CHARLIE CRIST
GOVERNOR

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

HOLLY BENSON
SECRETARY

September 30, 2009

Jerry L. McDaniel, Director
Office of Policy and Budget
Executive Office of the Governor
1701 Capitol
Tallahassee, FL 32399-0001

JoAnne Leznoff, Council Director
House Full Appropriations Council on General Government and Health Care
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Tallahassee, FL 32399-1300

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Cynthia Kelly, Staff Director
Senate Policy and Steering Committee on Ways and Means
201 Capitol
Tallahassee, FL 32399-1300

Dear Directors:

Pursuant to Chapter 216, Florida Statutes, our Long Range Program Plan (LRPP) for the Agency for Health Care Administration is submitted in the format prescribed in the budget instructions. The information provided electronically and contained herein is a true and accurate presentation of our mission, goals, objectives and measures for the Fiscal Year 2010-2011 through Fiscal Year 2014-2015. This submission has been approved by Holly Benson, Secretary of the Agency for Health Care Administration.

Sincerely,

Holly Benson
Secretary

HB/mt/jt
Enclosure

2727 Mahan Drive • Mail Stop #1
Tallahassee, FL 32308

Agency for Health Care Administration

Long Range Program Plan

FY 2010 - 2011 through FY 2014 - 2015

AHCA

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Agency for Health Care Administration's

Agency Management Team

Agency Secretary ..... Holly Benson
(850) 922-3809

Chief of Staff ..... Tom Arnold
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Deputy Secretary for Health Quality Assurance ..... Elizabeth Dudek
(850) 414-9796

Deputy Secretary for Medicaid ..... Dyke Snipes
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Deputy Secretary of Operations ..... Karen Zeiler
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General Counsel ..... Justin Senior
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Inspector General ..... Peter Williams
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Director of Communications ..... Sue Conte
(850) 922-5583

Director of Legislative Affairs ..... James McFaddin
(850) 922-5584

Director of the Florida Center for Health Information and Policy Analysis ..... Christine Nye
(850) 922-7036

Director for Information Technology ..... Robert Fields
(850) 921-7922

Medicaid Key Personnel

Health Care Services
(Division of Medicaid**)**

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

- Assistant Deputy Secretary for Medicaid Operations ..... Christine Osterlund (850) 488-3560

- Assistant Deputy Secretary for Medicaid Finance .....Phil Williams (850) 488-3560

Bureaus .....**Bureau Chiefs**
Medicaid Contract Management..... Alan Strowd (850) 922-2726

Medicaid Health Systems Development .....Melanie Brown-Woofter (850) 487-2355

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

Medicaid Pharmacy Services .....Anne Wells (850) 487-4441

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Medicaid Program Analysis ..... Michele Hudson (850) 414-2756

Medicaid Area Offices ..... Christine Osterlund (850) 488-3560
..... Fran Nieves (239) 338-2620

Area Offices **Field Office Managers**
Area 1 .....Amber Vaughn (850) 595-5700
Area 2a .....Ernie Brewer (850) 872-7690
Area 2b .....Ernie Brewer (850) 921-8474
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Area 3b ..... Marilynn Schlott (386) 418-5350
Area 4 .....Lisa Broward (904) 353-2100
Area 5 ..... Don Fuller, Acting (727) 552-1191
Area 6 ..... Sue McPhee (813) 871-7600
Area 7 .....Karen Monson (407) 317-7851
Area 8 ..... Fran Nieves (941) 338-2620
Area 9 .....Mark Pickering (561) 616-5255
Area 10 .....Rafael Copa (954) 202-3200
Area 11 ..... Rhea Gray (305) 499-2000

Health Quality Assurance Key Personnel

(Division of Health Quality Assurance)

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

Bureaus	**Bureau Chiefs**
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Plans and Construction	Skip Gregory (850) 487-0713
Managed Health Care	Thomas Warring (850) 922-6830
Long Term Care Services	Molly McKinstry (850) 414-9707
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Area Offices	**Field Office Managers**
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Area 5/6	Pat Reid-Caufman (727) 552-1133
Area 7	Diane King (407) 245-0850
Area 8	Harold Williams (239) 338-2366
Area 9/10	Arlene Mayo-Davis (561) 480-0156
Area 11	Steve Emling (305)-499-2165

Executive Direction, and Administration and Support Key Personnel

www.fdhc.state.fl.us/

Executive Direction

Agency Secretary.....Holly Benson (850) 922-3809
Chief of Staff ..... Tom Arnold (850) 922-5583

- Division of Communications and Legislative Affairs
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  - Chief Appellant Counsel ..... Tracy Cooper (850) 922-5873
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- Inspector General.....Peter Williams (850) 921-4897
  - Medicaid Program Integrity.....Ken Yon (850) 921-1802
  - Internal Audit .....Michael Blackburn (850) 414-5419
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  - HIPAA Privacy and Security Compliance..... John Collins (850) 487-9906

- Florida Center for Health Information and Policy Analysis

  Director .....Christine H. Nye (850)922-7036

  - Health Policy and Research. .....Heidi Fox (850) 922-3012
  - Data Collection, Data Quality, & Patient Safety Patrick Kennedy (850) 922-5531
  - Data Dissemination & Communication ..... Beth Eastman (850) 922-3803
  - Health Information Technology..... Christopher Sullivan, PhD (850) 414-542

- Division of Operations

  Deputy Secretary..... Karen Zeiler (850) 922-5583
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  - Budget Office.....Michele Tallent (850) 922-8414
  - Finance & Accounting.....Paula Shirley (850) 488-5869
  - Human Resources..... James Haynes (850) 922-8435
  - Support Services ..... Cathy McEachron (850) 921-4406

- Division of Information Technology (Proposed)

  Director.....Robert Fields (850) 921-7922

  - Enterprise Infrastructure ..... Andrew Burgess (850) 922-5593
  - Customer Service and Support..... John Edwards (850) 922-3615
  - Strategic Planning and Security..... Scott Ward (850) 922-2817
  - Application Development and Support ..... Ken Walker (850) 922-0992

Agency Mission and Goals

MISSION

Better Health Care for all Floridians

VISION

A health care system that empowers consumers, that rewards personal responsibility and where patients, providers and payers work for better outcomes at the best price

VALUES

Accountability – We are responsible, efficient and transparent.

Fairness – We treat people in a respectful, consistent and objective manner.

Responsiveness – We address people's needs in a timely, effective, and courteous manner.

Teamwork – We collaborate and share our ideas.

Secretary's Priorities

1. To make the Agency an employer of choice where employees believe their work is meaningful, that their opinions matter and that their efforts are recognized.

2. To ensure that patients in Florida's health care facilities are safe.

3. To ensure that Medicaid beneficiaries get access to the services they need and have improved health outcomes.

4. To ensure that all health care consumers are empowered with information to make informed choices about their health care and that technology is used efficiently and cost-effectively to share health information with patients and providers.

5. To ensure that the Agency treats providers as partners in the effort to provide better health care and that they are regulated fairly.

6. To use taxpayers' resources as efficiently and effectively as possible and to safeguard those resources from fraud.

7. To create a workplace that exemplifies the values of accountability, fairness, responsiveness and teamwork.

Agency Goals Listed in Order of Priority

Priority	Agency Goal	Goal Description	Program
1.	**Goal 1**	To ensure that Medicaid beneficiaries get access to the services they need and have improved health outcomes.	Health Care Services (Division of Medicaid)
2.	**Goal 2**	To maximize 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 are able to make informed choices about their health care while utilizing technology efficiently and effectively to share health information with patients and providers.	Administration and Support (Florida Center for Health Information and Policy Analysis)
4.	**Goal 4**	To combat fraud 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)
6	**Goal 6**	To provide innovative and cost effective technology solutions in support of routine and emergency operations while maintaining an excellent level of customer service through the retention of quality staff.	Information Technology

Agency Objectives

Health Care Services
Division of Medicaid

Goal 1: To ensure that Medicaid beneficiaries get access to the services they need and have improved health outcomes.

Objective 1.A: To limit the growth in the per-member per-month (PMPM) expenditures to eight percent or less under the Medicaid Reform 1115 Waiver. (The initial waiver was implemented in July 1, 2006, and expires June 30, 2011)

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.

Objective 1.C: To slow the growth in long-term care expenditures by $295 million by converting a portion of the institutional care budget to community-based long-term care, by FY 2014-2015.

Objective 1.D: To increase beneficiaries reported satisfaction with access to specialty care services to 85 percent by FY 2014-2015.

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 2014-2015.

Health Care Regulation
Division of Health Quality Assurance

Goal 2: To maximize 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 all facility license renewal applications electronically via the Internet by FY 2014-2015.

Objective 2.B To reduce the volume of Health Facility Regulation public record requests handled using Agency resources by 50 percent by FY 2014-2015.

Objective 2.C To reduce the numbers of uninsured Floridians by 500,000 lives by FY 2014-2015 by increasing the numbers of uninsured Floridians who obtain health insurance under Cover Florida and Florida Health Choices, Inc.

Executive Direction, and Administration and Support

Florida Center for Health Information and Policy Analysis

Goal 3: To increase the availability of transparent health care data and information so consumers are able to make informed choices about their health care while utilizing technology efficiently and effectively to share health information with patients and providers.

> **Objective 3.A:** To shorten the length of time required to process and post certified patient data on the Agency for Health Care Administration's (Agency) website, www.FloridaHealthFinder.gov from 485 days to a maximum of 158 days by FY 2014-2015.
>
> **Objective 3.B:** To increase the average daily number of persons who visit www.FloridaHealthFinder.gov by 10 percent annually through FY 2014-2015
>
> **Objective 3.C:** To increase the percentage of prescriptions submitted electronically in Florida at a rate of 75 percent increase per year through FY 2014-2015.

Inspector General

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

> **Objective 4:** To increase by eight percent in FY 2010-2011 the recoveries identified from Medicaid Program Integrity (MPI) prevention and detection activities and increase recovery identification by nine percent for subsequent years through FY 2014-2015.

Division of Communications and Legislative Affairs

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.

> **Objectives 5.A:** To increase by two percent annually, through FY 2014-2015, the number of contacts made through the Agency's Communications and Legislative Affairs offices 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.

Division of Information Technology

Goal 6: To provide innovative and cost effective technology solutions in support of routine and emergency operations while maintaining an excellent level of customer service through the retention of quality staff.

Objective 6.A: To ensure 100 percent of the Division of Information Technology's (I.T.) projects align with the Agency for Health Care Administration's "AHCA-celerate" initiative by FY 2014-2015. (The AHCA-celerate initiative was chartered in November 2008 to reduce unnecessary regulation and to allow technology to become a solution to streamlined business process improvements within the agency)

Objective 6.B: By FY 2012-2013, to provide 100 percent customer service, at all times, to all people and organizations that interact with or depend on the Division of Information Technology for technology support and solutions.

Objective 6.C: By FY 2014-2015 to achieve staff retention rate of 92 percent through use of improved training opportunities, better work environment, and total compensation.

Objective 6.D: To maintain a 99.99 percent up-time availability of critical network services during normal business operations through FY 2014-2015.

Objective 6.E: To extend remote computing capabilities to 70 percent of appropriate users by FY 2014-2015 so that the Agency may continue to operate in the event of a disaster or pandemic.

Objective 6.F: By FY 2011-2012 to identify and *secure* 100 percent of confidential or sensitive data that resides on, or passes through, *the Agency for Health Care Administration's Network Services*.

Objective 6.G: By FY 2012-2013 to be 100 percent complete in the development, piloting, and implementation of comprehensive Information Technology Risk Management Program.

Agency Service Outcomes and Performance Projection Tables

Service Outcome Measure 1.A: Target weighted per-member per-month (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 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015
Projected PMPM with 8% Growth $328.24	$413.48	$446.56	$482.29*	$520.87*	$606.95*
Actual PMPM $269.89	$339.98	$367.18	$396.55	$428.27	$462.53

*Assumes Waiver is renewed for additional years

Service Outcome Measure 1.B: Percent of outcome measures 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 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015
Number of outcome measures 33	30	12	12	20	20
Number of outcome measures maintained or improved N/A	N/A	N/A	10	N/A	N/A
Percent of outcomes maintained or improved	N/A	N/A	83%	N/A	N/A

Baseline/Year FY 2007-2008	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015
N/A					

Of the 33 existing measures, in the baseline year, four of them are no longer valid. In addition, only 12 of the remaining 29 measures are actual outcomes (i.e., performance measures). The 17 other measures are output measures, or counts, that do not have relevant performance goals attached. The Agency has submitted a budget amendment to revise and update the measures to bring them more in line with programmatic goals. Under that amendment, the total number of performance/outcome measures will equal 20 through deletion, revision or replacement of existing measures. That amendment is still pending. Of the 12 measures in FY 2010-2011 that are actual outcome measures, Medicaid improved or maintained on 10 (83 percent).

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 2005-2006	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015
Current LTC Projections $2,423	$2,552	$2,596	$2,641	$2,686	$2,732
Revised LTC Projections $2,294	$2,345	$2,362	$2,379	$2,396	$2,437
LTC Savings $129	$207	$234	$262	$290	$295

Table excludes Medicare nursing home crossover payments.

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 2005-2006	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015
Percent of MediPass patients who reported satisfaction with access to specialty care. 68%	75%	77%	80%	83%	85%

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

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

Baseline/Year FY 2003-2004	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015
Services/programs with consumer directed incentives 1	2	3	3	4	4

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

Service Outcome Measure Projection Table 2.A:

Baseline/Year FY 2008-2009	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015
Average annual number of renewal applications 8,649	1,730	3,460	5,190	6,920	8,649
Percent applications received via Internet 0%	20%	40%	60%	80%	100%

The Agency currently receives all applications from health care facilities in paper copy, including renewals. Each form must be signed and, depending upon the program, some must also be notarized before they can be accepted. To accept electronic applications over the Internet, the Agency must establish a web based linking program connected to FRAES/LicenseEase (the licensure tracking and regulatory system database) 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 (Chapter408, 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. 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 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" (web based) programming to implement on-line licensure applications. It is reasonable to expect the system will be implemented in late CY 2009 or CY 2010. Consequently, we anticipate a 100 percent e-renewal application rate by FY 2014-2015.

Objective 2.B: To reduce the volume of Health Facility Regulation public record requests handled using Agency resources by 50 percent by FY 2014-2015

Service Outcome Measure 2.B: The number of public records requests handled by the Agency's Division of Health Quality Assurance.

Service Outcome Measure Projection Table 2.B:

Baseline/Year FY 2008-2009	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015
Number of public record requests handled by the Division of Health Quality Assurance 3,207	2,886	2,556	2,245	1,938	1,604
Percentage reduction in the public records requests handled by the Division of Health Quality Assurance	10%	20%	30%	40%	50%

This service measure relates to streamlining Agency operations to enable increased productivity with existing FTE (full time equivalent position) resources. Failure to streamline operations will result in the need to increase staffing to meet the increasing demands of licensure and regulation programs. Automation of document management is one way in which streamlining has been accomplished. All segments of the automated document management system have been implemented in the Division of Health Quality Assurance. We have seen a very small reduction from 3,723 in FY 2003-2004 to 3,207 in Fiscal Year (FY) 2008-2009 in the numbers of public information requests made to the Division, but public information requests have still not been reduced to the levels originally anticipated. 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. Toward the middle of FY 2008-2009, the Agency placed all of its inspection reports online in a publicly available, searchable database attached to FloridaHealthFinder.gov. This site is refreshed nightly from the License Ease data base.

Service Outcome Measure 2.C: The number of additional lives covered by health insurance.

Service Outcome Measure Projection Table 2.C:

Baseline Year FY 2008-2009	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015
The number of Uninsured Floridians that have obtained insurance under AHCA sponsored programs 3,757	100,000	200,000	300,000	400,000	500,000

The Agency has determined that the objective of increasing the numbers of Health Flex plans available to the public is not a viable option. Even though the CY 2008 Florida Legislature amended the law to increase the income level of eligible Health Flex plan enrollees from 200 percent of the poverty level to 300 percent, the number of plans in Florida has declined by one. In view of the failure of Health Flex plans to decrease the numbers of uninsured Floridians, the Governor and the Legislature each supported additional options for increasing health care insurance during the CY 2008 legislative session. One of these opportunities to increase health insurance is the Cover Florida Program, developed by Governor Crist. The other is the Florida Health Choices Corporation, designed by the Legislature. Both are now operational and will be discussed further under Trends and Conditions.

Service Outcome Measure 3.A: The average number of days between receipt of certified patient data and posting that data on the Agency's website, www.FloridaHealthFinder.gov.

Service Outcome Measure Projection Table 3.A:

Baseline/ Year FY 2005-2006	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015
Number of days from data receipt to posting on website 485	388	310	248	198	158
Percent Decrease in days to post data on website 0%	20%	20%	20%	20%	20%

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 www.FloridaHealthFinder.gov.)

Service Outcome Measure Projection Table 3.B:

Baseline/Year FY 2006-2007	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015
Average daily number of web site visits per day 3,107	4,136	4,550	5,005	5,505	6,055
Annual percent increase in the number of sessions begun per day 10	10%	10%	10%	10%	10%

Service Outcome Measure 3.C: The percentage of new and refill prescriptions that are sent electronically as a percentage of all prescriptions.

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 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015
Percentage of Florida prescriptions that are sent electronically 1.7%	9.1%	15.9%	27.9%	48.8%	85.4%
Annual percent of increase in the percentage of electronic prescriptions 75%	75%	75%	75%	75%	75%

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

Service Measure Projection Table 4:

Baseline/Year FY 2003-2004	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015
Actual Collections* $16,674,293 for FY 2003-2004 projections for future FYs	$28.6 mil	$31.1 mil	$34 mil	$37 mil	$40 mil
Projected Increase %	8%	9%	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.

Service Outcome Measure 5.A. (1): The number of external information requests received and processed by the Agency's Communications Office.

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

Baseline/Year FY 2006-2007	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015
Number of correspondence pieces tracked by the Agency's Correspondence Unit 6,234	7,102	7,244	7,389	7,536	7,686
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 2003-2004	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015
Number of constituent and legislative inquiries handled by the Legislative Affairs Office 489	540	550	561	573	584

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) (c):

Baseline/Year FY 2006-2007	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015
Number of legislative bills tracked and analyzed 277	312	318	325	331	337
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 contacts received by the Communications Office from media representatives.

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

Baseline/Year FY 2007-2008	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015
Number of 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%

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 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015
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.

Service Outcome Measure 6.A: The percentage of Information Technology's (I.T.) projects that align with the Agency for Health Care Administration's "AHCA-celerate" initiatives.

Service Measure Projection Table 6.A:

Baseline Year FY 2008–2009	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015
Percentage of alignment of new I.T. Developments with newly recognized Business Process efficiency initiatives 10%	35%	60%	90%	100%	100%

Service Outcome Measure 6.B: Percentage of all customers with at least one substantive interaction with the Division of Information Technology rating their experience as "satisfied or higher" based on the averaged results of all customer satisfaction surveys for the fiscal year.

Service Measure Projection Table 6.B:

Baseline Year FY 2008–2009	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015
Measured percentage of all customers with at least one substantive interaction with the Division of IT who rate their experience as "satisfied or higher" based on survey results for current fiscal year 97%	98%	99%	100%	100%	100%

Service Outcome Measure 6.C: Information Technology's annual retention rate. (A Legislative Budget Request (LBR) will be submitted to address Information Technology's staff retention efforts.)

Service Measure Projection Table 6.C:

Baseline/Year FY 2009–2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015
Information Technology's annual retention rate. 87%	88%	89%	91%	91%	92%

Retention rate – The number of qualified staff, expressed as a percentage, who remain employed by the Agency from year to year.

Service Outcome Measure 6.D: Percent of availability of critical network services ("up-time") to authorized users during normal business operations.

Service Measure Projection Table 6.D: (Mission critical network services are: enterprise E-mail, Active Directory, network firewalls and related systems, and network shares/user shares.)

Baseline/Year FY 2009–2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015
Percent of measured up-time ability to provide availability of critical network services 99.99%	99.99%	99.99%	99.99%	99.99%	99.99%

Service Outcome Measure 6.E: Percentage Agency staff prepared for remote mobility to perform mission essential functions in the event of a disaster or pandemic.

Service Measure Projection Table 6.E:

Baseline/Year FY 2009–2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015
Percentage Agency staff prepared for remote mobility to perform mission essential functions in the event of a disaster or pandemic. 35%	42%	49%	56%	63%	70%

The Agency's goal is to have 70 percent of its work force equipped to work remotely by CY 2015, as needed, in the event of a disaster or pandemic. Currently, 35 percent of the AHCA work force is able to perform routine duties remotely (based on estimates – approximately 595 of 1700 staff are equipped to work remotely). The five-year plan requires that 119 personal computers (PC) a year (or seven percent each year) is upgraded to a mobile computing platform, either through virtual PC technologies or hardware replacement (replacing PCs with laptops).Service Outcome Measure

Service Measure Projection Table 6.F:

Baseline/Year FY 2009–2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015
The percentage of Agency for Health Care Administration secured e-mail verified through e-mail encryption server reporting. 85%	95%	100%	100%	100%	100%

Secure against disclosure – data shall be secured against the variety of threats currently in existence. Specifically:

- Intentional efforts to destroy, alter, or steal data through 'cybercrime' (hacking, Trojan horse programs, communication interception, etc.);
- Intentional, external efforts to destroy, alter, or steal data through human efforts (illegal physical access to the site, falsification or theft of valid credentials, etc.);
- Intentional, internal efforts to destroy, alter, or steal data by authorized personnel or outside persons and complicit authorized staff;
- Accidental disclosure of data through human action (failure to follow security protocol, loss of portable storage devices, etc.); and,
- Other threats as may be identified in rapidly evolving technology environment.

  Designated systems are E-mail networked file storage ("shares"), enterprise relational database management systems.

Service Outcome Measure 6.G (1): Progress towards completion of developing, piloting, and implementation of the Risk Management Program. (The progress of this initiative will be measured by Microsoft Project Server which can measure how many IT projects have a risk management component in IT project planning.)

Service Measure Projection Table 6.G (1):

Baseline/Year FY 2009–2010	FY 2010–2011	FY 2011–2012	FY 2012–2013	FY 2013–2014	FY 2014–2015
Progress towards completion of developing, piloting, and implementation of the Risk Management Program. 5%	50%	90%	100%	100%	100%

Service Outcome Measure 6.G (2): Ratio of *risks realized* to *risks prior-identified* through proper implementation of the IT risk management program. (In order to measure this outcome measure, the division will need to include risk management plans with each IT project and measure it through Microsoft Project Server and show the percentage from the statistics gathered through project planning reports. This risk management initiative commenced in FY 2008-2009)

Service Measure Projection Table 6.G (2):

Baseline/Year FY 2009–2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015
Ratio of *risks realized* to *risks prior-identified* through proper implementation of the IT risk management program N/A	N/A	N/A	50%	75%	90%

IT Risks realized – "risks realized" are those events which materially affect: a Division project, the execution of routine division responsibilities, or the fundamental elements of the division itself (thereby jeopardizing the division's ability to fulfill its duties, such as wholesale

replacement of leadership, significant budget cuts or layoffs. Specifically, risks realized are those events defined by the Risk Management Program's Risk Classifications as "Risks."

