of surveys and complaint investigations**	68,538	780.69	54,272,842	
Health Standards And Quality * **Number of transactions**	2,333,307	2.44	5,773,969	
Plans And Construction * **Number of reviews performed**	5,270	1,371.45	7,330,988	
Managed Health Care *	264	22,402.64	5,998,943	
Organ And Tissue Donor * **Number of donor designations**	1,634,137	0.21	343,037	
Background Screening * **Number of requests for screenings**	62,907	17.62	1,123,971	
Subscriber Assistance Panel * **Number of cases**	517	2,336.54	1,225,281	
Health Facilities And Practitioner Regulation - Medicaid Choice Counseling * **Number of new enrollees provided choice counseling**	167,080	52.56	8,907,591	
TOTAL			16,239,458,962	

SECTION III: RECONCILIATION TO BUDGET	
PASS THROUGHS	
TRANSFER - STATE AGENCIES	
AID TO LOCAL GOVERNMENTS	
PAYMENT OF PENSIONS, BENEFITS AND CLAIMS	
OTHER	234,619,446
REVERSIONS	22,894,175
TOTAL BUDGET FOR AGENCY (Total Activities + Pass Throughs + Reversions) - Should equal Section I above. (4)	16,496,972,583

SCHEDULE XI/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.

Administrative Procedures Act: Chapter 120, Florida Statutes. This Chapter provides statutory guidelines for state agency rulemaking, judicial review, activities of the Division of Administrative Hearings, attorneys' fees, meeting notice requirements for public meetings, rule challenges, agency investigations and other state agency administrative activities.

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.

Capitated Dental Plans: Dental plans for which payments are capitated.

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.

Cerebral Palsy: The term cerebral palsy refers to any one of a number of neurological disorders that appear in infancy or early childhood and permanently affect body movement and muscle coordination but don't worsen over time. Even though cerebral palsy affects muscle movement, it isn't caused by problems in the muscles or nerves. It is caused by abnormalities in parts of the brain that control muscle movements.

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

Choice Counseling Program: A program to empower eligible Medicaid beneficiaries to select a Medicaid pilot health plan that best meets their individual health care needs through the use of trained choice counselors.

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: These are serious conditions or occurrence in a nursing home or assisted living facilities that have compromised the residents 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.

District Managed Care Ombudsman Committees: Volunteer committees established in all areas where the Agency maintains Health Quality Assurance offices to serve as consumer advocates and to assist consumers with obtaining services from their HMOs.

Eligibility for Medicaid Reform: During the initial phase, participation in Medicaid Reform was mandatory for two eligibility groups currently covered by Florida Medicaid. The first group is the 1931 eligibles and related group, herein referred to as the TANF and TANF-related eligibility group. The second is the Aged and Disabled group.

Emergency Status System (ESS): A Web-based system developed by the Agency for reporting and tracking health care facility status before, during and after an emergency.

EmpoerRx: A prescription drug innovation using hand-held wireless devices by physicians.

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.

Family and Supported Living Waiver: A specific program to provide services to individuals with developmental disabilities to assist them to live in their home or the community.

Familial Dysautonomia: Familial dysautonomia is a genetic disorder that affects the development and survival of certain nerve cells. The disorder disturbs cells in the autonomic nervous system, which controls involuntary actions such as digestion, breathing, production of tears, and the regulation of blood pressure and body temperature. It also affects the sensory nervous system, which controls activities related to the senses, such as taste and the perception of pain, heat, and cold.

Familial Dysautonomia Waiver: A specific program to provide needed services to individuals diagnosed with Familial Dysautonomia.

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.

Hemophilia: A rare inherited bleeding disorder. The blood does not clot normally. Persons with hemophilia may bleed for a longer time following an injury.

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

Lock-in Program: A prescription drug program to prevent over utilization of pharmaceuticals.

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 Pilot: See Medicaid Reform below.

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.

Medication Therapy Management Program: A prescription drug program used to generate data on the prescription of drugs for specific diseases.

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.

1115 Waiver: Deviation from the requirements of s. 1115 of the Social security Act

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

PDL: Preferred Drug List

PMPM: Per member per month

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

Prader-Willi Syndrome: PWS is an uncommon genetic disorder. It causes poor muscle tone, low levels of sex hormones and a constant feeling of hunger. The part of the brain that controls feelings of fullness or hunger does not work properly in people with PWS. They overeat, leading to obesity.

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

Service: See Budget Entity.

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.

Spina Bifida: Spina bifida is a birth defect that involves the incomplete development of the spinal cord or its coverings. The term spina bifida comes from Latin and literally means "split" or "open" spine. Spina bifida occurs at the end of the first month of pregnancy when the two sides of the embryo's spine fail to join together, leaving an open area. In some cases, the spinal cord or other membranes may push through this opening in the embryo's back. The condition can typically be detected before a baby is born and treated right away.

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.

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

Title XXI Programs: State Children’s’ Health Insurance Programs under Section 21 of the Social Security Act.

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)

XML Schema: It is a description of a type of XML document, typically expressed in terms of constraints on the structure and content of documents of that type, above and beyond the basic syntactical constraints imposed by XML itself. An XML schema provides a view of the document type at a relatively high level of abstraction.