Linkage to Governor's Priorities

	Governor's Priorities	Agency Goals and Programs
1.	Protecting Our Communities	**Goal 4:** To combat fraud, and abuse in the Florida Medicaid Program **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	**Goal 4:** To combat fraud, and abuse in the Florida Medicaid Program
4.	Success for Every Student	
5.	Keeping Floridians Healthy	**Goal 1**: To ensure that Medicaid beneficiaries get access to the services they need and have improved health outcomes. **Goal 2**: To maximize the use of Agency resources by increasing the efficiency and effectiveness of Agency operations to achieve required outcomes and eliminate unnecessary health facility regulations. **Goal 3:** To increase the availability of transparent health care data and information so consumers are able to make informed choices about their health care while utilizing technology efficiently and effectively to share health information with patients and providers. **Goal 4:** To combat fraud, and abuse in the Florida Medicaid Program **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.

		Goal 6: To provide innovative and cost effective technology solutions in support of routine and emergency operations while maintaining an excellent level of customer service through the retention of quality staff.
6.	Protecting Florida's Natural Resources	

Linkage of Agency and Division Goals to the Secretary's Priorities

	Secretary's Priorities	Agency/Division Goals
1	To make the Agency an employer of choice where employees believe their work is meaningful, that their opinions matter and that their efforts are recognized.	**Goal 4:** To combat fraud, and abuse in the Florida Medicaid Program **Goal 6:** To provide innovative and cost effective technology solutions in support of routine and emergency operations while maintaining an excellent level of customer service through the retention of quality staff.
2	To ensure that patients in Florida's health care facilities are safe.	**Goal 4:** To combat fraud, and abuse in the Florida Medicaid Program **Goal 6:** To provide innovative and cost effective technology solutions in support of routine and emergency operations while maintaining an excellent level of customer service through the retention of quality staff.
3	To ensure that Medicaid beneficiaries get access to the services they need and have improved health outcomes.	**Goal 1:** To ensure that Medicaid beneficiaries get access to the services they need and have improved health outcomes. **Goal 2:** To maximize the use of Agency resources by increasing the efficiency and effectiveness of Agency operations to achieve required outcomes and eliminate unnecessary health facility regulations. **Goal 6:** To provide innovative and cost effective technology solutions in support of routine and emergency operations while maintaining an excellent level of customer service through the retention of quality staff.

4	To ensure that all health care consumers are empowered with information to make informed choices about their health care and that technology is used efficiently and cost-effectively to share health information with patients and providers.	**Goal 2:** To maximize the use of Agency resources by increasing the efficiency and effectiveness of Agency operations to achieve required outcomes and eliminate unnecessary health facility regulations. **Goal 3:** To increase the availability of transparent health care data and information so consumers are able to make informed choices about their health care while utilizing technology efficiently and effectively to share health information with patients and providers. **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. **Goal 6:** To provide innovative and cost effective technology solutions in support of routine and emergency operations while maintaining an excellent level of customer service through the retention of quality staff.

5	To ensure that the Agency treats providers as partners in the effort to provide better health care and that they are regulated fairly.	**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. **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. **Goal 6:** To provide innovative and cost effective technology solutions in support of routine and emergency operations while maintaining an excellent level of customer service through the retention of quality staff.
6	To use taxpayers' resources as efficiently and effectively as possible and to safeguard those resources from fraud.	**Goal 4:** To combat fraud, and abuse in the Florida Medicaid Program **Goal 6:** To provide innovative and cost effective technology solutions in support of routine and emergency operations while maintaining an excellent level of customer service through the retention of quality staff.
7	To create a workplace that exemplifies the values of accountability, fairness, responsiveness and teamwork.	**Goal 4:** To combat fraud, and abuse in the Florida Medicaid Program **Goal 6:** To provide innovative and cost effective technology solutions in support of routine and emergency operations while maintaining an excellent level of customer service through the retention of quality staff.

Health Care Services
(Division of Medicaid)

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, 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, in FY 2009-2010, 67.64 percent of the expenditures for most Medicaid services are reimbursed with federal funds under the provisions of the American Recovery and Reinvestment Act of 2009 that provides for enhanced federal match. Administrative costs continue to be reimbursed at 50 percent and information technology projects and services such as family planning are reimbursed at higher levels.

The need for Medicaid funded health care services is affected by population growth, the demographic profile (age) of the population, and economic conditions that impact employment and income. In July 2008, the U.S. Census Bureau estimated Florida's population to be approximately 18.3 million, making it the fourth most populous state in the nation. Its growth rate has been among the fastest in the nation for decades.

As of July 1, 2008, Florida had the highest percentage (17.4 percent) of elderly residents in the nation. The baby–boom generation begins reaching retirement age in the next few years and substantial numbers of retirees have historically relocated to Florida, indicating the demand for health care services will continue to grow at an increasing rate. Since the elderly use more health resources per capita than younger populations, the impact of the age distribution on demand for health care will be even greater than total population growth alone.

In FY 2008-2009, Medicaid served more than 2.8 million beneficiaries and paid claims to approximately 80,000 providers. With a budget of nearly $17.5 billion in FY 2009-2010, Medicaid is the second largest single program in the state budget behind public education, accounting for more than 26 percent of the state's total this year. It is the largest source of federal funding for the state. Medicaid caseloads in FY 2008-2009 are more than 60 percent higher than a decade ago. The caseload increased by nearly 10 percent in FY 2008-2009 over the prior fiscal year and is projected to increase in FY 2009-2010 by more than 9 percent compared to FY 2008-2009. The recent increase reflects external factors not within the Medicaid program's control, especially the rapid downturn in the economy in FY 2008-2009 and the resulting increase in unemployment.

In the last ten years, expenditures in the Medicaid program grew from almost $9 billion in FY 2000-2001 to $17.5 billion projected in FY 2009-2010, nearly doubling in that time period. The primary factors contributing to expenditure growth have been prescription drug costs, increased costs of medical services, long-term care, and enrollment growth. The largest expenditure categories for FY 2009-2010 are Prepaid Health Plans ($2.8 billion), Hospital Inpatient Services ($2.6 billion), Nursing Home Care ($2.6 billion), Prescription Services ($1.27 billion) and Low Income Pool ($1.1 billion).

MEDICAID PROGRAMS AND SERVICES

Medicaid Pilot Program

Florida's Medicaid pilot program, created in Section 409.91211, F.S., with the passage of Senate Bill (SB) 838 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 (CMS) 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 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.

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.

Children's Health Insurance Program / Florida KidCare

Florida KidCare is a partnership between the Agency for Health Care Administration, Department of Health, Department of Children and Family Services and Florida Healthy Kids Corporation. Except for the Medicaid component, KidCare is not an entitlement, and requires enrollees to contribute to the cost of their monthly premiums.

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.

Programmatic changes requiring families to document their income and complete an active renewal process resulted in Florida KidCare enrollment declining between FY 2004 and FY 2006. Except for a drop in enrollment due to complications with Florida Healthy Kids Corporation's third party administrator, Title XXI enrollment has increased 16.3 percent from 196,674 in July 2006 to 228,704 in July 2009.

In July 2003, in response to over-enrollment, new Kidcare enrollments stopped and applicants were placed on a waiting list. In March 2004, funding was appropriated for the wait list, followed in July 2004 by limited open enrollment periods, new income documentation and access to employer sponsored health insurance requirements. Enrollment plummeted as a result of these changes. In July 2005, year round open enrollment was reinstituted. In July 2006, the Florida Legislature funded $1 million in matching grants for KidCare community outreach. Also in July 2006, full pay options expanded with MediKids offering a Full Pay component to families with incomes over 200 percent of the federal poverty level. In July 2007, the Florida Legislature again funded $1 million in matching grants for KidCare community outreach, and the Governor's Office convened the Florida KidCare Outreach Task Force, with representatives from all of the KidCare partner agencies, to coordinate outreach activities throughout the state. In May 2008, Affiliated Computer Services, Inc. (ACS) began as Florida Healthy Kids Corporation's third party administrator, responsible for processing KidCare applications. Due to some transitional complications, KidCare enrollment decreased until November 2008 when outreach efforts were made to recapture the lost enrollment. In July 2008, funding for KidCare outreach was eliminated; however, the Governor's Outreach Task Force continues encouraging and coordinating outreach activities. In July 2009, the Florida Legislature passed KidCare administrative simplification legislation which should make the KidCare application and renewal process easier for families. KidCare enrollment is expected to increase and based on current enrollment projections, the Florida Legislature appropriated sufficient funding. Congress reauthorized the Children's Health Insurance Program in April 2009, allocating $68.9 billion to the states through September 30, 2013.

Source: Florida KidCare Enrollment Reports, 2004 through 2009; KidCare Appropriations Social Services Estimating Conferences, FY 2006-2007, FY 2007-2008 and FY 2008-2009, FY 2009-2010; Florida Children's Health Insurance Study 2007; Georgetown University Health Policy Institute's The Children's Health Insurance Program Reauthorization Act of 2009 Overview and Summary.

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 the state's 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

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 21 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 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.

Behavioral Health Services

During the last decade, the Medicaid program has become an increasingly important element of the mental health treatment system in Florida. Consistent with this growth, the Agency has introduced a number of initiatives that are designed to improve the efficiency and effectiveness of the Medicaid program. In its 2004 session, the Florida legislature passed HB 1843 that authorized the Agency to establish prepaid mental health plans for individuals enrolled in MediPass. During FY 2006-2007, the Agency expanded PMHPs statewide, with the exception of the counties in which Medicaid Reform has been introduced. The PMHPs have responsibility, within their AHCA areas, for providing the community mental health benefits.

In CY 2004, Florida passed legislation that directed the Agency to create a specialty prepaid plan for children with open cases in Florida Safe Families Network. At that time, children, in need of child welfare services and who resided in AHCA Areas 1 and 6, were enrolled in prepaid mental health plans that were specific to their regions. These children received specialty services, such as specialized therapeutic foster care, therapeutic group care services, and comprehensive behavioral health assessments, on a fee-for- service basis.

The Agency expanded the Child Welfare Prepaid Mental Health Plan in Hillsborough County in February 2009 to address the specialized continuum of care for children who receive services from the Department of Children and Families. In addition, the Agency has proposed to include AHCA Area 1 and all of Area 6 in the Child Welfare Prepaid Mental Health Plan to ensure that we have a statewide system of behavioral healthcare that addresses the needs of the transient child welfare population. Improved access, continuity, and quality of care are some added benefits of having a child welfare system managed by a single vendor.

The Agency is in the process of submitting the fourth renewal request for the 1915(b)(4) waiver authorizing the Agency to implement the Statewide Inpatient Psychiatric Program (SIPP) for Medicaid recipients under the age of eighteen (18). The SIPP program was developed to improve quality of, and access to, medically necessary residential mental health treatment for children and adolescents. Prior to SIPP, Medicaid did not fund residential treatment services. The decrease in recipient length of stay has resulted in a significant cost savings, as well as improved treatment outcomes. Approximately 1,100 children and adolescents are served each year under the waiver program. In the coming years, the Agency will continue a partnership with the Department of Children and Families (DCF) and the Florida Mental Health Institute (FMHI) at the University of South Florida to reduce and/or eliminate the use of seclusion and restraints in these inpatient facilities. Additionally, the Agency is supporting FMHI in its implementation of a trauma-informed behavior analysis service.

On August 1, 2007, the Agency developed and implemented a community-based substance abuse services program that enables Florida counties to receive federal match. This program is designed to provide early identification of substance abuse problems, rapid linkages, and effective treatment. This program will lead to increased opportunities for recipients to obtain substance abuse treatment. These substance abuse services should strengthen families while contributing to a reduction of school drop-out rates, crime, and incarceration. The Agency plans to continue expanding the program and providing technical assistance to participating counties and substance abuse treatment providers.

In May 2009, the Agency collaborated with the Department (DCF) and the lead agencies in Broward County to develop a plan for implementing a local model that allows for the integration of behavioral health and physical health with the local child welfare systems of care. The Agency anticipates entering into an agreement for the coordination of the behavioral health services.

Quality Management and Improvement

The Bureau of Medicaid Services is expanding its emphasis on quality assessment, measurement, utilization control, and quality improvement. Prior authorization, already required for hospitalization, is being required for all home health services statewide beginning in latter 2009. Pilot projects, authorized through SB 1986, are being implemented in Miami-Dade County to ensure appropriate service delivery in the home health delivery system. These include the following:

- **Pilot Project for Home Health Care Management**: AHCA is currently designing a comprehensive care management pilot project for home health services, for implementation during 2010. This program includes face-to-face assessments by a licensed nurse, consultation with physicians ordering services to substantiate the medical necessity for services, and on-site or desk reviews of recipients' medical records. The project will be conducted through a qualified quality improvement organization.

- **Pilot Project for Telephony Home Health Services Delivery Monitoring and Verification**: Through the competitive bidding process, AHCA is procuring a vendor to implement a program during 2010 that verifies the utilization and delivery of home health services and provides an electronic billing interface for home health services. The contract will require the creation of a program to submit claims electronically for the delivery of services, which will verify telephonically visits for the delivery of home health services using voice biometrics.

The increased utilization review provided through implementation of SB 1986 with both pilot projects is expected to improve accuracy, quality and cost effectiveness related to the provision of home health services. The goal is to ensure services are provided for those individuals truly in need in the most appropriate settings, with fewer inappropriate or unnecessary services or fraudulent activity.

AHCA is continuing to contract with a quality improvement organization to provide an on-going managed care external quality review (EQR) program. Health Services Advisory Group, Inc. (HSAG) conducts an annual independent review of access to, timeliness of and quality of outcomes for services provided to Medicaid recipients by managed care organizations and prepaid health organizations (health maintenance organizations and provider service networks, including the Medicaid pilot reform health plans and the specialty AIDS-HIV plan; prepaid mental health plans; the statewide child welfare prepaid mental health plan; and nursing home diversion plans.) EQR activities include federally required validation of reported performance measures, performance improvement projects, review of compliance with access, structural and operations standards, the development of an annual EQR Technical Report, and dissemination and EQR-related education among state and MCO staff and stakeholders. After the first year analysis and reporting in many additional areas, HSAG is continuing to work with AHCA toward improvements with consumer satisfaction surveys; enrollee race/ethnicity and primary household language information; value-based purchasing methodologies; AHCA's quality assessment and improvement strategies, along with annual strategic HEDIS analysis reporting and implementation of focused studies.

AHCA continues to contract with a quality improvement organization to provide an independent quality assessment/improvement program for its Home and Community Based Developmental Disabilities Waiver. This program has eight years of useful information and analysis through its multi-faceted approach of reviewing both providers and recipients to measure service quality outcomes, and is once again evolving and refining its approach for continually improving quality in access to and receipt of these waiver services. The next five years is expected to result in continued improvements in this area with a new contract following a re-procurement process currently underway.

Following a lengthy assessment and resulting procurement of a federal waiver, Florida became the first state in the nation to develop and implement a publicly funded program for children with a potentially life limiting illness. Known as Partners in Care-Together for Kids (PIC-TFK), this

program began in 2005 and is currently in seven areas, with plans for statewide expansion by 2011. The PIC-TFK program is exceptional and unique because it (1) enables children who are receiving curative care for potentially life-limiting medical conditions to benefit from palliative services in addition to the medical services already being received through the Children's Medical Services (CMS) Network, and (2) offers access to pediatric palliative care support services from the time of diagnosis, throughout treatment with hope for a cure, and if needed provides end of life care. In addition to improved quality of care being provided through this program, savings are anticipated from the decrease in monies spent on cyclical hospital and emergency room visits as these children receive specialized support services including pain and symptom management.

Wherever possible in all of its programs, AHCA Medicaid is moving toward greater standardization, improved quality and greater efficiencies in the provision of services.

Over the next five years, AHCA plans to continue working with its Medicaid recipients and providers, the federal government and the Florida Legislature as it seeks ways to measure, manage and improve the quality of services being provided as well as the dollars being spent in Florida.

MEDICAID PHARMACY

Innovations to Promote Evidence-Based Medicine

The Agency continues to promote innovations that facilitate evidence-based medicine and the use of technology in health care delivery through the following initiatives related to prescribing within the Medicaid fee-for-service program:

E-Prescribing Support

EmPowerRx

During FY 2003-2004 The Agency contracted with a vendor for a pilot project 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 through access to a clinical drug reference database and the Medicaid Preferred Drug List, the hand-held devices allowed prescribers to view all medications their Medicaid patients received in the preceding 100 days through the Medicaid Drug Program. The EmPowerRx product accessed drug profile information only for the physician's Medicaid patients. This limitation, lack of connectivity in rural areas, and lack of integration with electronic medical records systems stalled the adoption of the program by physicians.

Current Developments

Since initiation of the EmPowerRx pilot, recent technology developments in the marketplace support physician practice management systems that integrate electronic medical records and e-prescribing and billing for *all* patients within a physician's practice, regardless of their insurance status or payer. Prescribing physicians now have real-time review of their patients' insurance coverage details, drug profiles and e-prescribing integrated with electronic charts, medical records, and billing. Medicaid and other payers can now provide secure prescription records and real-time eligibility data to a central entity that the prescriber can access electronically for all his/her patients. This capability is no longer limited only to Medicaid records, and offers real-time data from all participating payers and pharmacies to an unlimited number of providers at a fraction of the cost of the initial Medicaid pilot program.

Future Enhancements
Physicians' practices can now choose from a broad array of vendors offering integrated practice management systems to access insurance coverage, formulary and drug reference, and prescription profiles for all patients, using the same hand-held device or laptop. Prescription information is instantly recorded in the patient's medical chart and the prescription is instantly submitted to the patient's pharmacy of choice. The enhanced functionality, now widely available to physician's practices through multiple vendors, is conducive to the Agency's broader support of electronic medical records and e-prescribing. Planning is underway to make the Medicaid Preferred Drug List (PDL) and individual patient prescription history available to all Medicaid prescribers statewide. Implementation is anticipated during FY 2009-2010, through the efforts of the Electronic Prescribing Advisory Panel that was created during the CY 2007 legislative session. Section 408.0611 F.S., requires the Agency to establish an informational clearinghouse on the Agency's website and to collaborate with stakeholders to create the clearinghouse.

Initiatives to Limit the Increase in Per-Case-Month Expenditures to Less than Eight Percent Per Year for FY 2009-2010 through FY 2013-2014 (Objective 1.A.)

Prescribed Drug Cost Containment Measures
The Medicaid Drug Program pursues a variety of cost containment measures while ensuring quality of care. Consistent with trends during FY 2008-2009, reimbursed prescription costs as well as net prescription cost after rebates have remained stable and below increases in the consumer price index for pharmaceuticals. Expansion of the cost containment measures, as described below, will help minimize the increase in the cost of pharmaceuticals purchased by Florida Medicaid over the next fiscal year:

Medicaid Preferred Drug List (PDL)
The Preferred Drug List (PDL) has been fully implemented across all therapeutic categories of medications, and the prior authorization processes for non-PDL medications continues to be refined. The Medicaid pharmacy program works closely with the contractor that negotiates supplemental rebate agreements with drug manufacturers to ensure competitive net pricing of available options within each therapeutic class. Agreements with manufacturers ensure that the state receives guaranteed net unit pricing for each drug, thereby affording the state protection from brand drug price increases for the duration of each contract.

Automated Quantity Limits; Dose Limits; and Clinical Prior Authorization
Real-time automated checking of prescription claims for specific Food and Drug Administration (FDA) guidelines, dispensing quantity limits, age limits, and dosing limits have been implemented systematically at the point of sale to control excessive utilization and ensure patient safety. As new drugs become available or clinical information is published, specific policies to ensure safe and efficacious utilization of pharmaceuticals will continue to be developed and implemented consistent with Agency Priority Number nine, Prescription Drug Management to reduce drug costs. Since June 2008, the Pharmacy Benefit Manager (PBM) contractor has steadily improved systematic electronic solutions to reduce the time and expense of paper-based prior authorization procedures and in appropriate circumstances offers immediate real-time utilization management at the point of prescribing and the pharmacy point of sale. Direct contact and review of prior authorization requests by clinical pharmacists is reserved for those drugs or circumstances that require such individualized review.

Efficient Use of Clinical Staff
Automation of certain high-volume prior authorization criteria as point-of-sale systematic edits has allowed the program's clinical pharmacists more time to audit automated processes and participate in designing program improvements. Further, in August 2008, the Area Office pharmacists were assigned activities to support the ongoing statewide contract for medication therapy management initiative. This clinic staff statewide continues to support outcome-based medical chart reviews; to interact with high volume Medicaid prescribers; perform auditing support for waiver programs; and to provide technical support of e-prescribing.

Medication Therapy Management
Through a contract initiated during FY 2008-2009, recipient population based initiatives targeting prescribers whose patients met specific criteria were implemented. These efforts are designed to improve overall health outcomes and eventually reduce costs for medication and for medical services. During FY 2008-2009, population-based interventions were directed at efficacious use of (1) gastrointestinal agents; (2) HIV/antiretroviral therapies; (3) medication compliance; (4) sedative hypnotic/benzodiazepine use in adults; (5) asthma disease management; and (6) hyperlipidemia therapy.

The medication therapy management contract also makes available a web-based tool and specific training for pharmacists to assist them in providing consultations with patients to improve the coordination and quality of their health care services. This function allows pharmacists to expand their roles in providing coordinated patient care by performing structured interventions to help reduce medical costs associated with emergency services and hospitalization.

Recipient Lock-In Program
Beneficiaries who have a history of over-utilization of pharmaceuticals may be required to receive all their Medicaid prescriptions through one pharmacy. The program has proven successful in controlling potentially dangerous or fraudulent patterns of obtaining prescriptions, particularly narcotics. While direct cost savings from this program are not significant given the relatively low cost of pharmaceuticals involved, the prevention of potential abuse or diversion of these drugs has a positive health and community impact.

Medicaid pharmacy related issues in the next five years include:

1. Expand electronic access to Medicaid eligibility, pharmacy claim history, and Medicaid Preferred Drug List through interface with provider's electronic medical records systems.

2. Develop an improved method of capturing NDC-level information on claims for physician administered drugs to allow more effective invoicing for manufacturer rebates.

3. Collaborate with other agencies to develop contingencies in the event of elimination of funding for the MEDS AD waiver.

4. Improve the automatic claim system edits to integrate diagnosis data with drug claims.

5. Improve patient safety through refined automatic system edits (quantity limits; dose limits; duration of therapy) for specific therapeutic classes.

6. Continue to eliminate paper-based processes through electronic indexing and filing of records.

7. Develop a web-based prior authorization system for physician-administered drugs.

List of Potential Policy Changes Affecting the Agency 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

Number	Identify Proposed Change	Describe Expected Results of Proposed Change	Describe Legislative Actions Required to Implement the Proposed Change
1.	Renewal and continuation of the Medicaid Managed Care Pilot Program	Renewal of the Managed Care Pilot Waiver during the CY 2010 legislative session	Legislative approval and federal CMS waiver renewal

List of All Task Forces and Studies in Progress

Number	Implementing Bill or Statute	Task Forces and Studies in Progress	Required / Expected Completion Date
1. Low Income Pool Panel	HB 285	(9) The Low-Income Pool Council shall consist of 24 members, including 2 members appointed by the President of the Senate, 2 members appointed by the Speaker of the House of Representatives, 3 representatives of statutory teaching hospitals, 3 representatives of public hospitals, 3 representatives of nonprofit hospitals, 3 representatives of for-profit hospitals, 2 representatives of rural hospitals, 2 representatives of units of local government which contribute funding, 1 representative of family practice teaching hospitals, 1 representative of federally qualified health centers, 1 representative from the Department of Health, and 1 nonvoting representative of the Agency for Health Care Administration who shall serve as chair of the council. Except for a full-time employee of a public entity, an individual who qualifies as a lobbyist under s. 11.045 or s. 112.3215 may not serve as a member of the council. Of the members appointed by the Senate President, only one shall be a physician. Of the members appointed by the Speaker of the House of Representatives, only one shall be a physician. The physician member appointed by the Senate President and the physician member	Medicaid Program Analysis Prior to CY 2010 Legislative session

Number	Implementing Bill or Statute	Task Forces and Studies in Progress	Required / Expected Completion Date
		appointed by the Speaker of the House of Representatives must be physicians who routinely take calls in a trauma center, as defined in s. 46 395.4001, or a hospital emergency department.	
2. Home Health Services	SB 1658	The Agency for Health Care Administration shall implement a comprehensive care management pilot project in Miami-Dade County for home health services by January 1, 2010, which includes face-to-face assessments by a state-licensed nurse, consultation with physicians ordering services to substantiate the medical necessity for services, and on-site or desk reviews of recipients' medical records. The Agency may enter into a contract with a qualified organization to implement the pilot project. The Agency may seek amendments to the Medicaid state plan and waivers of federal law, as necessary, to implement the pilot project.	Medicaid Services January 1, 2010
3. Medical Home Pilot Project	SB 1986	409.91207 Medical Home Pilot Project. — (1) The agency shall develop a plan to implement a medical home pilot project that utilizes primary care case management enhanced by medical home networks to provide coordinated and cost-effective care that is reimbursed on a fee-for-service basis and to compare the performance of the medical home	Health System Development January 1, 2010

Number	Implementing Bill or Statute	Task Forces and Studies in Progress	Required / Expected Completion Date
		networks with other existing Medicaid managed care models. The agency is authorized to seek a federal Medicaid waiver or an amendment to any existing Medicaid waiver, except for the current 1115 Medicaid waiver authorized in s. 409.91211, as needed, to develop the pilot project created in this section but must obtain approval of the Legislature prior to implementing the pilot project. (2) Each medical home network shall: (a) Provide Medicaid recipients primary care, coordinated services to control chronic illness, pharmacy services, specialty physician services, and hospital outpatient and inpatient services. (b) Coordinate with other health care providers, as necessary, to ensure that Medicaid recipients receive efficient and effective access to other needed medical services, consistent with the scope of services provided to MediPass recipients. (c) Consist of primary care physicians, federally qualified health centers, clinics affiliated with Florida medical schools or teaching hospitals, programs serving children with special health care needs, medical school faculty, statutory teaching hospitals, and other	

Number	Implementing Bill or Statute	Task Forces and Studies in Progress	Required / Expected Completion Date
		hospitals that agree to participate in the network. A managed care organization is eligible to be designated as a medical home network if it documents policies and procedures consistent with subsection (3). (3) The medical home pilot project developed by the agency must be designed to modify the processes and patterns of health care service delivery in the Medicaid program by requiring a medical home network to: (a) Assign a personal medical provider to lead an interdisciplinary team of professionals who share the responsibility for ongoing care to a specific panel of patients. (b) Require the personal medical provider to identify the patient's health care needs and respond to those needs either directly or through arrangements with other qualified providers. (c) Coordinate or integrate care across all parts of the health care delivery system. (d) Integrate information technology into the health care delivery system to enhance clinical performance and monitor patient outcomes. (4) The agency shall have the following duties,	

Number	Implementing Bill or Statute	Task Forces and Studies in Progress	Required / Expected Completion Date
		and responsibilities with respect to the development of the medical home pilot project: (a) To develop and recommend a medical home pilot project in at least two geographic regions in the state that will facilitate access to specialty services in the state's medical schools and teaching hospitals. (b) To develop and recommend funding strategies that maximize available state and federal funds, including: 1. Enhanced primary care case management fees to participating federally qualified health centers and primary care clinics owned or operated by a medical school or teaching hospital. 2. Enhanced payments to participating medical schools through the supplemental physician payment program using certified funds. 3. Reimbursement for facility costs, in addition to medical services, for participating outpatient primary or specialty clinics. 4. Supplemental Medicaid payments through the low-income pool and exempt fee-for-service rates for participating hospitals.	

Number	Implementing Bill or Statute	Task Forces and Studies in Progress	Required / Expected Completion Date
		5. Enhanced capitation rates for managed care organizations designated as medical home networks to reflect enhanced fee-for service payments to medical home network providers. (c) To develop and recommend criteria to designate medical home networks as eligible to participate in the pilot program and recommend incentives for medical home networks to participate in the medical home pilot project, including bonus payments and shared saving arrangements. (d) To develop a comprehensive fiscal estimate of the medical home pilot project that includes, but is not limited to, anticipated savings to the Medicaid program and any anticipated administrative costs. (e) To develop and recommend which medical services the medical home network would be responsible for providing to enrolled Medicaid recipients. (f) To develop and recommend methodologies to measure the performance of the medical home pilot project including patient outcomes, cost-effectiveness, provider participation, recipient satisfaction, and accountability to ensure the quality of the medical care provided to Medicaid recipients enrolled in the pilot.	

Number	Implementing Bill or Statute	Task Forces and Studies in Progress	Required / Expected Completion Date
		(g) To recommend policies and procedures for the medical home pilot project administration including, but not limited to: an implementation timeline, the Medicaid recipient enrollment process, recruitment and enrollment of Medicaid providers, and the reimbursement methodologies for participating Medicaid providers. (h) To determine and recommend methods to evaluate the medical home pilot project including but not limited to the comparison of the Medicaid fee-for service system, Medipass system, and other Medicaid managed care programs. (i) To develop and recommend standards and designation requirements for a medical home network that include, but are not limited to: medical care provided by the network, referral arrangements, medical record requirements, health information technology standards, follow-up care processes, and data collection requirements. (5) The Secretary of Health Care Administration shall appoint a task force by August 1, 2009, to assist the agency in the development and implementation of the medical home pilot project. The task force must include, but is not	

Number	Implementing Bill or Statute	Task Forces and Studies in Progress	Required / Expected Completion Date
		limited to, representatives of providers who could potentially participate in a medical home network, Medicaid recipients, and existing Medipass and managed care providers. Members of the task force shall serve without compensation but are entitled to reimbursement for per diem and travel expenses as provided in s.112.061. (6) The agency shall submit an implementation plan for the medical home pilot project authorized in this section to the Speaker of the House of Representatives, the President of the Senate, and the Governor by February 1, 2010. The implementation plan must include any approved waivers, waiver applications, or state plan amendments necessary to implement the medical home pilot project. (a) The agency shall post any waiver applications, or waiver amendments, authorized under this section on its Internet website 15 days before submitting the applications to the United States Centers for Medicare and Medicaid Services. (b) The implementation of the medical home pilot project, including any Medicaid waivers authorized in this section, is contingent upon review and approval by the Legislature.	

Number	Implementing Bill or Statute	Task Forces and Studies in Progress	Required / Expected Completion Date
		(c) Upon legislative approval to implement the medical home pilot project, the agency may initiate the adoption of administrative rules to implement and administer the medical home pilot project created in this section.	
4. Home Health Agency Monitoring Pilot	SB 1986	The Agency shall develop and implement a home health agency monitoring pilot project in Miami-Dade County by January 1, 2010. The Agency shall contract with a vendor to verify the utilization and delivery of home health services and provide an electronic billing interface for home health services. The Agency must award the contract through the competitive solicitation process.	Medicaid Services January 1, 2010
5. Report on Pilot	SB 1986	The Agency shall submit a report to the Governor, the President of the Senate, and the Speaker of the House evaluating the pilot project by January 1, 2010.	Medicaid Services January 1, 2010
6. Pilot Evaluation	SB 1648	The agency shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives evaluating the pilot project by January 1, 2010.	Medicaid Services January 1, 2010
7. Task Force Report	s. 409.9 F.S.	Task Force to report to Legislature by February 1, 2010.	Medicaid Services January 1, 2010

Number	Implementing Bill or Statute	Task Forces and Studies in Progress	Required / Expected Completion Date
8. LIP Report	GAA/ S.A. 171	The Agency shall contract with an independent consultant to prepare recommendations on the financing and distribution of funds for the low income pool, disproportionate share hospital program and adjustments to hospital outpatient and inpatient rates, rebased rates or otherwise exempt hospitals for Fiscal Year 2010-2011. The findings and recommendations shall be submitted to the Executive Office of the Governor, the chair of the Senate Policy and Steering Committee on Ways and Means, and the Chair of the House Full Appropriations Council on General Government and Health Care within 15 days after the LIP Council's recommendations are submitted for Fiscal Year 2010-2011.	Medicaid Program Analysis

Health Care Regulation

(Division of Health Quality Assurance**)**

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

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 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).

Some of the same reasons behind privatization of certain functions are now seen as reasons to bring these same functions back into the Agency. For example, we now appear to be able to save dollars and improve efficiency by staffing our own call center functions because the available telephone technology has improved dramatically since the original privatization occurred. The Agency has prepared a legislative budget request for FY 2010-2011 to bring the outsourced Complaint and Information Call Center back in-house using state workers. This is possible due to improvements in telephone technology. When the contract was originally awarded, the Agency indicated a one-time savings in capital expenditures of approximately $1 million because it would not have to purchase a new telephone system. Now the Agency is contracting with EMBARQ (a communications company) to establish a phone system using Voice Over Internet Protocol technology. This will permit establishment of a branched system without the high capital outlay expenditures originally associated with the telephone system. This Division-proposed budget issue is expected to save the state about $360,000 per year in contractual expense dollars.

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 (March 2009), (full report) 7.9 percent of the registered nursing positions in Florida hospitals were vacant in May 2008. This statistic trended down from 11 percent in CY 2007. Vacancy rates differed by nursing specialty, with the highest vacancy rates seen for Advanced

Registered Nurse Practitioners. Although three quarters of hospitals reported difficulties in filling nursing positions, more than two-thirds of hospitals reported being able to fill vacant RN positions within 60 days. The percentage of RNs leaving the hospital setting averaged 15 percent statewide. Florida must be particularly vigilant in its recruitment and retention efforts because of the State's large senior population.

The nursing shortage is increased and nurse recruiting efforts are further curtailed by the shortage of available slots in nursing education programs. Florida nursing programs declined a total of 12,563 qualified applicants – a number nearly capable of alleviating the current nursing shortage, were these students to complete programs successfully, pass the nursing licensure examination, and join the nursing workforce in Florida. Generic Advanced Registered Nursing Practitioner (ADN)) and Bachelor of Science Nursing (BSN) programs turned away the highest percentages of qualified applicants at 51.6 percent and 50.2 percent, respectively. Compared with Academic Year (AY) 2006-2007, in AY 2007-2008 Licensed Practical Nursing and ADN programs turned away a larger proportion of qualified applicants, while BSN programs turned away a smaller number and proportion. (Florida Center for Nursing Statewide Status Report on Nursing Supply, Demand and Education, August 2009)

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 staffs members receive offers from health care providers that are often well above — sometimes even double--their current surveyor salaries.

Having lost 12 nursing positions during the CY 2009 budget session, as of July 22, 2009, the field offices where the majority of health quality assurance nurses are employed, had a 12.7 percent vacancy rate for registered nurses as compared to a 1.7 percent vacancy rate for all other types of field office staff. This rate is only slightly higher than last year's nurse vacancy rate, which was 12.5 percent. The rate for non-nursing staff is much lower than last year's rate of 9.4 percent, possibly reflecting the downturn in the economy. Nurse surveyor staff members are on call 24/7/365 and salaries are not commensurate with the level of their responsibilities.

A somewhat dated review of surveyor salaries in the United States 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 2009 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 $52,500. The budget request was not successful, but will be reinstated as a request for the CY 2010 legislative session. The CY 2010 Legislative session will be the fourth year in which this request has been made.

Partially because salaries are so low and partly because responsibilities are extensive, the turnover rate for nurses in the field offices has remained at or near 20 percent every year since CY 1999. The turnover rate for 2008/2009 was, not unexpectedly, 19.66 percent.

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 overall occupancy rate of nursing facilities in Florida for CY 2008 was 87.35 percent, down by 0.7 percent from the prior year. As of March 1, 2009, there were 79, 245 licensed and 1,158 approved community nursing home beds in Florida. This represents a 0.22 percent statewide change from the prior year and results from revocation of the license for a 185-bed facility effective in November, 2008. Medicaid occupancy for CY 2008 was 60.69 percent; six-month Medicaid occupancy was 61.20 percent during the period July 2008 through December 2008. Total occupancy for the second half of calendar year 2008 decreased by nearly 1.4 percentage points from 88.04 percent to 86.67 percent.

There is a federal side to the nursing home quality assurance program as well. The Government Performance and 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 reductions in the use of restraints. Restraint use is down from 9.3 percent in the third quarter of CY 2003 to 4.9 percent in the first quarter of CY 2009. Less progress is evident with pressure ulcer incidence. Pressure ulcer incidence is down from 9.7 percent in the third quarter of CY 2003 to 9.4 percent in the first quarter of CY 2009. However, pressure ulcers increased in CY 2009 over their 8.3 percent for the second quarter of CY 2008.

Given these statistics, a further effort to improve the quality of long term care has begun. *PACT*, "Positive Action Critical Thinking" is a pressure ulcer reduction initiative underway in the Southeast CMS region (Region IV). States participating in this initiative are coordinating with nursing home, hospital and other health care providers to improve the continuum of care particularly in the area of pressure ulcer prevention. In Florida, we have begun this initiative by focusing on South Florida (Dade County). However, other areas of the state are asking to become part of the initiative and we are expanding the project statewide. The Agency is currently in the process of partnering with the Florida Directors of Nurses Association, which will take the initiative to the next level and provide statewide coordination.

Streamlining and Regulatory Reduction

The Agency is becoming adept at accomplishing more with the same or reduced resources. As the graph below will show, over the past nine years, the Division of Health Quality Assurance has received reduced appropriations while, over time, full time equivalent positions have been increased and then reduced. Although the makeup of full time equivalent (FTE) positions has changed over time with program and priority shifts, the number of staff for FY 2009-2010 is 618 FTE positions--exactly the same number that the Division of Health Quality Assurance had in

CY 2002 after the Medical Quality Assurance function was transferred to the Department of Health. (See Table 2-1) However, the budget for state fiscal year 2009-2010 is only $49.5 million as opposed to its $49.8 million in CY 2002. Over this same period of time, in the face of budget reductions, the Division's complement of licensed, registered, certified and regulated service providers and facilities has increased from 21,409 to 37,700—more than a 76 percent increase! (See Table 2-2)

Table 2-1: Budget Appropriations by State Fiscal Year for FY 2001-2002 through FY 2009-2010

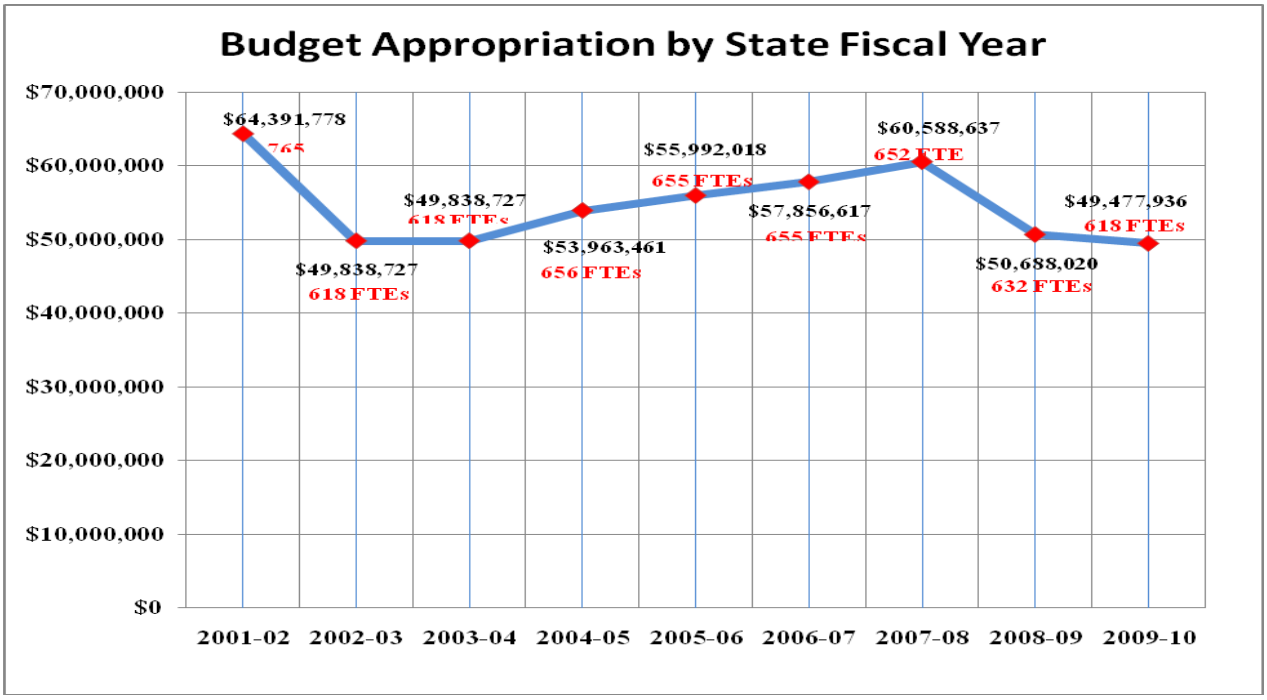
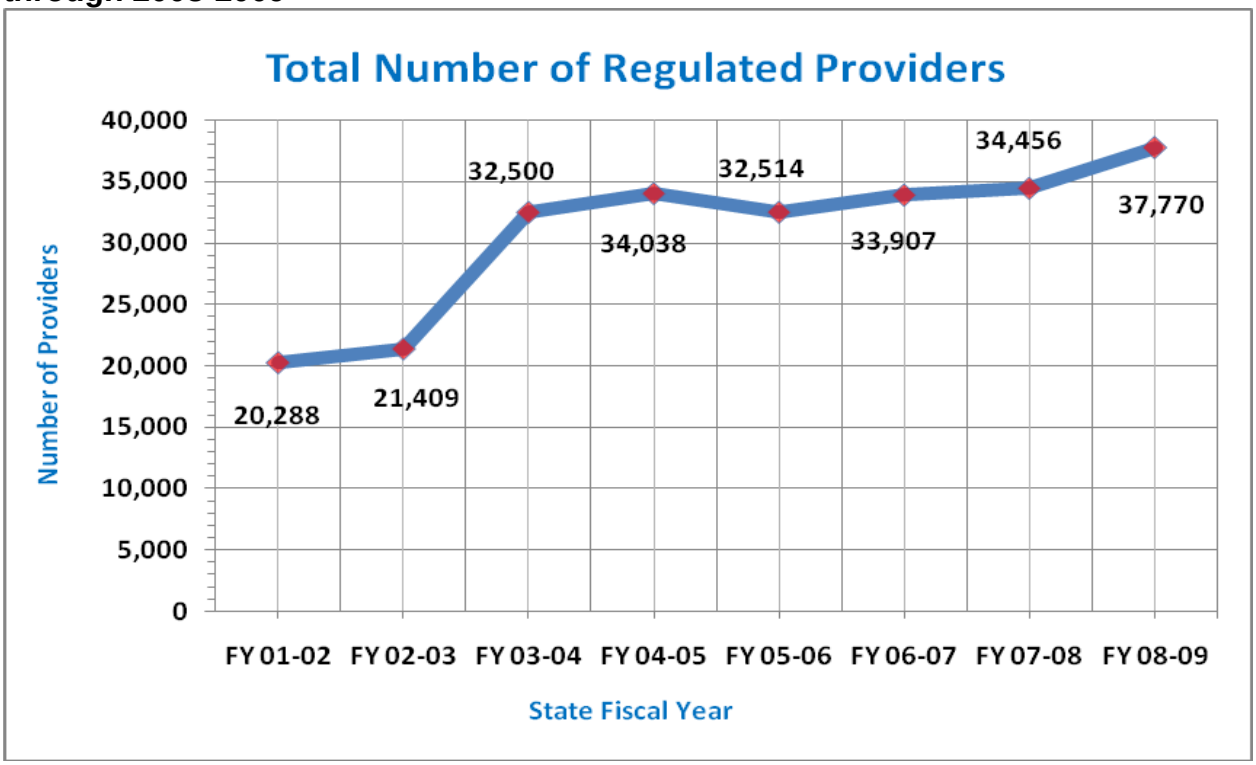


Table 2-2 - Total Numbers of Regulated Providers for State Fiscal Years 2001-2002 through 2008-2009



During the CY 2009 legislative session, the Agency was successful in obtaining passage of Senate Bill 1986, an omnibus bill dealing with both regulatory reduction and fraud/abuse prevention.

Among the many goals achieved by that bill was a major objective mentioned in last year's long range program plan: the elimination of state licensure requirements for clinical laboratories doing only waived testing and utilization review agents. The request to eliminate registration of homemaker companions was not successful. Elimination of state licensure for waived clinical laboratories means that these services will no longer have redundant federal/state requirements to meet. Although the state will still be responsible for ensuring that the approximately 11,600 waived labs in Florida meet federal requirements, that Certificate of Waiver (COW) surveys are done and that complaints against such facilities are investigated, they will no longer have the duplicative licensing workload issues previously associated with these facilities.

Senate Bill 1986 made numerous changes to save resources through regulatory reduction and streamline the Agency's licensure and inspection processes:

- Repealed registration of private utilization review organizations and state licensure for waived clinical laboratories.
- Eliminated the quality of care monitoring program in nursing homes.
- Repealed the monthly bed vacancy report previously required from nursing homes.
- Revised language related to adverse incidents in nursing homes and assisted living facilities.
- Removed the requirement to print hard copies of the nursing home guide.

- Eliminated a requirement for the Agency to adopt rules on the use or provision of feeding assistants in nursing homes.
- Allowed a year for a clinic to get accreditation after replacing its core Magnetic Resonance Imaging (MRI) equipment.
- Changed the definition of a Change of Ownership (CHOW) to be 51 percent change in ownership, shares, membership or controlling interest.
- Revised the definition of voluntary board member for Health Care Clinics.
- Conformed the Medicaid and HQA definitions of a CHOW
- Allowed a provisional license to be issued for a CHOW.
- Exempted Adult Family Care Homes from the requirement of an unannounced inspection.

Centralized Processing for Labor-Intensive, High Volume and Uniform Functions

Certain functions in every licensure unit are exceptionally labor intensive, high volume, and require uniformity in processing. These include receiving, opening and date stamping mail; scanning documents into the document management system; collecting and processing checks; and entering initial data for applications processing. To handle these functions more efficiently and effectively, Health Quality Assurance established the Central Systems Management Unit (CSMU). Composed of staff from each of the licensure units, CSMU will provide intake for all mail, initial data entry processing for applications and checks, and front-end scanning for applications in all licensure units by the end of Fiscal Year 2009-2010. The new unit's functions are a work in progress and that work is being transferred gradually, by the licensure unit. Anticipated benefits include improved processing time; insurance against lost applications and lost checks; and improved quality control over style and format for data entry. The Central Systems Management Unit tasks will transition as our online application capability improves over time, allowing the centralization of other common and uniform tasks. The Division's ability to conceive and implement centralized processing is further testimony to its versatility, fluidity and efficient management of change.

Streamlining the Application Process

Over the past several years, streamlining has occurred with the implementation of an enhanced electronic background screening system; a new document management system using Laser fiche technology; improvements in the LicenseEase licensure and enforcement system; and Statewide Enforcement Tracking (SET) a system that combines information from the federal survey tracking and enforcement system and the state licensure enforcement system. Increasing amounts of information have been placed on the internet, allowing access to survey reports and enforcement actions by the general public for use in making health care decisions. This not only increases transparency, it also reduces the workload on staff responding to public records requests.

In an additional effort to streamline operations, the Agency is working to implement an e-gateway licensing system to offer provider facilities the opportunity to renew their licenses online. This requires the technology to create an online identity management application as well as new programming. The Agency is working with its contractor, VERSA, to upgrade LicenseEase/FRAES to "VERSA Regulation." VERSA Regulation, when tied into the Agency's internet site, will permit providers to renew their licenses online and even apply for new licenses online, paying for these licenses electronically. Three significant advantages for the Agency from online applications are:

(1) reduced omissions, since licensure information will not be accepted by the system without required input;

(2) reduced check handling requirements as the new system will permit payments with debit and credit cards; and

(3) substantially reduced time spent on data entry.

The advantages for the providers are also significant:

(1) immediate feedback about the adequacy of their responses to licensure questions;

(2) no re-entry of information that has not changed on renewal licenses;

(3) payments with debit or credit cards online; and

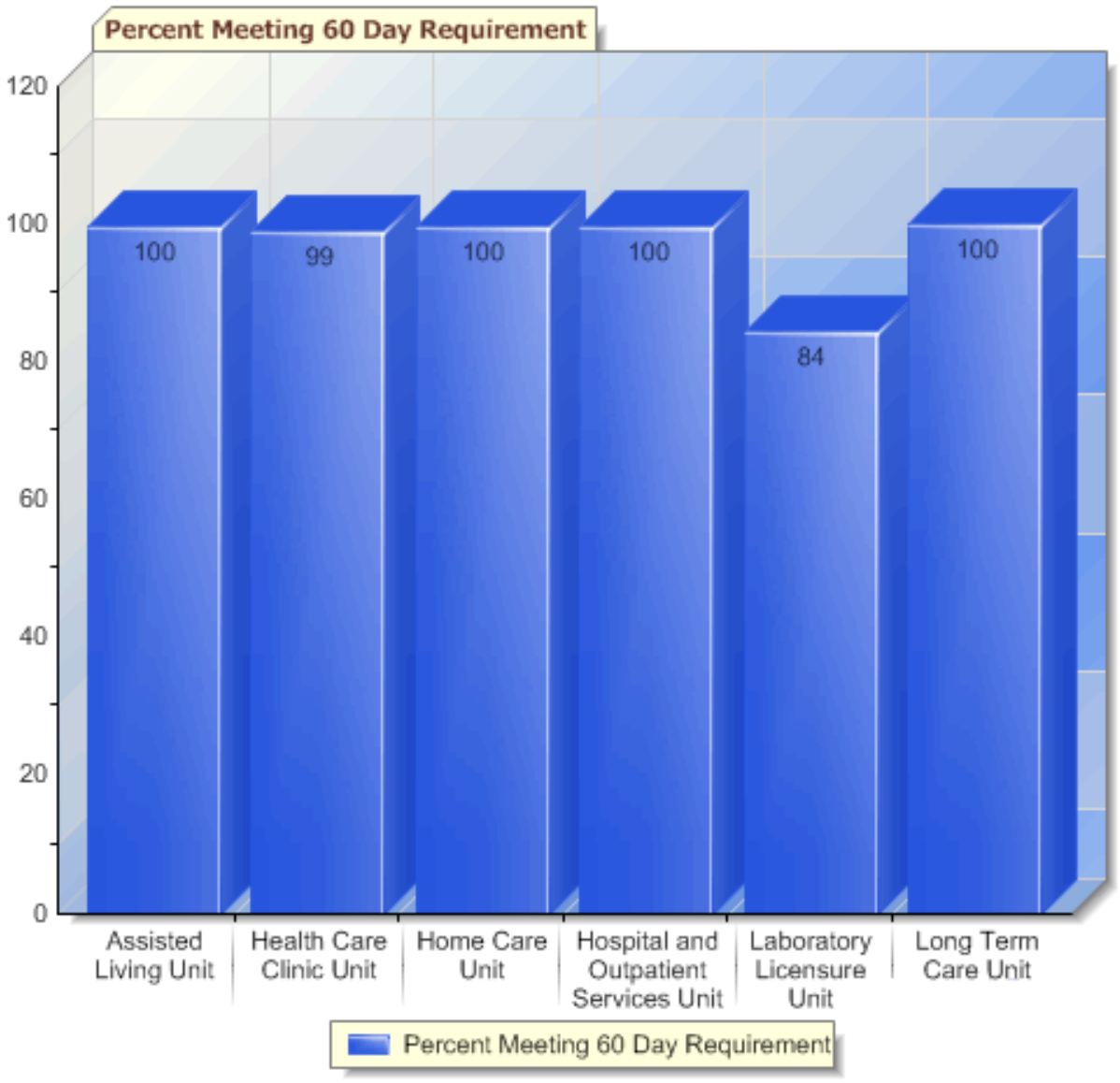
(4) substantially reduced time spent waiting for updates and responses from the state Agency.

Currently, nearly 54 percent of the license applications received have incorrect or missing information. Once the online technology is implemented, such license applications will not be accepted until they are correct. Online applications also remove the need for redundant data entry: the provider will input the data directly into the system, where it will be "held" until it is reviewed and either approved or denied. Responsibility for correct data entry will reside entirely with the applicant.

Since the percentage of correct applications---those requiring no omissions letters--is only about 46 percent, the Agency believed its application needed further clarification and perhaps less detail. Consequently, in addition to streamlining the means for entering licensure applications, the Division reduced and clarified the verbiage in the license application itself. Combined with the online application process, this improvement should serve to stretch existing resources further to accommodate the burgeoning numbers of providers.

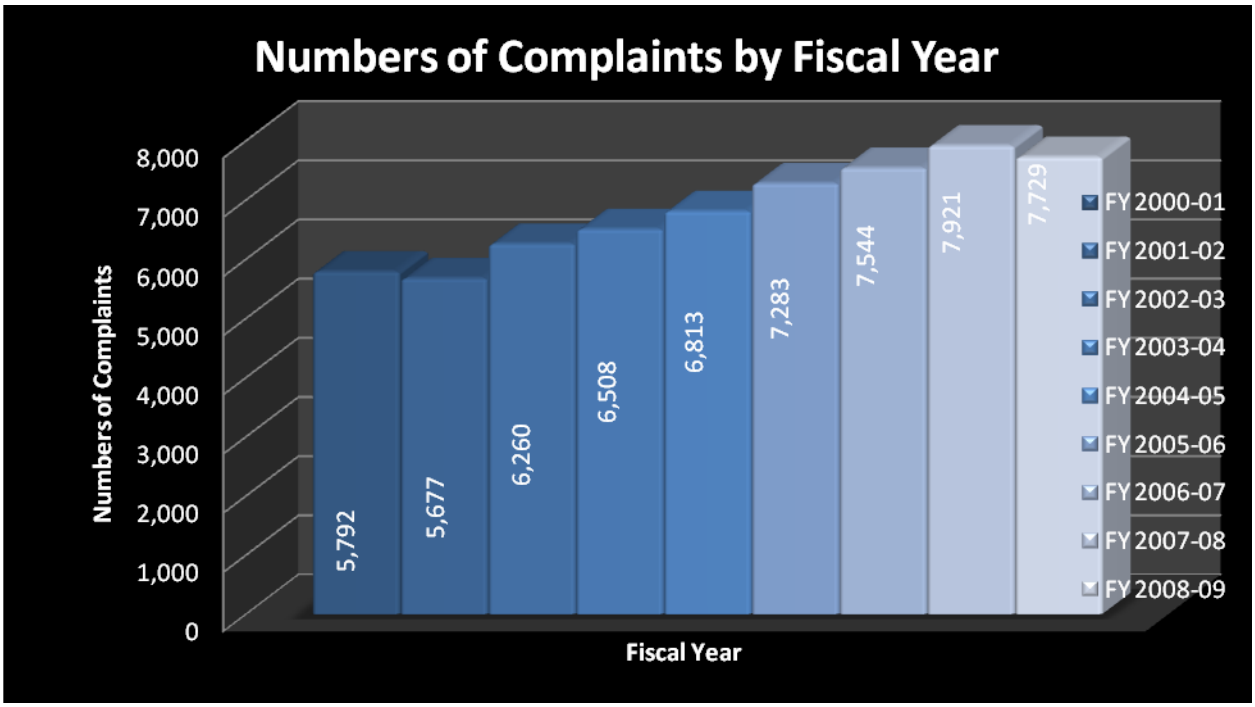
As shown in the graph below, most of the units are able to keep up with the licensure applications and meet the statutory requirement to issue or deny licenses within 60 days of obtaining a complete application. For those facilities that must have a survey before they can begin operations, a complete application is defined as one that includes the survey. As indicated on the graph below (Table 2-3), only the laboratory unit, due to the excessive numbers of providers (13,084) it regulates, has been unable to meet this requirement. Since passage of Senate Bill 1986, we anticipate that will change.

Table 2-3 - Percentage of Licensure Applications by Unit Meeting the Statutory Requirement to be Approved or Denied Within 60 Days of Agency Receipt of a Complete Application



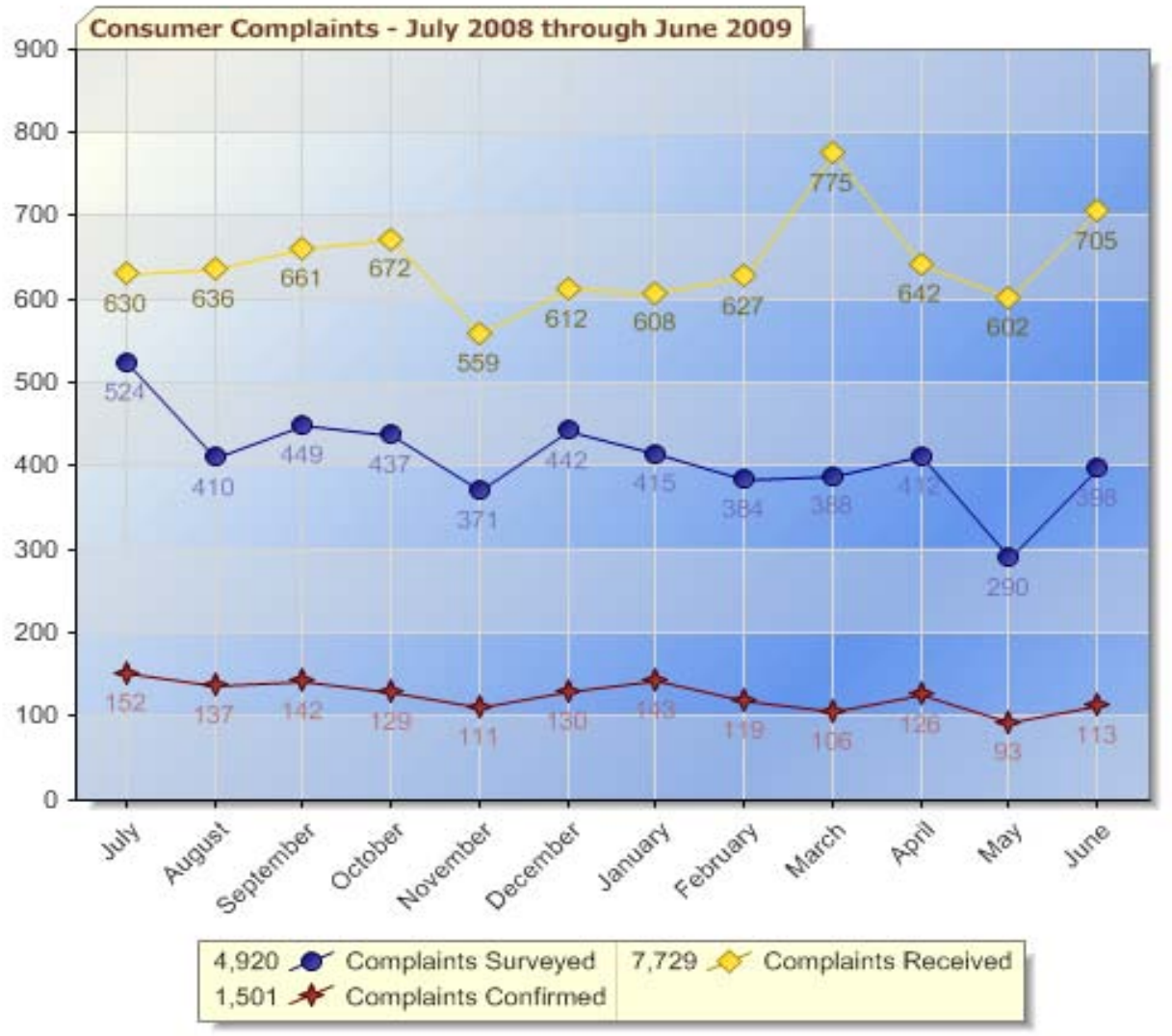
Consumer complaints about health care facilities trended upward for eight of the last nine years, not necessarily because there were more problems in health care facilities, but often because consumers are more capable of using the Internet to obtain information than in the past. Complaints coming into the Division for review and potential investigation have increased substantially over the past nine years, rising from 5,792 to 7,921 and falling slightly, back to 7,729 in FY 2008-2009. (See Table 2-4) 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.

Table 2-4 - Number of Consumer Complaints Against Health Care Facilities Fiscal Years 2000-2001 through Fiscal Year 2008-2009



Not all complaints are investigated, as the chart for Fiscal Year 2008-2009 will show (See Table 2-5). 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. Often, when complaints are investigated, they cannot be substantiated or confirmed. 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.

Table 2-5 - Number of Complaints Received, Surveyed and Confirmed State Fiscal Year 2008-2009



Public Information and Transparency

The Agency is leveraging technology and electronic document management to post valuable information online. As part of on-going efforts to promote transparency in health care, the Agency now publishes health care facilities' and providers' inspection reports on its Web site. The site incorporates regular inspections and complaint inspection 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 .

These reports are used by the State Long Term Care Ombudsman Program and consumers seeking information about facilities. We anticipate expanding the types of documents available online to better inform consumers and link these documents to the appropriate resources, consolidating multiple pieces of information into a single location on the Agency website. The Agency will merge multiple systems including the Nursing Home Guide, Inspection Documents, Annual Report of Fines for Assisted Living Facilities, and Emergency Actions Against Providers into the Florida Health Finder website to provide comprehensive Agency information.

Fraud and Abuse: Licensure as Prevention and Deterrence

Medicare has recognized that massive fraud exists in Miami-Dade County and that home healthcare providers are taking in more Medicare money than their colleagues in the rest of the country combined, thanks to inappropriate billings for patients with diabetes. In fact, Medicare proposes to cap any agency treating homebound patients with diabetes or other chronic conditions at 10 percent of the bill. (Miami Herald, Medicare to Cap Payments Amid Rampant Fraud, August 4, 2009.) During the CY 2008 and CY 2009 legislative sessions in Florida, fraud/abuse prevention was one of the biggest topics of both discussion and legislation. Fraud deterrence and prevention bills were passed by both houses in both sessions. Much of the legislation was aimed at reducing fraud and abuse in home health agencies in CY 2008. The 2009 legislation, Senate Bill 1986, actually designated Miami-Dade County as a health care fraud crisis area for purposes of regulating home health agencies, health care clinics, home medical equipment providers and other health care providers. Numerous additional provisions were added by this legislation to prevent fraud and abuse by health care providers. These most significant of these include:

- Restricts the Agency's ability to renew home health agency licenses based on parameters established in the legislation (any county that already has more than one Home Health Agency (HHA) per 5,000 people under certain circumstances). Prior to July 1, 2010, no initials and no changes of ownership (CHOWS) can be approved in any county where there is at least one active HHA and fewer than 1,200 people aged 65 or over for each agency. Any agency application received before that date would have to have applied for accreditation prior to May 1, 2009 in order to be given a license. Senate Bill 2658 makes this effective for CHOWS only on October 1, 2009—so the Agency expects to receive many home health agencies (HHA) CHOWs between July 1, 2009 and October 1, 2009.

- Allows suspension or revocation for a demonstrated pattern of billing Medicaid for medically unnecessary services.

- Additional licensure requirements for home health agencies, home medical equipment providers and health care clinics. Requires clients to be given the toll free number to call for suspected fraud.

- Adds to grounds for license denial or revocation based on convictions, guilty or no contest pleas to felonies under chapter 409 (social & economic assistance) 817 (fraud) 893 (drug abuse) and similar federal statutes unless offense/conviction was more than 15 years prior to the application.

- Denial is permitted under certain circumstances if the applicant was terminated for cause from Medicare or Medicaid in any state.

- Effective October 1, 2009, adds additional felony offenses to background screening requirements. (Most relating to fraud or similar transgressions).

Licensing is a relatively inexpensive form of prevention that provides a means to reduce both financial fraud schemes and substandard or hazardous patient care. There are numerous safeguards incorporated in any licensing program where trained healthcare professionals inspect the operation of the licensed entity. Representative safeguards provided by an effective licensing program include:

1. Confirmation of submitted licensing information.
   - On-site validation of the ownership, key licensed health professionals and operational information submitted on the paper applications. This is a deterrent to many commonplace fraudulent schemes as the documentation of ownership and licensed medical personal operating the facility is crucial to the successful prosecution of individuals engaging in inappropriate or illegal activates. Simple paper-only registration of submitted materials is less rigorous.

   - Required background screening, serves to exclude individuals with criminal and sexual predator histories, and is best enforced by on-site verification of the ownership, management and staffing listed on the licensing application. This is also a means to discover falsified applications, which can be revoked or denied.

   - In the healthcare industry, where ownership changes can occur frequently, and when claims reviews can occur many months after the payment is made, documenting who owned the facility and who were the key personnel during any prior period is important to investigators seeking to identify not only the ringleaders in fraud schemes, but also potential collaborators and witnesses.

   - Information gathered and verified through these processes is available to the public, law enforcement and insurance companies that credential healthcare service providers and review claims for errors and fraudulent billings.

2. Observation of the facility, sampling medical records and billing files, questioning facility staff, talking with patients, -- “practical auditing” of operations.

   - Experienced and trained surveyors conduct unannounced on-site inspections and can often identify unsafe healthcare practices, incapacitated practitioners, negligent practices, and potentially fraudulent billing activities;

   - In situations where the licensing authority is not directly responsible for the observed violations, the surveyors will make referrals, often with documentation that can be acted upon by the Department of Health, Office of Insurance Fraud, Office of the Statewide Prosecutor, or other public health and law enforcement authorities.

   - Surveyors are both the “front line” and the “thin blue line” that functions to protect the public. Surveyors’ knowledge of acceptable practices and prevailing Standards of Care makes outlier practices readily apparent when observed or encountered. Characteristically, it is often a surveyor’s communication of a strange encounter or situation that triggers an investigation and exposes a new scheme.

3. Complaint inspections and repeated complaints against a facility are a call to action.

    - Surveyors are often the best and most effective patient advocates. Surveyors talk to patients, sometimes at the patients' request; other times when chart reviews point to an unreported event, or perhaps inappropriate interventions with a patient. In either instance, the surveyor can track down the pertinent documentation, identify the severity of the injury or event, and look for frequency and trends to determine the seriousness and extent of the situation before requiring corrective action or referring to other authorities.

In summary, licensing as a deterrent provides taxpayers and patients with a tool for ensuring public safety. Any paper-only registration has small risk of exposure, even when the penalty is potentially severe. Further, even if an offender is somehow exposed, the challenges to successful prosecution and appropriate punishment remain substantial. Paper- only registration is subject to both inadvertent errors and intentional inaccuracies. Did the perpetrator "knowingly and willfully" commit fraud? What substantive documentation stands to convict a perpetrator? There is wide agreement among Agency professionals that it is the experienced healthcare surveyor who is the watchdog, whose actions most readily define the substance, extent, and enforcement of any state or federal licensing program.

Disaster Preparedness

The Agency's disaster preparedness system, called the Emergency Status System (ESS), is 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, transportation vendors, facility damage, facility accessibility, needs and available beds in non-evacuating facilities for those that must move their residents and patients. During CY 2009, additional modifications were made to this system, one of which allows analysis of transportation needs when facilities evacuate prior to an anticipated disaster, such as a hurricane. The CY 2009 Legislature passed Senate Bill 1986, which mandates use of the ESS by all hospitals, nursing homes, assisted living facilities and other facilities that provide residential treatment and services.

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 2008, there were 39 licensed Health Maintenance Organizations (HMOs), up from 35 in CY 2007.

The following statistics are based on data available for these 39 HMOs. Data show enrollment in Florida's HMOs had declined from 4.5 million in CY 2001 to 3.4 million by December 2008 (based upon the most recent available AHCA and OIR Data Reports). Well Care had the largest market share with 553,650 enrollees, including the two Medicaid plans HealthEase and Staywell, followed by Aetna with 528,002 enrollees and Humana with 490,238. HealthEase generally reports separate enrollment figures to the Agency and OIR, although they are wholly owned subsidiaries of the same parent organization.

The CY 2008 decline in enrollment did not negatively affect the profitability of Florida's HMOs. The Office of Insurance Regulation reports that the HMOs had profits of $491 million for calendar year 2008.

As of December 2008, 22 of the HMOs offered commercial managed care, 27 provided a Medicare product and 16 offered Medicaid plans.

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. Also affecting Medicaid enrollment were the acquisition of two Provider Service Networks (PSNs); the transition of those beneficiaries into HMOs; and the downturn in the economy, all of which combined to increase overall Medicaid enrollment from 787,344 in July 2008 to 1.1 million in July 2009. (AHCA internal reports) HealthEase and Staywell, both product lines of WellCare, had the largest market share with 369,543 enrollees or 33 percent of the total, despite the company leaving the Medicaid Reform pilot project areas.

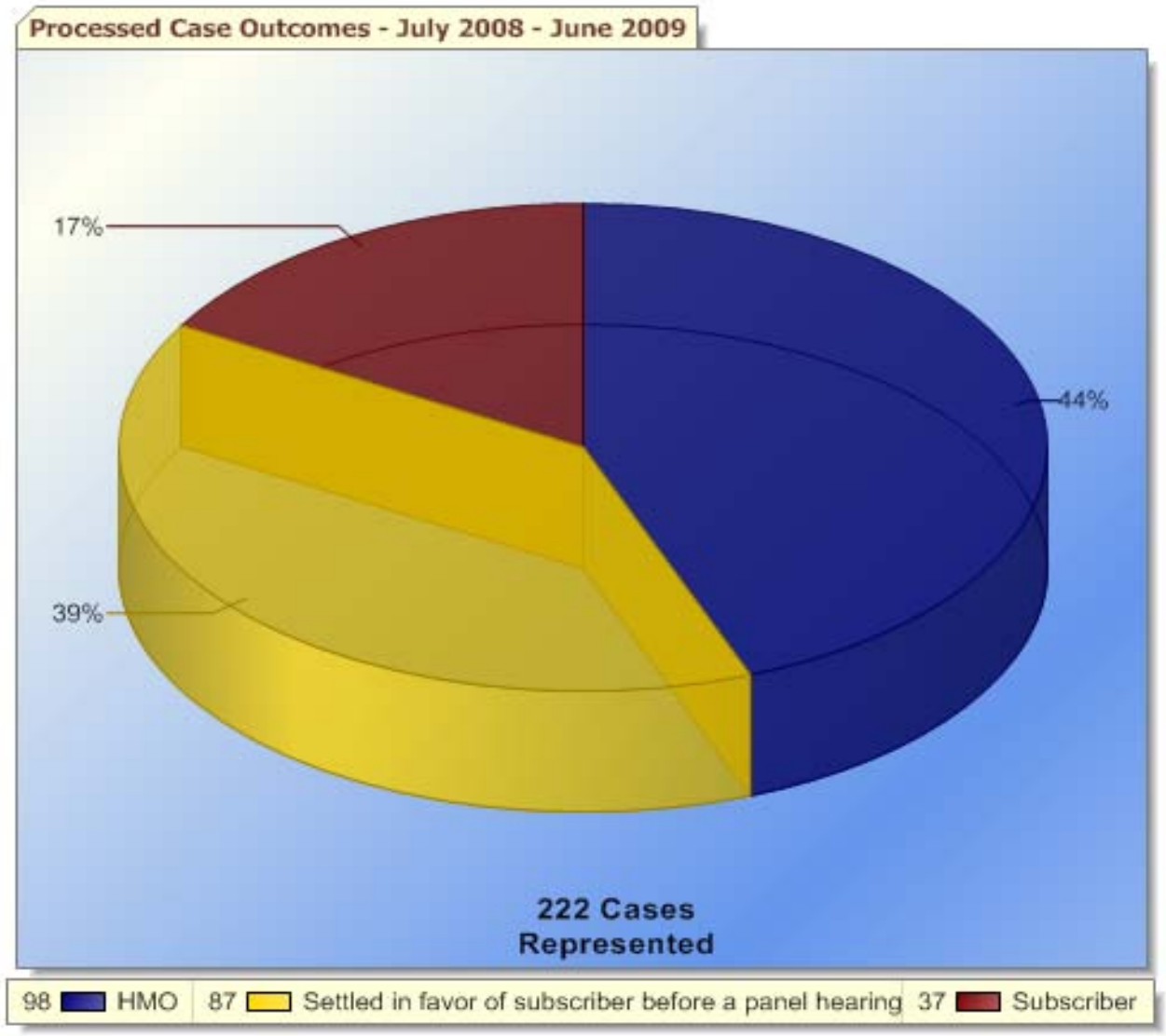
Medicaid HMOs reported operating income of $66.7 million in CY 2008 compared to $104.7 million in CY 2007 for the Medicaid product line only. The consolidated HMO operating income for the 16 Medicaid HMOs over all product lines declined from $271.4 million in CY 2007 to $71.5 million in CY 2008.

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.

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 Fiscal Year 2008-2009, this program reviewed more than 552 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.

As shown in Table 2 - 6 below, about 56 percent of the cases that come to the panel are either settled by the staff before they go to a panel hearing or are decided by the panel in favor of the subscribers.

Table 2-6: Subscriber Assistance Programs—Outcomes of Processed Cases for State Fiscal Year 2008-2009



In addition to the Subscriber Assistance Program, 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.

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, 15 cases in CY 2007 and 41 cases in CY 2008. Initially successful as a review option, it appears that the cases being sent to Maximus are trending downward. Of the 41 cases processed in CY 2008:

- Four providers submitted incomplete information and the cases were returned;
- Seven cases were returned to the filing entities because the submitted cases did not meet the review criteria;
- Ten cases were withdrawn by Maximus because the cases were not within its jurisdiction;
- One case was withdrawn by Maximus because the claim for the member no longer met the minimum amount in controversy requirement;
- Five cases were accepted for full review and are still pending;
- Four cases completed the review process and a final order is still pending;
- Three cases completed the review process and a final order was issued;
- One case was accepted for partial review and is still pending; and
- Six cases are still pending the review process

Initiatives to Resolve the Problem of Un-Insurance

"The uninsured draw most of the attention from policy makers and the public, but the number of underinsured is growing even faster. The underinsured have some, but not enough, health insurance coverage. When they show up in hospitals, emergency rooms, and doctor's offices, they often can't or won't pay the high deductibles and co-pays for the services they need. In addition, as the number of uninsured and underinsured individuals grows, we can expect more cost shifting to commercial plans and patients delaying and foregoing care. The number of uninsured individuals in the United States increased from 45 million to 45.7 million between CY 2003 and CY 2007, an increase of 1.6 percent. However, an estimated 25 million adults qualify as underinsured, an increase of 60 percent since CY 2003, according to the Commonwealth Fund." (*How Many are Underinsured? Trends among U.S. Adults, 2003 and 2007*, The Commonwealth Fund, June 10, 2008, as quoted in *Top Nine Health Industry Issues in 2009: Outside forces will disrupt the industry* PricewaterhouseCoopers Health Research Institute.)

Florida must tackle the problem of un-insurance first, since it has about 3.7 million uninsured individuals of whom 51.5 percent are employed. The total number of uninsured represents about 20.5 percent of the total population. According to a recent study by Families USA, 3,560 Florida residents lose their health insurance coverage every week. By the end of calendar year 2010, the total of additional Floridians losing their insurance will reach 556,070. Most indicated that the primary reason is escalating premium costs. (*The Clock is Ticking*, Families USA, July 2009)

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 in 2008 with passage of Senate Bill 2534 (Chapter

2008-32, Laws of Florida). Cover Florida is intended to provide low cost 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 program went into effect January 5, 2009, with six companies participating, including:

- Blue Cross Blue Shield of Florida
- Florida Health Care Plan
- United Health Care
- Medical Health Plans of Florida
- JMH Health Plan
- Total Health Choice

As of June 30, 2009, these plans had 3, 757 members. Projections lead the Agency to believe that these plans will cover more than 500,000 lives within five years.

An additional legislative mandate from 2008 created the Florida Health Choices Corporation, a not for profit corporation operated in compliance with Chapters 112, 119, 286 and 617, Florida Statutes. This corporation will establish a centralized market for sale and purchase of various "insurance" products to enable people to pay for health care. The products are not required to be licensed by the Department of Financial Services, Office of Insurance Regulation and may include health insurance plans, health maintenance organization plans, prepaid services, service contracts and flexible spending accounts. The program must include enrollment of employers, administrative services to those employers, services to individual participants, recruitment of vendors, certification of vendors, collection of data, monitoring and reporting of vendor performance, information services for individuals and employers and program evaluation. The corporation will collect premiums and distribute payments by contracting for a third party benefits administrator. The Board has had five organizational meetings, the first of which occurred on February 27, 2009, and has elected officers, adopted by-laws, obtained a federal ID number, opened a bank account, appointed outside counsel and is conducting an executive search.

The Corporation is functioning to develop this market place and has had a number of meetings since the organizational meeting in November 2008.

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.

Several different health care reform plans are currently under discussion in Washington D.C. All require individuals to obtain health insurance coverage, although one plan would allow hardship exceptions. The difficulty with universal health insurance is the price tag: an estimated $1.3 to $2 trillion dollars. More than $52 million has already been spent this year on health care reform-related advertising according to the Campaign Media Analysis Group. (Washington Post, August 10, 2009) In addition, Florida officials have calculated that the health-care proposals being debated in Congress could add 1.4 million uninsured residents to the state's Medicaid rolls. The Agency's analysis revealed Florida's already mushrooming

Medicaid rolls would grow from 2.6 million people to about 4 million people under proposals to overhaul the health-care system. The cost of this addition to the Medicaid rolls will depend upon the final structure of the federal health care package and federal participation percentages. On the brighter side, however, if federal insurance reform does occur as an individual mandate, it is highly likely that Cover Florida plans and other innovative, less regulated types of health insurance will increase significantly. If that happens, we believe the goal will need to be altered to increase potential covered lives to perhaps two million from the currently projected 500,000.

List of Potential Policy Changes Affecting Agency Budget Requests

Number	Potential Policy Changes	Legislative Budget Requests (LBR) Affected	Impact on Agency Policy if LBR Request is not Approved
1	Moving the contracted complaint and information call center in House.	Complaint and Information Call Center	Continued expenditure of approximately $360,000 additional in general revenue per year.
2.	Obtaining federal grant funds to complete ambulatory surgery center surveys in an effort to improve the quality of care in those facilities.	Ambulatory surgery center surveys	Inability to perform ambulatory surgery center surveys.

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	Amend statutes to clarify the definition of an adult family care home.	429.65 F.S.	None	None	Statutory Clarification
2	Improve transparency and consumer information by requiring certain information be reported by licensed assisted living facilities and adult family care homes including occupancy and other consumer information.	429.07(3)	None	None	Statutory Change
3	Modify the fire protection and life-safety code requirements for new assisted living facilities to meet the code existing at the time the facility is built. The current law requires compliance with 1996 codes.	429.41(1)(a)	None	None	Statutory change

Number	Changes in Current Programs	Statutory Reference	Changes in Current Services	Changes in Current Activities	Substantive Legislative Action Required to Support Changes
4	Amend Chapter 408, Part II, F.S., and authorizing statutes to remove maximums on licensing fees and allow fees to be adjusted to pay for the cost of regulatory activities. Adjustments are limited to the Consumer Price Index (inflation) plus 10% annually. Pursuant to 408.805, F.S., licensing fees must cover Agency costs.	408.805, F.S.	None	None	Statutory changes
5	Require all fingerprints to be provided in electronic format.	408.809(7), F.S.	None	None	Statutory Change
6	Adopt Selected Federal Standards for ICF-DDs.	Ch 400, Part VIII	None	None	Statutory Change
7	Adopt Selected Federal Standards for Home Health Agencies.	Ch 400, Part III	None	None	Statutory Change

Number	Changes in Current Programs	Statutory Reference	Changes in Current Services	Changes in Current Activities	Substantive Legislative Action Required to Support Changes
8	Accreditation Requirement for Home Medical Equipment Providers.	Ch 400, Part VII	None	None	Statutory Change
9	Allow revisions to the design criteria for public educational facilities and state licensed facilities more often than once every four years.	553.73(7)(g)	None	None	Statutory Change
10	License Renewal Notices.	408.806(2)9d), F.S.	None	None	Statutory Clarification
11	Eliminate Routine Submission of Documents at Licensure.	400.171, 400.1183, 400.181, 400.141, F.S.	None	None	Statutory Change

Number	Changes in Current Programs	Statutory Reference	Changes in Current Services	Changes in Current Activities	Substantive Legislative Action Required to Support Changes
12	Eliminate Automatic Complaint Investigations of Emergency Access Issues in Hospitals and substitute federal flexibility requirements. Eliminate confidentiality requirements for such investigations.	395.1046, F.S.	None	None	Statutory Change
13	Exempt Homemaker-Companion Agencies under Contract with APD from AHCA Registration.	400.509(1)	None	None	Statutory Change
14	Modify Penalty for Nursing Homes for Staffing.	400.141, F.S.	None	None	Statutory Change

Number	Changes in Current Programs	Statutory Reference	Changes in Current Services	Changes in Current Activities	Substantive Legislative Action Required to Support Changes
15	Clarify Explanation of Benefits insurance language.	395.301(2)(a)5., 400.165, 458.323, 459.012, 460.41, 461.009, 627.643(4), F.S.	None	None	Statutory Clarification
16	Eliminate managed care ombudsman committees.	641.65, 641.67, 641.68, 641.70, 641.75, F.S.	Removes services that are redundant to existing processes and procedures.	None	Statutory Change
17	Eliminate the exemption for certain prepaid capitated Medicaid contractors from licensure.	Ch. 641, Parts I and II, F.S.	None	None	Statutory Change

List of All Task Forces and Studies in Progress

Numbers	Implementing Bill or Statute	Task Forces and Studies in Progress	Required / Expected Completion Date
1.	s. 408.909 (9) F.S.	Annual report on Health Flex to be submitted jointly with the Office of Insurance Regulation	January 1, 2010
2.	s. 408.7057(2)(g)2., F.S.	Annual Report on the Cases of the Statewide Managed Care Dispute Resolution Program	February 1, 2010
3.	s. 400.191(2), F.S.	Nursing Home Guide Quarterly Report	February 15, May 15, August 15 and November 15, 2010
4.	s. 408.9091(10), F.S.	Cover Florida Health Care Access Program Evaluation to be submitted jointly with the Office of Insurance Regulation	March 1, 2010
5.	s. 429.19(9), F.S.	Assisted living facilities report of fines of $5,000 or more for violation of state standards	July 30, 2010
6.	s. 395.10972 F.S.	Risk Managers Advisory Group – This is a standing advisory group that has not met in several years.	None
7.	s. 408.0361(6), F.S.	Organ transplant programs advisory group	Nothing after 2005
8.	s. 408.0361(7)	Certificate of Need advisory group to study distribution of hospital beds	Not required after the 2005 report
9.	s. 483.26, F.S.	Technical Advisory Panel (laboratory)	Nothing recent

Florida Center for Health Information and Policy Analysis

The Florida Center for Health Information and Policy Analysis (Florida Center) performs several important functions to improve the effectiveness and efficiency of health care services in the state and to support consumers in health care decision making. The Agency's consumer oriented website, www.FloridaHealthFinder.gov, was developed in support of the Florida Center's 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 is responsible for collecting, compiling, coordinating, analyzing, and disseminating health related data and statistics for the purpose of developing public policy and promoting the transparency of consumer health care information. These data provide accurate and timely health care information to consumers, policy analysts, administrators, and researchers in order to evaluate cost, quality, and access to care. The Florida Center is highly regarded throughout the nation as a primary resource for state health care data.

The Florida Center promotes the exchange of secure, privacy-protected health care information, the adoption of electronic health records among providers, and the use of personal health records by all consumers. The goal is to provide better health care for all Floridians through the spread of appropriate health information technology. Currently, the Florida Center is actively promoting the adoption of electronic health record systems through health information exchange, electronic prescribing and personal health records software in partnership with health care stakeholders statewide.

The Florida Center is also responsible for collecting adverse incident reports from hospitals, ambulatory surgery centers, health maintenance organizations, nursing homes, and assisted living facilities. The Florida Center works closely with facilities and regulatory agencies to assure that corrective actions have been implemented.

Data Collection, Data Quality, and Patient Safety:

Data collection is guided by §408.061, Florida Statutes. Data collection is the core of the Florida Center activities. Accurate, timely, and unbiased data are essential to good analyses and efforts to model and understand Florida's health care system. To that end, the Florida Center collects and maintains three major databases:

- Hospital Inpatient
- Ambulatory Surgery
- Emergency Department

Patient Data Collection: A Brief Synopsis of the Process

In accordance with Chapters 59E-7 and 59B-9, Florida Administrative Code, the data collected from the following sources are submitted to the Florida Center electronically: hospitals, ambulatory surgery centers, emergency departments, and long-term psychiatric hospitals. Facilities submit data reports quarterly and record inclusions are based on the patients' dates of discharge or visit.

The submitted data are checked for errors by a specifically designed computer program that identifies data that might have been reported incorrectly. Reports detailing any identified inconsistencies in the data are sent to the facility for data correction and verification. Following appropriate facility action, the corrected data are processed again for final validation.

Once the data successfully pass the checks, with no identified errors or unexplained outliers, a report is sent to the facility for a final review. If the facility agrees the data are correct, the facility's Chief Executive Officer or Chief Financial Officer is provided a certification form to sign and return to the Agency for Health Care Administration (Agency). After data are certified, they are added to the main database where they are available for public release.

Inpatient Data Collection

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

The hospital inpatient database contains patient-level information for each patient discharged from approximately 262 acute care Florida facilities, including long-term care hospitals, short-term psychiatric hospitals, and long-term psychiatric hospitals. The number of hospital inpatient discharge records submitted each year has increased from 2,386,661 in CY 2002 to 2,563,518 records in CY 2007. The CY 2007 data was certified as complete in CY 2008.

The number of reporting facilities varies over time, as new hospitals open and others close. Each facility reports quarterly under a unique identification number individually assigned to it by the Agency.

Discharge 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 diagnosis codes, procedure codes, principal procedure date, present on admission indicators, and attending and operating Florida physician license numbers. Discharge information includes discharge date and discharge status.

Charge data include total charges and charges broken down by individual revenue charge categories. Revenue charge categories include room and board, nursery, intensive care unit, pharmacy, medical/surgical supplies, oncology, laboratory, pathology, radiation, operating room services, anesthesia, respiratory therapy, physical and occupational therapy, emergency room services, cardiology, recovery room, labor room, trauma response, behavioral health, and other categories. Sixteen principal payer codes (including Medicaid, Medicaid health maintenance organization [HMO], Medicare, Medicare HMO, and Commercial HMO) are also reported.

Facilities provide a unique 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 included in each record.

Ambulatory Surgery Data Collection
Ambulatory surgery data collection is authorized under §408.061 (1) (e), Florida Statutes, and Chapter 59B-9, Florida Administrative Code.

The ambulatory surgery (AS) database contains "same-day surgery" data on reportable patient visits to approximately 645 Florida facilities, including freestanding ambulatory surgery centers, short-term acute care hospitals, lithotripsy centers, and cardiac catheterization laboratories. The actual number of facilities varies over time as new facilities open and others close. Each facility submits quarterly reports under a unique Agency-assigned identification number. There were 2,953,661 ambulatory patient records collected in CY 2007. The CY 2007 data was certified as complete in CY 2008.

Reportable AS visits are those with primary procedures in the following Current Procedural Terminology (CPT) code ranges: 10000 through 69999 and 93500 through 93599. These codes include surgical procedures, cardiac catheterization, and lithotripsy. Facilities documenting less than 200 patient visits in a quarter may formally request, in advance of the due date, an exemption from reporting on the specified quarter.

Ambulatory surgery data records include, but are not limited to, patient demographics, medical information, and charge data. Demographics include race, birth date, gender, and zip code. Medical data include diagnosis (ICD-9-CM) codes and procedure (CPT) codes. Facilities also report patient visit date and license numbers for attending and operating Florida physicians. Charge data include total charges and charges broken down by individual revenue charge categories. Revenue charge categories include pharmacy, medical/surgical supplies, radiation, laboratory, operating room services, anesthesia, recovery room, treatment or observation room, cardiology, and other charge categories. Principal payer code (selected from a list of sixteen choices including Medicaid, Medicaid HMO, Medicare, Medicare HMO and Commercial HMO) is also reported. The data also contain individual record identification numbers and Social Security numbers.

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

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

The comprehensive inpatient rehabilitation database (initiated in CY 1993) is a companion to the hospital inpatient database. Although there are far fewer comprehensive inpatient rehabilitation records than hospital inpatient or ambulatory surgery records, rehabilitative care continues to be an important feature in the health care delivery system in Florida. There were 17,234 records collected in CY 2007.

The comprehensive inpatient rehabilitation data are primarily collected for special requests and ad hoc reporting. Many of these requests come from within the Agency, the Legislature, researchers, and the general public.

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

In CY 2005, the Florida Center began collecting Emergency Department (ED) data as directed by §408.061 (1) (a), Florida Statutes, and administrative rule Chapter 59B-9, F.A.C. This statute requires the reporting of all emergency department visits in which ED registration occurs and the patient is not admitted for inpatient care. Accordingly, all patients registered by the facility and generating a record are now reported by emergency departments by their acuity level using an evaluation and management (E&M) code, to indicate the level of seriousness of their condition.

Data elements include the hour of arrival, the patient's chief complaint, principal diagnosis, race and ethnic status, and external causes of injury. The data elements reported are very similar to those used for reporting ambulatory surgery data. This report is electronically transmitted by the facilities to the Agency via a secure Internet data submission system.

As of December 2008, 21 million emergency department records were collected, processed, and certified by the Florida Center (approximately 5.7 million in CY 2005 and 5.8 million in CY 2006, 5.7 million in CY 2007 to date). Since the first year of reporting, the ED data collected represent almost twice the number of records collected for inpatient admission and ambulatory surgeries over the same reporting period.

Florida Statutes require the Agency to analyze the use of emergency department services by patient acuity level and to assess the impact on increasing hospital costs by providing non-urgent care in emergency departments pursuant to §408.062(1)(i), Florida Statutes.

Patient Data Collection System and Process Improvements
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 increasingly timely collection and posting of quality data. Achieving the ambitious goal of data turnaround in 198 days, though, will require significant upgrades in both technology and process.

In CY 2008, the Data Collection unit performed extensive process mapping in order to better model the current method of collecting and processing patient data. This process mapping has allowed data collection staff to model a more effective and efficient business model. Several of the changes identified through the process mapping were implemented before year's end.

Paperless Data Collection
The most significant process improvement saw the data collection process go "paperless." This process improvement involved rendering all communications with submitting facilities electronic in format. This change allowed the Florida Center to save significant amounts of

time for Agency and facility staff in addition to large amounts of paper. The Florida Center later returned two file rooms totaling over 200 square feet to office space.

Enforcement
In CY 2009 the Florida Center reinstated fines for facilities that fail submit their data according to the deadlines provided in rule. The fining was undertaken with the understanding that the demand for timely data required providing submitting facilities as many incentives as possible. The initiative was as success as the first quarter in which facilities were fined saw only two of nearly 1,000 failing to meet the deadline.

Facility Outreach
Another big change precipitated by the process mapping was the fine-tuning of our facility outreach program (FOP). With the implementation fines for late submitters the Agency concurrently began to offer facilities "hands-on" help getting their data submitted. The Florida Center now provides focused support and service to facilities struggling with their discharge data reporting. Some of the most notable features of the FOP include:

- Proactively identifying "struggling" facilities;
- Reaching out to establish a dialogue with the facility's submission staff;
- Identifying the functions or actions at the root of the delinquency;
- Indentifying the resources available to mitigate/improve deficient areas;
- Collaboratively construct a recovery plan to reestablish reporting currency; and
- Monitoring progress through regular status review calls.

New Data Collection Information System
Aggressive data turnaround goals demand that the Florida Center identify and maximize all technological resources. The future technological needs for data collection can therefore be said to be driven by the need for system-wide technical enhancements and increased automation. Such improvements will help accelerate the Florida Center's ability to collect, audit and disseminate data while enhancing 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 within the reality of limited financial resources. To this end, the process mapping initiative has provided the Florida Center the opportunity to identify specific system processes that might be upgraded using existing resources (e.g. improving the program that unzips submitted data files). The Agency's Bureau of Information Technology is currently spearheading these efforts.

Quality Assurance
The Florida Center is also embarking on a significant effort to begin discretely measuring the performance of individual processes and comparing them over time against specific goals and benchmarks. This Quality Assurance program is increasingly supported by automated reports of system-based measurements that can then be used to focus Center resources in the most efficient ways, yielding the greatest process improvement results.

Risk Management and Patient Safety
In CY 2008, adverse incident reporting for Assisted Living Facilities and Nursing Homes was assigned to the Florida Center. Staff are working to streamline incident reporting across all facility types and to encourage the use of electronic reporting. The newly-

renamed Office of Risk Management and Patient Safety (RMPS) are now focusing on customer service and best practices. Priority has been assigned to changing the Agency's relationship with facility risk managers from adversarial to collegial. It is hoped that improved relations will help increase the number and quality of adverse incident and Code 15 reports received by the agency.

One of the most notable initiatives in this effort has been to significantly reduce the volume of reports that RMPS is requiring from facilities. Facilities now no longer have to re-submit reports as part of their year-ending Annual Report. RMPS is also working with the Bureau of Information Technology to design a new web-based reporting system that will help the Agency leverage facility reports into usable data. Not only will this be less burdensome to the facilities, it will allow the Agency to provide this data back to the facilities. It is hoped this data will then provide material support to facility-level patient-safety programs, making them more effective.

New Rule

In CY 2008, the Agency initiated rule promulgation for both Inpatient and Ambulatory/ Emergency Department data collection rules. The rules were filed for adoption on June 22, 2009, and will be effective beginning January 1, 2010. The new Inpatient rule will expand data collection elements and include a new data set to capture rehabilitative services performed in general acute care hospitals. The Ambulatory rule will include freestanding emergency department (ED) data and the addition of new data elements to estimate the ED length of visit time. The Data Collection Rule aligns data collection data elements with Uniform Bill UB-04. This rule improves health care, and will continue to do so in the future, by evaluating rehabilitative services statewide and providing information to address ED utilization. Future steps include education and outreach to prepare for new data collection in January 2010.

Data Guide

Facilities currently look to the administrative rules governing the Florida Center's data collection program for guidance on how their data should be reported to the Agency. However, these administrative rules are legal documents. They were not intended to function as guidelines to assist in the actual compilation and submission of patient data. To further assist facilities, the Data Collection, Data Quality, and Patient Safety Unit produced the Guide to Submitting Inpatient & Ambulatory Discharge Patient Data (Data Guide). The Data Guide draws upon years of questions, comments, and requests that have been received by the Agency's staff. The Data Guide represents a commitment to helping facilities with the complex task of filing discharge data. The goal in producing the Data Guide is to help facilities clearly understand what data to file, when to file it, and how it should be filed. Therefore, every facility should be able to confidently submit data with a minimum of time and error.

As additional resources, the following figures provide a visual comparison for the historical volume of data collected.

Figure 3-1:

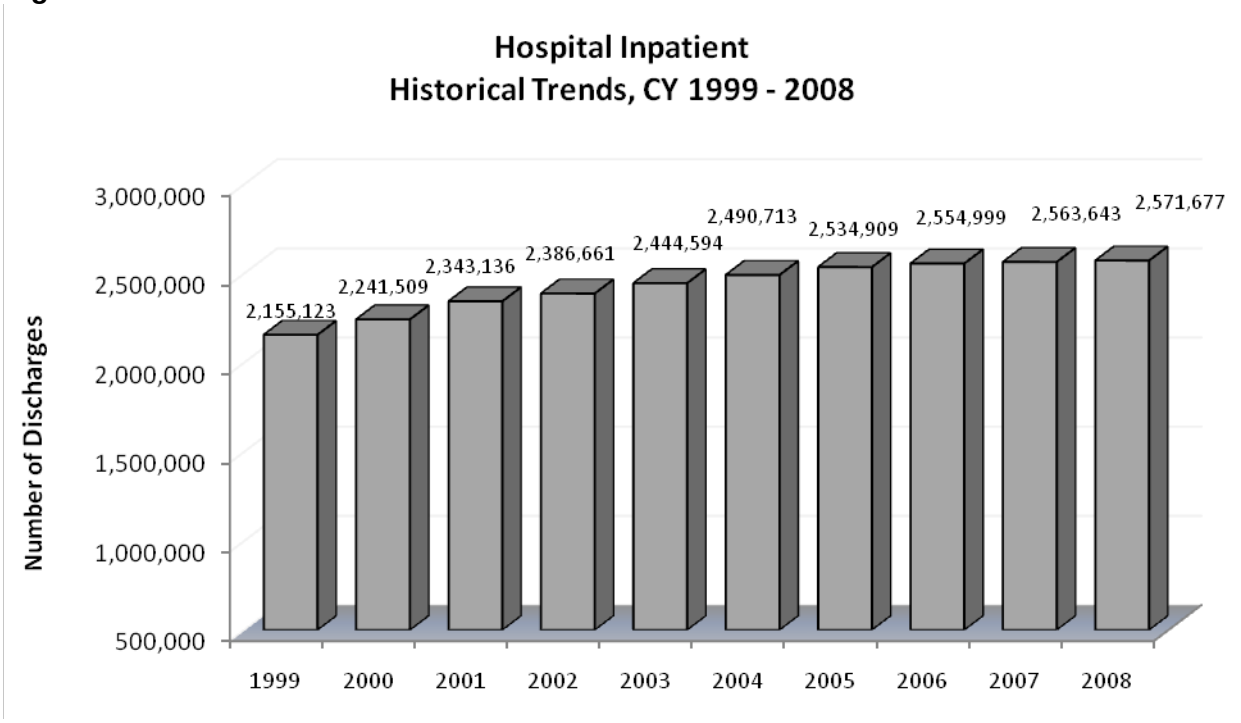


Figure 3-2:

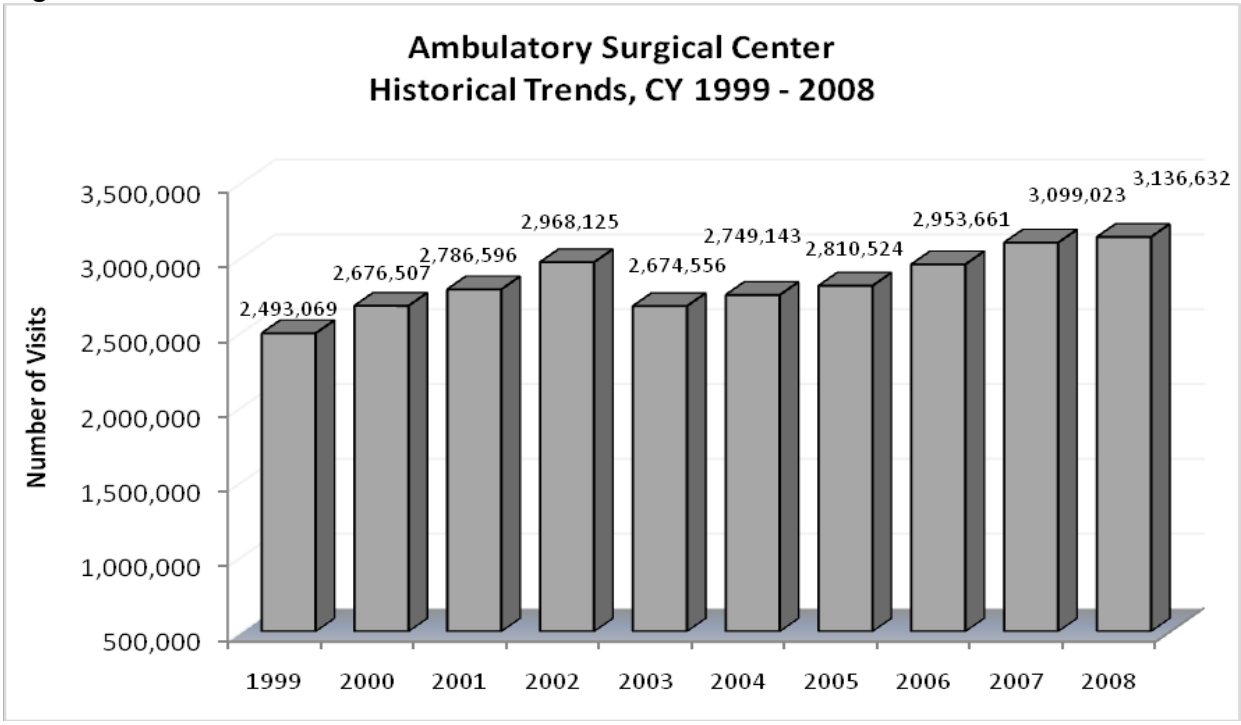
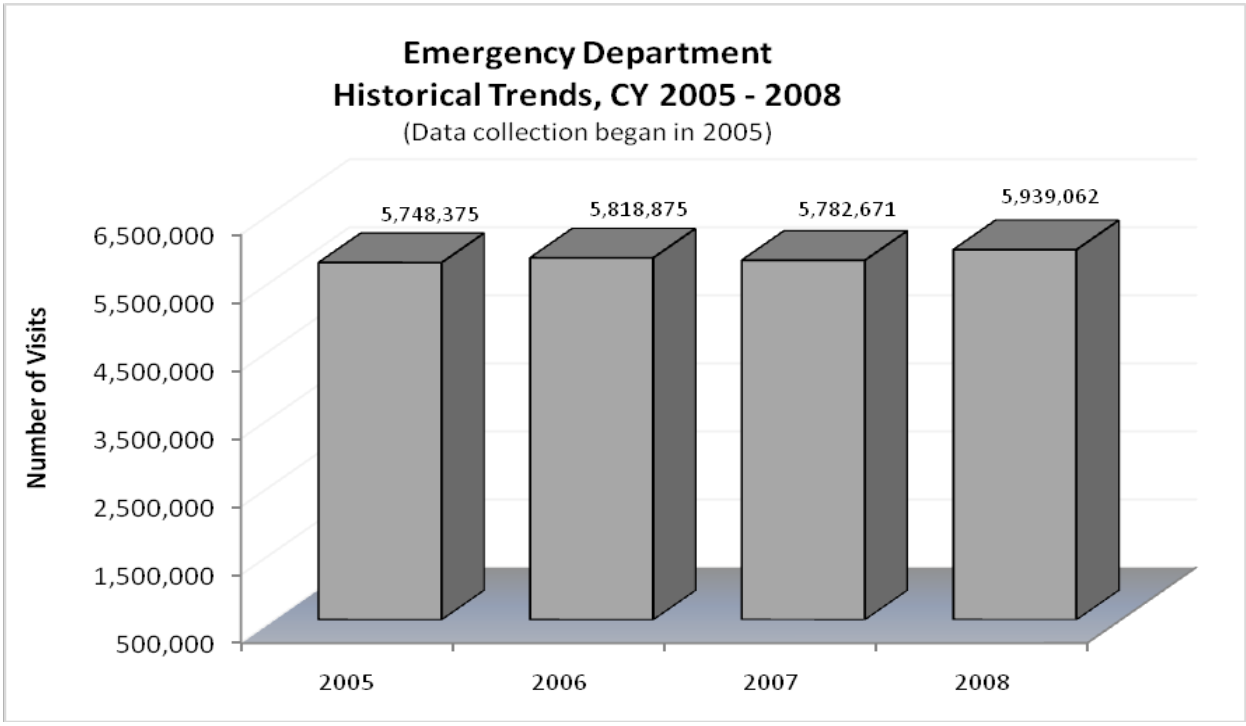


Figure 3-3:



Health Policy and Research

Health care research, policy analysis, studies, and reports are guided by §408.062, Florida Statutes. Research is a primary function of the Florida Center. The Office of Health Policy and Research transforms the data collected by the Florida Center into information that the public can use. This Office collaborates with researchers nationally to identify trends in health care utilization. In addition, the Office provides policy coordination and leadership within the Florida Center, and Agency. Copies of any report available on the Internet at www.FloridaHealthFinder.gov.

This Office is charged with numerous responsibilities relating to §408.05 and §408.061, Florida Statutes. The following details the health care initiatives being implemented by this Office.

Florida Center Annual Report

The publication and dissemination of the Florida Center Annual Report is required by §408.05(5) (d), Florida Statutes. Section 408.062(1) (j), Florida Statutes, directs the Florida Center to publish an annual status report on the collection of data and publication of performance outcome indicators. This includes the Long-Range Plan, and Facility Performance Data Status Report.

Health Plan Quality Indicator Data

Health Plan Quality Indicator Data Collection is required under §641.51(9), Florida Statutes, and implemented under Chapter 59B-13, Florida Administrative Code. Health plan quality indicator data are reported in a summary format by Florida's licensed health maintenance organizations for each line of business (commercial, Medicare, and Medicaid). The data display annual statewide quality measures gathered by health plans

and reveal trends. This begins with data reported in CY 1999. Health plan quality performance data are collected, analyzed, and published annually on the Agency website. Data come from the Healthcare Effectiveness Data and Information Set and compare the quality of services provided by health plans, across all health plan product lines.

Emergency Department Report
The Emergency Department Report fulfills the requirements of §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. This report provides patient demographic information and other characteristics on visits to hospital Emergency Departments, as well as information on visits to the Emergency Department that resulted in an inpatient hospital admission.

Health Care Expenditures Report
The Health Care Expenditures Report, is a report on health care expenditures in Florida required by §408.063(5), Florida Statutes. This report details annual spending by health care service providers (hospital, physician, pharmacy, and others) and payers (commercial, Medicare, Medicaid, and others). The report also compares Florida data to national trends. The Health Care Expenditures report describes payments for services delivered in Florida, including services delivered to nonresidents.

Health Care Cost and Utilization Project
The Florida Center submits facility discharge and visit data to a national project as maintained by the federal Agency for Healthcare Research and Quality (AHRQ). The database rolls up discharge data from 38 states, creating the largest national database of health care facility information, which also allows for comparisons amongst those states. This voluntary project builds on the data and efforts of state data organizations, state hospital organizations, and other private data organizations to create a national resource of health care data. Florida data is a key component in several Healthcare Cost and Utilization Project national databases, such as: 1) National Inpatient Sample, the largest all-payer health care database in the United States; 2) Kids' Inpatient Database, containing two million hospital discharges for children; 3) State Ambulatory Surgery Databases; and 4) State Emergency Department Databases. Florida data are included in many publications of the Healthcare Cost and Utilization Project, including the National Health Disparities Report and the National Health Quality Report.

In these reports, the annual performance of Florida facilities may be compared against the performance of other states. This allows researchers and policymakers to focus on deficient areas in Florida's health care system. Finally, the Florida Center has partnered with the Agency for Healthcare Research and Quality and other states on various research projects. These efforts include understanding post-hospital mortality; the effects of vaccination on rotavirus hospital admissions; the use of clinical data in improving the performance of the Quality Indicators; and ways to improve the collection and utilization of patient racial and ethnicity data. These projects have not been completed as of this date.

MyFlorida Rx
The Florida Prescription Drug Price Website, MyFloridaRx.com, was developed by the Florida Attorney General and the Agency to help consumers shop for the lowest price for prescription drugs in their area. The website provides retail pricing information ("usual and customary charge") for the 100 most commonly used prescription drugs in Florida.

Confidential Data Review Committee
The Security Administrator reviews requests for confidential data and the Committee reviews requests as appropriate. Data are considered confidential if they contain direct or indirect patient identifiers. The Committee members consist of Administrators from the Office of Data Dissemination and Communication; the Office of Health Policy and Research; and the Office of Data Collection, Data Quality, and Patient Safety. The Florida Center's Data Security Administrator and one representative from the Office of the Florida Center Director also serve as members on the Committee. The Committee decides whether to recommend the request, deny the request, or amend the request. Once approved, the application is forwarded to the Florida Center Director, Chief of Staff, Officer of the Health Insurance Portability and Accountability Act (HIPAA), General Counsel, and Agency Secretary for review and approval. Successful applicants must sign a Data Use Agreement that outlines the terms and conditions of their use of the Agency's confidential data. The Data Use Agreement contains provisions to ensure that the use of confidential data is consistent with state and federal law.

State Consumer Health Information and Policy Advisory Council
The Florida Center facilitates the scheduling, coordination, and operation of the State Consumer Health Information and Policy Advisory Council (Advisory Council), its sub-committees, and ad hoc workgroups in the fulfillment of legislative mandates. The Advisory Council advises Agency staff regarding health information and statistics. The composition and functions of the Advisory Council are described in §408.05(8) Florida Statutes and §408.61 Florida Statutes. The 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 committees and technical workgroups, the Advisory Council members and Florida Center staff have developed and implemented action plans in these developments. The committees and technical workgroups, as of August 2009, include: Data Standards and Transparency Committee, Health Information Exchange Coordinating Committee, and the Public Relations Workgroup. The Health Information Exchange Coordinating Committee is facilitated by the Office of Health Information Technology within the Florida Center.

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, 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;
- Staying abreast of new technologies to improve education and reach consumers more effectively;
- Examining rules to determine if current data collection should be expanded;
- Discussing expansion of current measures and inclusion of additional measures;
- 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 ambulatory surgery centers quality/outcome measures;
- Incorporate the appropriate AHRQ Patient Safety Indicators with Present on Admission;
- 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.

The collaborative effort between the Advisory Council and the Florida Center has yielded best practices for public reporting and consumer focused transparency activities which are implemented in the design of www.FloridaHealthFinder.gov.

Health Plan Member Satisfaction Data

The collection and publication of health plan member satisfaction information, is required under §641.58(4), Florida Statutes, and for commercial plans under Chapter 59B-14, Florida Administrative Code. The survey is known as the Consumer Assessment of Health Plan Survey (CAHPS). The Agency provides consumers a health plan link on the www.FloridaHealthFinder.gov website, which displays comparative information about benefits and performance of health plans throughout Florida.

Commercial health plans report data directly to the Florida Center. Companies complete a separate set of surveys for HMO plans and for PPO/indemnity plans. Medicaid and Healthy Kids HMO plans are surveyed by an independent vendor who forwards the data to the Agency. In CY 2009, there were a total of 18,340 completed surveys. The number of

CAHPS surveys by plan type that were completed and reported in CY 2009 is shown below:

- Medicaid HMO surveys 7,260
- Healthy Kids HMO surveys 1,756
- Commercial HMO surveys 6,248
- Commercial PPO surveys 3,076

Over the past four 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. It is believed that the posting of performance data for all health plans should have a positive effect on the delivery of care as they will strive to improve their performance over time.

Policymakers should review the member satisfaction information with an eye to areas that may need improvement. These data will allow policymakers to focus efforts on the weak areas while pointing to the strong performing areas as examples of excellence.

There is a need to better publicize the data that AHCA 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 poor performing plans decreases, while well-performing plans increase, 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. If successful in improving plan performance, this approach should be applied, where possible, to all other managed care plans.

State Health Data Directory

The creation of the State Health Data Directory is authorized in §408.05(4) (g), Florida Statutes. The State Health Data Directory was developed to assist individuals searching for health data and statistics. Its purpose is to facilitate referrals to the responsible data administrator. The administrator then provides detailed information regarding available data and promotes the efficient use of data for research and public policy purposes. The State Health Data Directory is available at 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.

Data Dissemination and Communication

Data dissemination is guided by §408.063, Florida Statutes. The Office of Data Dissemination and Communication performs several functions to ensure the public has access to health care information to assist them in making well informed health care decisions. The public includes consumers, policymakers, the Legislature, the Governor, the health care industry, the media, universities, foundations, students, private businesses, and advocates. This Office developed, and maintains, the consumer health care website, www.FloridaHealthFinder.gov. This website was created in the fall of 2007 when FloridaHealthStat.com and FloridaCompareCare.gov were consolidated. The website provides easy access to health care data, encourages health care transparency,

and includes a variety of information to assist consumers and professionals with their medical needs and medical research.

The Office also produces the Consumer Awareness Series. These are brochures that cover topics such as Florida Medicaid, home health care, long-term care, end-of-life issues, and patient safety, among others. Health care education is also provided through participation in community outreach programs for the purpose of heightening awareness on the importance of health care literacy.

Florida Health Finder Website

The Agency's website, www.FloridaHealthFinder.gov, was established to assist consumers in making informed health care decisions and lead to improvements in quality of care in Florida. Consumer reports and health related links are posted on the website as well as the ADAM Interactive Health Care Encyclopedia and Symptom Navigator. The website also provides performance data for selected medical conditions and procedures in Florida's short-term acute care hospitals and ambulatory (outpatient) surgery centers, as well as information to compare health plans on member satisfaction, coverage areas, and quality of care. For facilities, this includes volume, charges, length of stay, readmission rates, mortality rates, infection rates, and complication rates with a separate section for pediatric patients.

In June 2008, an additional measure was added to the website - Potentially Preventable Readmissions. This measure was developed in conjunction with 3M Health Information Systems and based on input from the State Consumer Health Information and Policy Advisory Council. Potentially Preventable Readmissions are a clinically-based classification system that identifies acute care hospital readmissions that are potentially preventable, based on the hospital discharge data. Florida is the first state in the country to publish Potentially Preventable Readmissions. This is another step in ongoing efforts to provide patients and health care providers with more information about the quality of Florida's health care system.

In addition, the Florida Legislature mandated the information provided on the website by increasing the number of conditions and procedures displayed to no fewer than 150 of the most commonly performed adult and pediatric procedures, including outpatient, inpatient, diagnostic, and preventative procedures. This information was added to the FloridaHealthFinder.gov website in November 2008.

Available Reports and Information

Several standard reports are available on www.FloridaHealthFinder.gov. From the home screen, users may select "Florida Consumers" or "Researchers and Professionals". Selecting "Florida Consumers" permits users to look up medical conditions and procedures and find out more information, including health outcomes. The site permits consumers to locate health care facilities and providers as well as driving instructions. It allows consumers to find and compare health plans, hospital and ambulatory surgery centers, hospice providers (added in April 2009), and nursing homes, for health outcomes and/or pricing information. The Florida Consumers page also contains a symptom navigator site that permits individuals to click on a human form and obtain more in-depth information. The "Researchers and Professionals" link allows specialized data queries but may require users to have some knowledge of medical coding and terminology. It permits users to search for health data, health reports, and guides. Pharmacy pricing data are available through a link to www.MyFloridaRx.com.

The Inpatient Facility Query allows a user to search by diagnosis and procedure codes and the ability to search by Medicare Severity-Diagnostic Related Groups. The Outpatient Facility Query allows users to search by CPT procedure codes and ICD-9-CM diagnosis and procedure codes. A new query tool for the Emergency Department data is now available and researchers and professionals can query by the patient's reason for visit, diagnosis, and evaluation and management codes (based on the principal CPT code).

Results can be returned by various demographics and other criteria. The results of the queries will return the most recent four quarters (one year) of data. Note that only principal diagnoses and procedures are used. Queries using secondary diagnoses and procedures must be requested from the Office of Data Dissemination and Communication.

Community Outreach and Education

E-mail requests from the public received through www.FloridaHealthFinder.gov are responded to by staff from the Office of Data Dissemination and Communication. Requests include data requests, educational information on health care issues, information on specific health care facilities and providers, Medicaid, and referrals to meet basic needs like health care, medication, insurance, food, and shelter. In CY 2008, the Florida Center responded to 1,706 requests for information as compared to 1,287 requests in CY 2007.

Staff from the Office of Data Dissemination and Communication also initiate and participate in community-based programs, as authorized by §408.063 (3) and (6), Florida Statutes. Such programs educate the public about health care issues, make consumer brochures available, and introduce the www.FloridaHealthFinder.gov website.

The Florida Center also works with community outreach and education through the publication of consumer materials, response to requests from the public, and participation in community outreach programs. The Florida Center participated in the Nova Southeastern University's Senior Health Fair on March 30, 2008, by providing resources such as bookmarks and consumer brochures. Last year, staff began, and continues, to develop ideas for outreach through an Internal Communications Team charged with preparing an action plan and marketing strategies for increasing visits to the FloridaHealthFinder.gov website. This internal team works in conjunction with the State Consumer Health Information and Policy Advisory Council's (Advisory Council) Data Standards and Transparency Committee and the Public Relations Technical Workgroup. Together, they work to expand and enhance marketing efforts by developing training videos on how to navigate the website, initiating outreach efforts to Advisory Council members' colleagues to provide tools for use at conferences, meetings and seminars, as well as researching and developing Web 2.0 marketing strategies.

The Florida Center has also been working with the Florida State University College of Information, Information Use Management and Policy Institute to perform a needs assessment study and testing of the website to provide various target audiences better access and to increase Florida residents' knowledge and awareness of the website.

Consumer Awareness Series

The Consumer Awareness Series is directed by §408.05(5) (a), Florida Statutes. The Consumer Awareness Series is written for health care consumers. The series consists of brochures designed to assist the public in making well-informed health care decisions. The brochures are available in English and Spanish and are 15 to 20 pages long. They can be

ordered by calling the Agency's Call Center and are also available on www.FloridaHealthFinder.gov. The brochures contain general information on health care topics as well as a resource directory for further information. In CY 2008, 142,804 brochures were distributed. Of these, 85.4 percent were English (121,906) and 14.6 percent were Spanish (20,898). The brochures published since CY 2000 include:

- A Consumer's Guide to Health and Human Services Programs;
- A Patient's Guide to a Hospital Stay;
- Assisted Living in Florida;
- Emergency Medical Care;
- End of Life Issues - A Practical Planning Guide;
- Florida Medicaid - A Reference Guide;
- Health Care Advance Directives (now available only online);
- Home Health Care in Florida;
- Long-Term Care;
- Patient Safety; and
- Understanding Prescription Drug Costs.

Next Steps

Continue to increase ease of access to information to allow consumers to make better choices in their health care while providing quality and performance measures and pricing information for providers. This continued effort will benefit Floridians by providing a more user-friendly format with more quality comparative information while providing more easily accessible information for Florida consumers. Transparency in health care enables consumers with the information necessary to compare the quality and price of health care services, so they can make informed choices among hospitals and providers. The Agency's website, www.FloridaHealthFinder.gov exemplifies transparency in health care while working towards the goal of providing better health care for all Floridians.

Continued outreach efforts include the ongoing development of bookmarks and brochures for website marketing efforts including open enrollment, conferences, meetings, health fairs, etc. while coordinating outreach with other agencies to provide links and materials for distribution. In addition, promotional videos of www.FloridaHealthFinder.gov are also being developed.

The Florida Center will also continue utilizing the Data Standards and Transparency Committee and the Public Relations Workgroup, sub-committees of the State Consumer Health Information and Policy Advisory Council, to continue the promotion and enhancement of www.FloridaHealthFinder.gov.

Health Information Technology (HIT)

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

During the CY 2009 Legislative Session, §408.051, Florida Statutes was created. This new legislation, also titled the *Florida Electronic Health Records Exchange Act*, provides the following:

- Deletes the exemption that allows long-term ombudsman councils to have access to certain nursing home patient records.
- Provides definitions for electronic health record, qualified electronic health record, certified electronic health record technology, health record, identifiable health record, patient and patient representative.
- Establishes standards as well as immunity from civil liability for accessing or releasing health information during an emergency.
- Requires the adoption and distribution of a Universal Patient Authorization Form, electronic or paper, developed by the Agency by July 1, 2010.
- Amends §395.3025 (4), Florida Statutes to provide that appropriate disclosure can be made to health care practitioners and providers involved in the care or treatment of the patient.
- Amends §483.181 (2), Florida Statutes to provide that appropriate disclosure may be made by the clinical laboratory to health care practitioners and providers involved in the care or treatment of the patient as specified in §456.057 (7) (a), Florida Statutes.
- Provides immunity from liability for a health care provider releasing an identifiable health record in reliance on the information provided to the health care provider on a properly completed Agency authorization form.
- Provides for compensatory damages, plus reasonable attorney's fees and costs if a person obtains the patient's authorization by forging a signature on the authorization form or materially altered the authorization form of another person without the patient's authorization, or if the requesting entity obtained an authorization form or an identifiable health record on another person under false pretenses.
- Subject to the availability of eligible donations from public or private entities and funding made available through §3014 of the Public Health Services Act, the Agency may operate a certified electronic health record technology loan fund subject to a specific appropriation as authorized by the General Appropriations Act.
- Requires the Agency, by rule, to develop standard terms and conditions for use in the loan program.

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 §408.05 (8), Florida Statutes. The HIECC has continued the work of the Governor's Health Information Advisory 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. In May 2009, Governor Charlie Crist designated the Agency for Health Care Administration, with the advice of the Health Information Exchange Coordinating Committee (HIECC), as the entity to lead Florida's efforts to draw down stimulus dollars for health information initiatives.

The health information technology initiatives of the Florida Center, listed below, will be implemented as a result of the American Recovery and Reinvestment Act of CY 2009 (ARRA). The following pages detail Florida Center activities as they relate to ARRA and provide information on current and future steps of these initiatives

Florida Center Health Information Technology (HIT) Activities and ARRA

Florida's HIT Infrastructure

Section 3011 ARRA directs the Health and Human Services (HHS) Secretary to immediately fund health information technology infrastructure. The Secretary shall invest funds through specified federal agencies. The use of funds includes health information technology architecture for nationwide electronic exchange. Electronic health records (EHR) for providers are not eligible for support under Medicare or Medicaid. Training on and dissemination of information on best practices to integrate health information technology will be provided. Funding will also be provided for infrastructure and tools to support telemedicine.

Regional Extension Centers

Section 3012 ARRA directs the Health and Human Services (HHS) Secretary to support regional extension centers to provide technical assistance to accelerate adoption of HIT. This will be overseen by the Office of the National Coordinator (ONC) for Health Information Technology. The purpose of Regional Extension Centers is to assist health care providers in the adoption, implementation and effective use of certified EHR technology. There will be financial support to the regional centers. Funding will be an unspecified portion of $2 billon and match will be 50 percent in-kind. Only not-for-profit entities are eligible. It is required that the entity submit applications that document the ability of the applicant to provide assistance appropriate to particular categories of providers, the services provided, geographic diversity, and amount of in-kind commitment. Funds will be used for training and technical assistance as well as dissemination of best practices consistent with ONC strategic plan.

Florida's Health Information Exchange (HIE) Plan

Section 3013 ARRA directs the HHS Secretary to support regional or sub-national efforts toward HIE through planning and implementation grants. This will be overseen by the Office of the National Coordinator for Health Information Technology. The purpose is to facilitate and expand the electronic movement and use of health information among organizations according to national recognized standards. Funding for this effort is $300 million. No match is required in CY 2010, a 10 percent match in CY 2011, a $1 for every $7 match in CY 2012, and a 33 percent match thereafter. State or state-designated entities are eligible. It is required that entities submit a qualified plan and consult with stakeholders. Funds will be used with broad discretion with various HIE projects; enhancing broad and varied participation in HIE; creating solutions to barriers to HIE, assisting patients in utilizing HIT, supporting public health agencies in the use of electronic health information; and promoting use of EHRs for quality improvement.

Electronic Health Records

Section 3014 ARRA provides that the HHS Secretary may issue competitive grants to states for the development of loan programs to facilitate the widespread adoption of certified EHR technology. This will be overseen by the Office of the National Coordinator for Health Information Technology. The purpose is to provide loans to providers for

certified EHR technology. Funding is an unspecified portion of $2 Billion. A required match is $1 for each $5 which may come from private entities. The funding provides four percent for administration. States or Indian tribes are eligible. It is required that entities submit an application, strategic plan, and documentation. Funds will be used to facilitate the purchase of certified EHR technology; enhance utilization included the cost of upgrades; train personal; and improve the secure electronic exchange of health information.

Electronic Health Record Incentive Program

Sections 4101/4102 and 4201 provide Medicaid support and Medicare incentives for certified EHRs. This is overseen by the Centers for Medicare & Medicaid Services (CMS) (sec. 4101/4102) and State Medicaid agencies (sec. 4201). The purpose is to support the costs for acquiring, implementing certified EHRs. Funding is $17 billion. This includes Medicaid and Medicare. Eligible Medicaid providers may receive up to 85 percent of allowable costs for EHR technology and support services up to 85 percent of $75,000 over five years. Funding for hospitals is capped at the Medicaid IT share for the hospital. Match is 10 percent for Medicaid administration. Eligible entities include Medicaid providers, including eligible professionals (physicians, nurse mid-wives and nurse practitioners) where 30 percent of patients are Medicaid eligible, federally qualified health centers, rural health clinics, and children's and acute care hospitals (with not less than 10 percent Medicaid eligible patient volume). A requirement is that the state must track Medicaid provider usage of systems; provide adequate program oversight; and pursue initiatives to encourage the adoption of certified EHRs to promote health quality and exchange of health information. Recipients must demonstrate meaningful use to receive Medicare incentives.

Broadband

Section 6001 ARRA directs the National Telecommunications and Information Administration (NTIA) to deploy wireless and broadband via grant programs. This is overseen by NTIA and Rural Utilities Services (RUS). The purpose is to deploy wireless and broadband in rural areas. The funding is $4.7B through NTIA and $2.5B through RUS (25 percent in unserved and 75 percent in underserved areas). This includes unspecified funding for wireless. This funds no-recurring costs. Match is 80/20 where match can be third party partnering with applicant. Eligible entities include a wireless provider, including satellite provider; a State or unit of local government, or agency or instrumentality thereof; any other entity, including construction companies, tower companies, backhaul companies, or other service providers if such entity is required to provide access to on a neutral, reasonable basis to maximize use. It is required that states submit a list of priorities within 75 days of enactment. Various factors will be considered – at least one per state. Use of funds is for loans, loan guarantees, and grants.

Florida Center HIT Initiatives and Next Steps

Medicaid Health Information Network: Personal Health Records/Baby Book

In June 2009, the Agency contracted with Availity, LLC to deliver Medicaid claims history along with claims from multiple payers to providers and to consumers. Health Trio was engaged via subcontract to provide the personal health record (PHR) for Medicaid recipients. The PHR empowers Medicaid patients with their own individual health data. The first target population for the PHR is new mothers with children and is expected to become available in late CY 2009. The online PHR tool is where parents/caregivers will be able to access their child's medical information in an easy to view and use format. The record will allow parents/caregivers to:

- Save their baby's information and retrieve it at anytime and anywhere;
- Enter height, weight and other health-related information;
- View health check-up and immunization schedules and check off completed visits and shots;
- Sign up for email or text message health check-up and immunization reminders;
- Review health information related to their baby's specific condition, if applicable and receive related email or text messages;
- View paid health claims for their baby displayed in plain language;
- Have access to other vendors; and
- Give their baby's provider access to the information.

Florida's Health Information Exchange Plan (HIE Plan)
Florida's HIE Plan is being developed by the Agency and the Health Information Exchange Coordinating Committee (HIECC). The HIE Plan provides background.

Over the past several years, the Agency, in collaboration with multiple stakeholders, has developed and implemented a strategic plan to facilitate the exchange of health information among health care providers, consumers and payers. Funds provided for health information technology through the American Recovery and Reinvestment Act of CY 2009 (ARRA) will provide Florida with the ability to further our efforts substantially.

The Agency, advised by the Health Information Exchange Coordinating Committee, has recently been designated by Governor Crist to lead Florida's health information exchange efforts to be funded by the economic stimulus. The following provides Florida's proposed vision statement for health information exchange, goals and objectives, including an action plan to prepare a proposal for submission to the Office of the National Coordinator for state planning and implementation grant funding, and a high-level overview for putting into effect statewide health information exchange in Florida.

Florida Health Information Network – Vision Statement
The Agency and its partners will work to achieve a sound and logical approach to health information exchange that produces the delivery of better health care for Floridians, including enhanced patient safety and improved coordination of care, by promoting the adoption of interoperable electronic health record systems and through the use of health information technologies meeting national standards. This is best accomplished through a public-private partnership, in collaboration with payers, providers, consumers and health information technology partners.

Florida's HIE Plan addresses the following:

- Overall vision, goals, and system components;
- Technical model for HIE;
- Business model for HIE;
- Types of functions and expertise required for implementation;
- HIE development and operations;
- Quality analysis database development;
- Broadband infrastructure development;
- Medicaid EHR Program;
- Regional Extension Centers for provider EHR training; and

- Comments from stakeholders.

Comments on Florida's HIE Plan and other activities can be found at www.FHIN.net.

Point of Care Model Electronic Health Record Grants Program
The purpose of this program is to provide support for the deployment of an electronic health record (EHR) system in outpatient clinics for improved case management of patients that could serve as a model for implementation in other clinics in Florida. For Fiscal Year 2008-2009, grant funding was $100,000, dispersed on a quarterly basis. At the July 10, 2009, meeting of the Health Information Exchange Coordinating Committee (HIECC), Miami-Dade County Health Department presented on activities through June 30, 2009. They focused on the implementation, training, go-live, evaluation process, successes, perceived benefits, challenges, cost savings, lessons learned, and future plans. The Miami-Data County Health Department implemented a training program that is Onsite; Online (tutorials); and WebEx with HCN Trainers (One-on-One). This training is meant to ensure success in the implementation of EHRs. The EHR went live on schedule; there is an enthusiasm for future use and development; and systems and all modules are actively being used. The modules implemented and actively used are as follows: Practice Management: Patient Registration; Scheduling; Referrals; Phone Messaging; Electronic Health Record: Encounter Notes; Rx Writer; Digital Office Manager/Imaging; Health Management; Lab results; and Trending. The commencement of project report and invoice was January 10, 2009. The interim technical report through March 31, 2009, was given on April 10, 2009. The final report and presentation through June 30, 2009, was given at the July 10, 2009, meeting of the HIECC.

The benefit to using EHRs includes: the elimination of "paper"(forms, charts, referrals); increased productivity (e.g. no longer waiting on hold for lab results from hospitals); improved documentation; improved patient flow; Rx contraindications alerts when ordering or dispensing medications; evidence based protocols (point of care decision making); reduced duplication; the ability to give migrant workers a Personal Health Record; advanced reporting to assist free clinics in grant writing activities; and the back-up & archive of records. The implementation of EHRs provides better management of diseases and improved patient education; helping to keep Floridians involved and responsible in making better health care decisions.

The implemented electronic health record system is meant to capture patient information at the point of care for patient management, provide real-time access to that information, ensure that electronic health records are accessible to all participants, and provide a standardized format for health care procedures and reporting of patient information. All of these components work to create better health care for all Floridians.

Outreach and next steps include working with stakeholders to apply lessons learned. We will also assist in developing an implementation plan for outreach strategies of the Medicaid EHR Adoption Program. Fostering collaboration between free clinics on EHR and non-EHR operational issues is important to successful implementation as well as the continuation of training programs on EHRs. Next steps also include the evaluation of the implementation of EHRs in order to understand the impact on workflows; satisfaction with EHR technology; improvements in quality care delivery; and cost benefits.

Availity Care Profile: Electronic Health Records for Medicaid Treating Providers
In CY 2008, the Agency issued a Request for Information (RFI) to determine the capability of vendors to offer a statewide, multi-payer health information exchange which would include Florida Medicaid claims data at no cost for a two-year demonstration. In early CY 2009, the Agency contracted with Availity, LLC to deliver Medicaid claims history along with claims from multiple payers to providers and to consumers. Availity, LLC was engaged to provide the electronic health record to Medicaid treating providers.

This will benefit consumers by providing Medicaid treating providers with the claims history of Medicaid recipients that is retroactive by eighteen months, to ensure quality care, prevent duplicate tests or treatment, and supplies up-to-date laboratory information. This initiative improves the way information is communicated between a Medicaid recipient and his or her Medicaid treating provider. This initiative is expected to roll out in Fall 2009. Next steps include engaging providers to participate in the roll out through provider outreach activities being initiated by the Florida Center and the Agency's Office of Communications. Outreach activities will include training, brochures, newsletters, e-mails, and other forms of communication and marketing.

Participation in the Health Information and Security Privacy Collaboration
A new interactive Crosswalk Tool has been developed for retrieving information on state and federal laws and regulations related to electronic health records and health information exchange. The Crosswalk Tool is the latest addition to the Agency's Health Information Privacy and Security Resource Center available at: www.FHIN.net.

The Crosswalk Tool is a result of the FY 2008-2009 federally-funded project under the Health Information Security and Privacy Collaboration. The project created a database titled the Comparative Analysis Matrix. The Comparative Analysis Matrix is a collection of almost 150 categories, typically addressed by state law, that involve or impact health information exchange.

The Crosswalk Tool provides user-friendly features to assist in searching the Comparative Analysis Matrix database. Users can search by subject matter keyword, Comparative Analysis Matrix category, or by alphabetical listing. The results illustrate the difference in privacy regulations between Florida requirements, the Health Insurance Portability and Accountability Act (HIPAA), and other federal regulations. HIPAA privacy law is the federal standard regarding health information exchange. However, states may require more stringent privacy standards that providers must follow. The Crosswalk Tool displays relevant federal and state citations in a side-by-side presentation, where differences are noted and highlighted. Links to the federal and state laws and regulations are provided to assist the user.

The Crosswalk Tool is designed to serve as an educational resource for health care providers regarding health information exchange requirements and consumer rights and protections.

Federal Communications Commission (FCC) Rural Health Care Pilot Project
In November 2007, the FCC awarded $9.6 million to Big Bend Health Regional Health Information Organization (RHIO) to build a gigabit fiber optical network connecting nine rural hospitals in the Florida Panhandle. Agency staff drafted the proposal, and now administers the project as a public-private partnership. A major barrier to initiating construction was the requirement to raise 15 percent of the award in matching funds. The

staff of the Florida Center wrote a Rural Infrastructure Grant for Enterprise Florida in early 2009 and was awarded a $1.12 million grant from the Office of Tourism, Trade, and Economic Development to cover the match and allow the project to begin. The Rural Infrastructure Grant was announced in April, 2009.

The FCC Rural Health Care Pilot Project will bring high speed broadband access to rural hospitals in the Florida Panhandle with the opportunity of accessing the health information exchange services of the Big Bend Health RHIO. The health care network could provide high speed connectivity to specialists in Florida via videoconferencing, and will allow the rapid, secure transfer of large digital imaging files such as x-rays and MRIs. This is an improvement in health care because it allows physicians and other clinicians located in rural areas to treat patient conditions locally. Next steps include discussion of construction and building the network necessary for this project.

List of Potential Policy Changes Affecting Agency Budget Requests

Number	Potential Policy Changes	The Legislative Budget Requests (LBR) Affected	Impact on Policy if LBR Request not Approved
1.	Create electronic prescribing adoption incentives.	Medicaid Electronic Prescribing	Continued inefficiencies and medical errors.
2.	Improve efficiency of patient data collection and dissemination systems.	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.	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	Implementing Bill or Statute	Task Forces and Studies In Progress	Required/ Expected Completion Date
1.	§408.05(3) (k) (1) 4, F.S.	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.	Beginning January 1, 2006: Annually
2.	§ 408.0611 (3) F.S.	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.	January 31: Annually
3.	§ 408.0611 (3) F.S.	By January 31 of each year, the Agency shall report on the progress of implementing electronic prescribing to the Governor and the Legislature.	January 1, 2006: Annually
4.	§ 408.05 (3) (k) F.S.	Develop, in conjunction with the State Consumer Health Information and Policy 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.	October 1, 2006: Quarterly

Number	Implementing Bill or Statute	Task Forces and Studies In Progress	Required/ Expected Completion Date
5.	§ 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.	Annually
6.	§ 408.05 (1) (d) F.S.	The Florida Center shall be responsible for publishing and disseminating an annual report on the center's activities.	January 1, 2005: Annually
7.	§ 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.	Beginning January 1, 2006: Annually
8.	§ 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.	January 31: Annually
9.	§ 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.	January 1, 2006: Annually

Number	Implementing Bill or Statute	Task Forces and Studies In Progress	Required/ Expected Completion Date
10.	§395.0197(8) F.S.	The Agency shall publish on the Agency's website an annual summary and trend analysis of all adverse incident reports and malpractice claims information provided by facilities in their annual reports, which shall not include information that would identify the patient, the reporting facility, or the practitioners involved.	Annually/ Quarterly
11.	§408.05(4) (a), F.S.	The center shall provide technical assistance to persons or organizations engaged in health planning activities in the effective use of statistics collected and compiled by the center. State Health Data Directory	Annually
12.	§408.05(3) (k)2, F.S.	Make available performance measures, benefit design, and premium cost data from health plans licensed pursuant to Chapter 627 or Chapter 641	Annually
13.	§408.051, F.S.	By July 1, 2010, the agency shall develop forms in both paper and electronic formats which may be used by a health care provider to document patient authorization for the use or release, in any form or medium, of an identifiable health record.	By July 1, 2010

Inspector General

The Medicaid program is a $16 billion program with over 80,000 providers providing Medicaid services to more than 2.3 million recipients. Within the Office of the Inspector General, the Bureau of Medicaid Program Integrity (MPI) is primarily responsible for recouping overpayments and overseeing the integrity of the State's Medicaid program. Section 409.913, F. S., and Section 42, Code of Federal Regulations mandate that 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.

The Agency for Health Care Administration and the Medicaid Fraud Control Unit of the Department of Legal Affairs annually (January 1) 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. This report contains 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. This report captures MPI's efforts for the fiscal year. (Annual Report 07-08)

In February, 2006, President George 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. 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. 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.

As part of its MIP initiative CMS's subcontractors are reviewing Florida's Medicaid claims history data and conducting 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 needs to be strengthened.

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.

MPI case management units, discovery and detection units continue their efforts to monitor Florida's Medicaid Program. The Office of the Inspector General Annual Report (s. 20.055 (7) F.S.), to the Secretary details the Office of the Inspector General's efforts to combat Medicaid fraud and abuse. The Annual Report on The State's Efforts to Control Medicaid Fraud and Abuse to the Legislature for FY 2007-2008 (Annual Report 07-08) was issued in December, 2008. The FY 2008-2009 report should be available for release in December, 2009. MPI recovery efforts as reported in FY 2007-2008 were $28.9 million.

As noted in the Fraud and Abuse report several factors significantly affected MPI operations in FY 2007-2008:

- Major transition to the new Florida Medicaid Management Information System and Decision Support System (FMMIS/DSS). -- MPI was necessarily and extensively involved in the testing and fine tuning of the systems, since they are critical to the fraud and abuse detection and investigation activities of the bureau.

- Also, the Agency's contract with the Third Party Liability contractor ended and the awarding of the new contract was challenged. -- Services were not fully available for several months in FY 2007-2008 and FY 2008-2009. Detection services provided by the contractor were vital to our efforts to detect fraud and abuse claims and affected overpayment recoveries.

- During this same time period, the federal government's pilot auditing test for which Florida was a participant began. MPI actively assisted Centers for Medicare & Medicaid Services (CMS) in the development of provider audit protocols and was comprehensively involved conducting detection, suggesting providers for audit and sharing information concerning its extensive provider audit history and experience.

- In addition, The Agency's use of statistical sampling was challenged in the courts. -- Legal proceedings culminated in a court decision upholding the Agency's practices in this regard; but, not before the Agency was precluded, for more than a year, from issuing binding audit reports incorporating statistical sampling.

Medicaid Program Integrity oversight efforts of prevention, detection and recovery require review of individual provider records in detail: a one-by-one review of provider claims for compliance and medical necessity. In light of this fact, we will request additional staff to conduct detection, prevention, recoupment activities and to impose sanctions – all of which work together in synergy to provide overall bureau success. In the normal course of business and to accomplish our goals of increasing recovery over the next five years and of preventing, reducing and mitigating health care fraud in the Medicaid program, Medicaid Program Integrity will use available resources in the most effective and efficient manner to focus on crisis designated locations and provider types. Medicaid Program Integrity will work collaboratively with interagency divisions (Health Quality Assurance, Medicaid, and etc.) as well as with other state (Medicaid Fraud Control Unit, Department of Health, and APD) and federal agencies. The bureau will continue generating quality referrals by our field and detection units and will move toward the development of a health care fraud data website where various agency actions against various health care providers is readily available to facilitate the electronic exchange of information between those regulating health care providers. It will provide oversight for managed care by reviewing the compliance of various plans in conjunction with contract language, recommending enhancements to such contract language, and developing an audit program. Data detection and research units will continue to improve methodologies and tools for data analysis including reviewing possibilities of vendor assisted participation. In general, we will strive to continue to increase prevention efforts (site visits, prepayment reviews, etc.); to increase detection efforts (data analysis and research for improved methodologies and tools) and to increase recovery efforts (increased number of audits and recoupment).

Medicaid fraud and abuse is a national concern. The CY 2009 Legislative Session with Senate Bill s1896.pdf designated Miami-Dade as a health care fraud crises area. The bill stresses the urgency the Legislature places on the need for additional efforts to prevent, reduce and mitigate health care fraud, waste and abuse as we strive to maintain the integrity of the Medicaid program, oversee the financial responsibility associated with administration of the program and provide "BETTER HEALTH CARE FOR ALL FLORIDIANS." Medicaid Program Integrity will continue to work with local, state and federal law enforcement and prosecutorial agencies to stop criminals, reduce fraud and protect the integrity the Florida Medicaid program from abuse.

The Agency is in the process of implementing Senate Bill s1896.pdf. The bill emphasizes and requires a wide range of communication, exchange of information, and application of action. It impacts, among other things, licensing of parties; enrollment of Medicaid providers; Medicaid provider suspension and termination; standard and sunshine reporting; referrals to Health Quality Assurance, Medicaid, Medicaid Program Integrity, Department of Health, and the Medicaid Fraud Control Unit; calculation of overutilization and follow-up; and rule amendments. Collaborative partnership of all involved will enhance upfront prevention measures in general and specifically in designated high risk areas such as home health agencies, durable medical equipment suppliers, and medical health care clinics in Dade County.

Table 4.1:

MPI Recovery of Overpayments (millions)				
Activity	FY 2004-2005	FY 2005-2006	FY 2006.2007	FY 2007-2008
MPI Audits	$11.6	$16.3	$18.9	$15.6
Reversals	1.5	0.9	0.7	.5
Claims Adjustments	7.4	10.8	15.0	12.8
Total	$20.5	$28.0	$34.6	$28.9

List of Potential Policy Changes Affecting Agency 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

Number	Identify Proposed Change	Describe Expected Results of Proposed Change	Describe Legislative Actions Required to Implement the Proposed Change
1	None		

List of All Task Forces and Studies in Progress

Number	Implementing Bill or Statute	Task Forces and Studies in Progress	Required / Expected Completion Date
1.	Medicaid Fraud and Abuse Report (409.9l3, F.S.)	Annual: Joint report AHCA and MFCU documenting effectiveness of efforts to control fraud.	January 1 each year
2.	Annual Audit Plan (20.055(5) (h), F.S.)	Annual: Schedules engagement for the upcoming fiscal year.	September 30th annually
3.	Office of Inspector General Annual Report (20.055(7), F.S.)	Annual: Summary of all activities within the Inspector General's office for the previous fiscal year.	September 30th annually
4.	Senate Bill 1986	Implementation and coordination with AHCA, DOH, MFCU, APD, etc. (74 sections of bill) effective July 1, 2009	As soon as possible

Trends and Conditions Statements

Communications and Legislative Affairs

The financing of health care for Americans is a focus of significant state and national attention. The funding challenges for our state continue to increase during the current economic downturn and will only become more challenging as more Floridians age and the demands for health care services and information increase. Contact between the Agency and the public, the media, and state and federal legislators becomes even more critical in such times of change. The trends indicate that Communications and Legislative Affairs must play a critical 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.

Through coordination and communication of the Agency's activities and objectives, federal and state policy makers have access to 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 Florida's health care delivery system. As a result, the Agency's legislative staff's commitment to promoting health care initiatives that provide assistance to Floridians in need will remain a top priority. To ensure that health care consumers have access to information that helps them make informed choices, the Agency will continue to develop and promote transparency and access to health care outcome and performance information through its websites. 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, advocates and stakeholders 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 they do not provide an accurate picture of the majority of interactions of the Legislative Affairs and Communication Offices with outside entities. 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.

Communications and Legislative Affairs have 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.

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List of All Task Forces, Studies in Progress

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Information Technology

The Agency for Health Care Administration's Division of Information Technology (IT) is responsible for overseeing the Agency's use of existing and emerging technologies in government operations, and its use in delivering services to its customers and the public. The Division's overall goal is to maximize the Agency's efficiency through technology.

The administration of enterprise security of data and information technology is governed by §282.318 F.S. which provides comprehensive guidelines in conducting risk analysis, the development of policies and procedures, security audits, and end-user training. This statute also instructs agencies to develop a process for detecting, reporting and responding to security incidents, and the procurement of security services.

Currently, the Division's functional areas are represented by four Bureaus, each with clear and distinct responsibilities but deeply invested in working as a unit to ensure that the Agency's goals are met. The Division's Bureaus are: Customer Service and Support, Application Development and Support, IT Strategic Planning and Security, and Enterprise Infrastructure.

Agency Responsibilities and Obligations

As Florida's population ages, finding new and more cost efficient ways to support vital health care services is critical to the continued success of the Agency and its charge to keep Floridians healthy.

With the national and state spotlight brightly focused on health care initiatives, the Agency's success depends on its response to new programs and initiatives. For this reason, the Agency has chosen to prioritize innovation, return on investment, efficiency, and customer service. To this end, the Agency brings new energy and direction to bear on its mission with a heightened regard for information technology and its capacity to strengthen and streamline the Agency's internal operations and services to providers.

The Agency recognizes that its routine and mission critical operations must be consistently and reliably available to internal business users and providers. A key factor in the Agency's ability to meet its responsibilities in this regard is the quality of its staff. The Agency must do everything in its power to recruit and retain qualified and experienced staff. The Agency's rate of compensation is critical to keeping valued staff employed by the Agency: it is a significant component of employee job satisfaction. In years past when the state economy flourished, Agency employees were often lost to the private sector. Now, in times of economic hardship, the private sector is not as much of a threat to retention; instead, other state agencies, many of which have much higher salary levels, are in a position to draw much needed resources away.

Strategic Planning, Vision, and Oversight

The Agency's executive management team strongly supports the use of technology as an effective tool in furthering the Agency's goals and objectives. Evidence of the Agency's commitment to its present and future investment in technology solutions and the staff responsible for them is the Secretary's decision to elevate the organizational status of the Bureau of Information Technology to the Division level (FY 2008 – 2009). The effects of doing so have been profound. The Division of Information Technology now functions as a partner in Agency strategic planning and vision creation in contrast to its former role, which was for all

intents and purposes, a bureau tasked with providing information technology utility services (Helpdesk and Call Center services, application development and support, and infrastructure support) but without a strong presence in the Agency's decision making and planning processes.

The appointment of an agency chief information officer (CIO) is governed by §282.3055 F.S. This statute instructs the CIO to coordinate and facilitate the management and planning of agency information technology services using standards and procedures developed by the Agency for Enterprise Information Technology.

The Agency's long term policy intentions with regard to the ways in which information technology is leveraged are further demonstrated by the efforts of the executive management team to consolidate all information technology purchases and other significant decision-making (with the exception of the Medicaid program fiscal agent Florida Medicaid Management Information System/Decision Support System FMISS / DSS) within the Division. This effort is in its nascent stage during FY 2009 – 2010 but is a key factor aligned with the Agency's "AHCA-celerate Florida" initiative, an ongoing effort to streamline and eliminate redundancy and inefficiency across all of the Agency's regulatory and operations practices and procedures. The consolidation of information technology efforts within the Division of Information Technology will facilitate the identification of duplicative efforts and purchases that cross purposes with the Agency's long-term goals.

To this end, the framework established by the Agency facilitates a process whereby management teams representing business units and the Division of Information Technology discuss and determine the priority, feasibility, and viability of information technology projects within the context of what will most benefit (with respect to cost and purpose) the Agency. The Agency's Governance Steering Committee and its division-level partner, the Technology Advisory Group (TAG), and their concomitant review and decision-making processes will ensure that information technology projects are designed to fulfill current or immediate needs and serve the Agency's mission in the future. Recent successes that are directly attributed to the Governance Steering Committee and the TAG are:

- Implementation of virtual servers. The impact of this effort is the reduction of server hardware in the Agency's data center. Fewer physical servers results in reduced power consumption, hardware maintenance and licensing costs.

- The Agency reduced power consumption associated with its data center as a result of the virtualization project and the adoption of advanced power management technology.

- Upgrade of the Agency's facilities licensing database which will allow for future application integration.

- Installation of Voice over Internet Protocol (VoIP). The Agency's analog phone system is in the process of being replaced by a VoIP system.

- Where possible, the Division replaced Enterprise Oracle© software with Oracle Express©. The Division is moving to replace its Oracle RDBMS© with SQL Server©.

The Governance Steering Committee and the TAG are highly motivated to seek and evaluate cost-savings and efficiency enhancing opportunities similar to those listed above.

As health care needs evolve, the Agency seeks to not only keep pace with but intends to actively prepare for conditions that threaten to disrupt normal operations. Natural disasters and pandemics, though rare, are a real threat. To mitigate the risk of major disruptions in service, the Agency is in the process of providing mobile computing devices and technologies (laptops, tablets, Virtual Private Network [VPN]) to staff identified as critical to maintaining operations. In the case of a pandemic or hazardous workplace conditions, these staff will be equipped and prepared to work from locations designated as safe.

New Division & Leadership Promotes a Cultural Shift

The appointment of strong leadership combined with a forward-thinking approach to technology has generated a positive cultural change within the Agency. In the past, new technology projects were proposed by stakeholders without consideration of projects already in development or production. Here again, the Governance Steering Committee, the CIO, and the TAG provide direction and oversight to the Agency by reviewing all proposed projects and prioritizing them according to need. It is the express purpose of these bodies (Governance Steering Committee and the TAG) to align all information technology initiatives with the ongoing mission of the Agency.

Employees of the Division have been greatly inspired by new leadership and the resulting environment of innovation and collaboration. Employees are encouraged to research new approaches and develop creative solutions for business users. By leveraging technological advances and state resources, the Division has been able to maximize the use of its current operating budget. The Division is a leader in collaborating with other state to provide its customers with needed tools.

The Division has adopted a customer-centered approach, encouraging all bureaus to work together to help solve user issues, develop requirements for new applications, and enhance existing systems. The emphasis on the quality of customer service fosters and rewards a culture of trust, issue ownership, and collaboration.

The Agency regularly surveys staff and providers who receive Call Center and Helpdesk services. The efforts associated with the surveys are twofold: 1) to measure the level of customer satisfaction experienced by consumers of the Division's services; 2) and to monitor the effectiveness of the surveys themselves. The Division intends to expand these efforts to survey members of the Agency's business units who participate in requirements gathering and application development processes.

Internal and External Influences

There are several factors that, singularly and together, strongly influence the Agency's options for fulfilling its current responsibilities and achieving its future goals. Of the many (often competing) factors the Agency contends with each year, there are three which most significantly influence the Agency's use of information technology to support its efforts and reach its goals:

- the rapidly growing need for information technologies to implement and support health policy;
- increasing importance of securing data from threats and disclosure; and the
- IT public sector labor market.

This section describes the nature of the issues and how they influence the Agency's five-year planning as well as highlights the specific objectives of the Division created as a result these influences, and how the objectives will help the Agency achieve its goals.

The most powerful trend influencing the Agency's planning is the continued rise of the need for the integration of information technology in health care. Every sector of the health care industry has experienced significant growth and increases in the cost of doing business and providing services. Information technology will become instrumental in facilitating the following:

- integrating of disparate systems;
- Health Information Exchange capabilities; and
- Automation of regulatory processes.

The second strong influence on the Agency is comprised of two trends that show no signs of abating: the heightened concern and legal requirement to protect sensitive, personal, and confidential information; and the rapid increase in the capabilities and sophistication of criminal organizations and individuals specializing in the theft and illegal use of data.

While the national awareness of the issue data security is clearly heightened, the seriousness of the subject is made clear by the proliferation of federal, state, and local requirements and laws for the protection of data. Consider the following examples of regulatory action related to data security from the past decade:

- **Health Insurance Portability and Accountability Act (HIPAA).** Under HIPAA, a person may face criminal penalties if the person "knowingly and in violation of" HIPAA "obtains individually identifiable health information relating to an individual" or "discloses individually identifiable health information to another person." If convicted for any of these crimes, the person faces up to $250,000 in fines and up to five years imprisonment depending on the circumstances.

- **Federal Trade Commission (FTC).** The FTC act prohibits "unfair or deceptive acts or practices in or affecting commerce" and empowers the Federal Trade Commission (FTC) to enforce the FTC act.

- **State Data Breach Laws**. Many states have enacted data breach notification statutes, requiring entities to disclose any actual or potential breach of security that could result in the disclosure of protected information.

- **Confidentiality Laws.** Every state has laws that restrict the disclosure of at least certain health care information. In particular, many of these state laws provide protections for areas of heightened confidentiality concerns, such as AIDS/HIV, substance abuse, mental health, developmental disabilities, and genetic testing. Some states have elaborate regulatory approaches. Additionally, federal regulations impose stringent confidentiality requirements for substance abuse treatment information.

- **Information Crimes**. Federal law has created numerous crimes that may be implicated by the theft of a laptop containing identifiable information or other security breach, including identity theft; fraudulent access of a computer; aiding and abetting a crime; and conspiracy to commit a crime.

- **The Federal Privacy Act**. The Federal Privacy Act of 1972 also imposes strict privacy obligations on government agencies. Although there are many similarities to HIPAA and other confidentiality laws, there are significant differences.

The Agency for Health Care Administration (AHCA) is working assertively to be compliant with a large number of complex laws and regulations. Additionally, while requirements and responsibilities to protect data have grown, and the repercussions for failure to protect data have become more severe, the number and sophistication of threats to data security have also grown. Consider this selection of findings by International Business Machines (IBM):

- CY 2008 showed a 13.5 percent increase in security vulnerabilities compared to CY 2007 includes vulnerabilities in operating system software, application software, and embedded programming).

- The overall severity of vulnerabilities increased, with high and critical severity vulnerabilities up 15.3 percent and medium severity vulnerabilities up 67.5 percent.

- Similar to CY 2007, nearly 92 percent of CY 2008 vulnerabilities can be exploited remotely.

- Of all the vulnerabilities disclosed in CY 2008, only 47 percent can be corrected through vendor patches…46 percent of vulnerabilities from CY 2006 and 44 percent from CY 2007 remain vulnerable with no available patch at the end of CY 2008.

- The two largest categories of vulnerabilities in CY 2008 are Web application at 55 percent and vulnerabilities affecting PC software at roughly 20 percent. Web applications in general have become the Achilles heel of IT security: nearly 55 percent of all vulnerability disclosures in CY 2008 affect Web applications, and this number does not include custom-developed Web applications. Further, 74 percent of all Web application vulnerabilities disclosed in CY 2008 had no available patch to fix them by the end of CY 2008.

- Although the number of vulnerabilities affecting Web browsers went down in comparison to CY 2007, they continue to be the main target of exploitation. New categories of threats affecting clients are on the rise, specifically in the areas of malicious documents, multimedia applications, and potentially Java applications which are easy to host on the Web.

Source: IBM Internet Security Systems X-Force® 2008 Trend & Risk Report, IBM Global Technology Services, January 2009.

The Agency for Health Care Administration, overall, has been in the forefront of recognizing the importance of data security and developing programs and strategies to secure data under the Agency's stewardship. The Agency's Computer Security Incident Response Team (CSIRT) is at

the forefront of coordination with the FL Agency for Enterprise Information Technology in its operations. Despite past success, the Division believes more must be done. Particularly, the risk of security breaches from unintentional human mistake or lack of compliance by users must be better mitigated. Additionally, the profile of the issue must be raised, and the leadership of the Agency must ensure the issue of data security is consistently visible. Objective 6. F., shall be accomplished as part of the overall effort to strengthen the Agency's data security capabilities. Upon completion, any data stored on or passing through on Division-managed resources will be secured according to the Department's security standards on access, encryption, backup, etc.

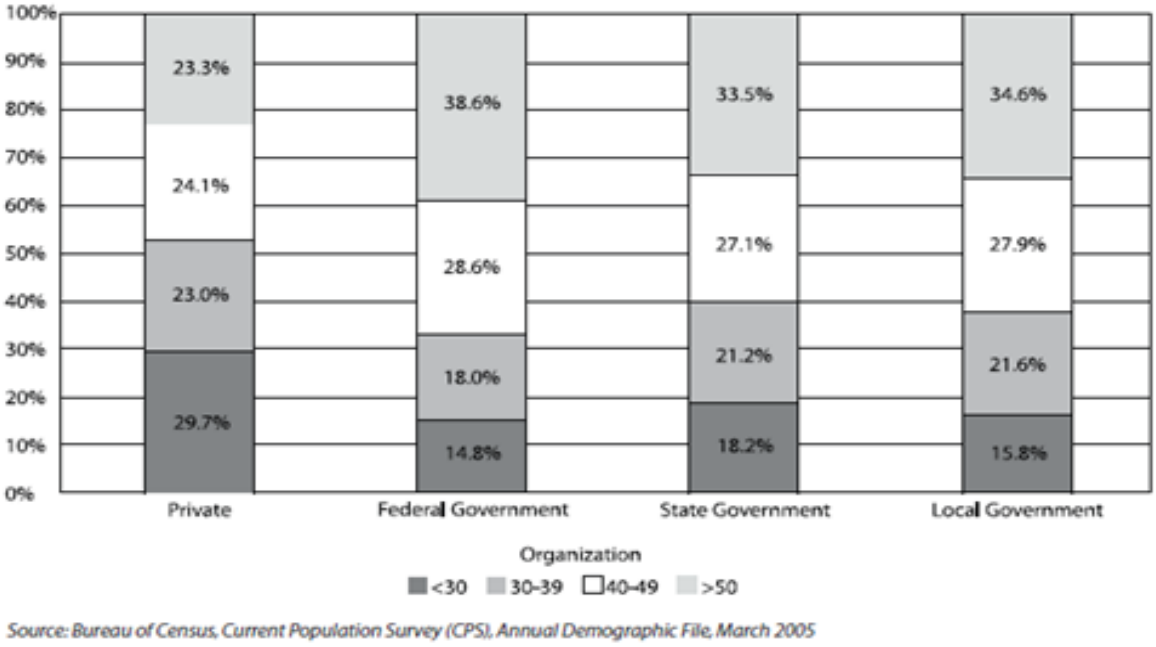
The final influencer to be addressed in this plan is the state of the public sector IT market. The public sector traditionally has difficulty competing with the private sector for skilled IT workers. Benefits, training, flexible schedules, and other factors can partially compensate for the lower salaries. However, there are several additional trends that are critically jeopardizing the Agency's ability to retain or hire qualified staff. When combined with the need to aggressively apply technology to lower costs, as well as the increasing responsibility and rising complexity of securing data, the impact of understaffed or under qualified IT staff is the single most significant influence on the Agency's IT planning and execution.

As indicated by the description of data security, above, the general IT landscape is growing more complex with each year. The range of skills needed today is much greater than even ten years ago. The increase in skills required per worker makes recruiting qualified staff more difficult than ever before

Another nationwide (and to some extent global) trend is also making matters more difficult for the public sector. Technology was first adopted by a few industries, such as the financial sector and the technology industry itself. Since then, IT adoption has become widespread, and is continuing to penetrate throughout all facets of the global economy. This will put increasing pressure on every organization as the demand for IT staff begins to outstrip the supply.

As with the pressure on health care costs, the aging of the "baby boomer" demographic is a factor in the supply of IT workers outstripping the demand. The "baby boomer" generation entered technology careers in large numbers, and there are relatively less workers in the ensuing generations (see Figure 6.1, below).

Figure 6-1 – Aging IT Workforce



Source: NASCIO, "State IT Work Force: Here Today, Gone Tomorrow?" (September, 2007)

Finally, the most significant factor affecting AHCA's ability to retain the necessary IT workforce is that among state of Florida agencies, the Division's IT staff are paid below the state average in every position save one. The Agency is at a very real risk of losing staff to other public sector agencies, much less the private sector.

The loss of workforce can be made up for to some degree by increasing the amount of money allocated to outsourced and staff augmentation. Over many years, however, this strategy is more costly to the state and counter to the Division and Agency's goal to reduce the total cost of health care. Even to the extent Agency staff is supplemented successfully by vendors, the current budget climate makes it unlikely that staff augmentation will be a consistently available resource. Even more significant is the loss of institutional knowledge and expertise. When a person with several years of experience leaves the Division, additional, unplanned time and dollars must be spent to retrain new staff, perform the same work less efficiently, or fail to deliver some services at all (with the attendant risks to the Agency and its customers).

Because of these factors, the Division creates an environment that overcomes the low compensation in order to retain as many staff as long as possible. The Division stands behind that commitment by setting aggressive goals for employee retention (see Objective 6. C). Salary dollars entrusted to the Division are a solid investment, as the Agency places employee satisfaction and retention high on the priority list. As the scarcity of and competition for IT workers will only increase each year, the Agency will be additionally handicapped in its ability to hire and retain new staff, thereby losing effectiveness year over year.

The three factors discussed above are the most influential of the many trends and conditions that the Agency must contend with each year. Without minimizing the need to understand and respond to other influences, the Agency holds that those three factors: rising costs, data

security, and IT staff retention are the factors that will most strongly influence the role technology will play in AHCA's future; specifically, whether that role will be one of an integral part of the Agency's success or an ongoing liability and risk. The recent Agency commitment to technology and its potential demonstrates that appropriate attention and investment yields great benefits.

Outcomes

The goal and objectives of the Division indirectly, but critically, affect all consumers of health care in Florida. The Division is responsible for supporting the ongoing operations of the Agency; without reliable technology infrastructure and applications, no modern state Agency is able to fulfill its mission. Additionally, and particularly in the health care sector, technology holds the promise of helping the Agency to deliver better services at a lower cost and higher speeds. The goal states clearly the Division's fervent support of the Agency and its mission, and the Division's objectives. When accomplished, this goal will be vital in helping the Agency fulfill its mission and achieve its goals.

Conversely, if the Division fails to achieve its goal or objectives, the impact on consumers will be indirect, but could be significant. The Agency's ability to fulfill its mission will be impaired by slower service delivery, unnecessarily increased costs, potential violations of federal and state data security and confidentiality laws, and other risks that accrue when the IT services of an organization is inefficient and unreliable. Further, those objectives of the Division which proactively improve the effectiveness of the Agency will obviously be unrealized.

The outcome standards measuring the accomplishment of the objectives were designed though a collaborative, iterative methodology during the latter half of August 2009. The expertise of all staff was collected in group interviews. It is important to note that CY 2009 the Agency's division of IT was elevated to a Division (from a Bureau); the current leadership has initiated a number of proactive and aggressive programs designed to dramatically improve IT service delivery. Therefore, while the current outcome standards reflect the combined experience of many talented staff from diverse backgrounds, the Division expects to closely monitor the effectiveness of the measures and will adjust them as necessary if better measures become available or are developed.

List of Potential Policy Changes Affecting Agency Budget Requests

Number	List of Potential Policy Changes	Describe the Legislative Budget Request or Governor's Recommended Budget Items Affected	Describe Potential Policy Impact if the LBR or the Governor's Recommended Budget is not Approved
1.	Awaiting FL Agency for Enterprise Information Technology (AEIT) Data Center Transition Plan results (late Sept. 2009). The Transition plan will influence our current LBR.	TBD	TBD

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	Implementing Bill or Statute	Task Forces and Studies in Progress	Required / Expected Completion Date
1	None		

LRPP Exhibit II - Performance Measures and Standards

Department: AGENCY FOR HEALTH CARE ADMINISTRATION	Department No: 68000000

Approved Performance Measures (Words)	Approved Prior Year Standards FY 2008-09 (Numbers)	Prior Year Actual FY 2008-09 (Numbers)	Approved Standards for FY 2009-10 (Numbers)	Requested FY 2010-11 Standard (Numbers)
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%	n/a	7.7%	Delete
Percent of eligible uninsured children receiving health benefits coverage	100%	n/a	100%	Delete
Percent of children enrolled with up-to-date immunizations	85%	n/a	85%	Revise
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%	n/a	97%	Delete
Percent of families satisfied with the care provided under the program	95%	89.4%	95%	95.0%
Total number of children enrolled in Kidcare	228,159	228,704	228,159	n/a
Total number of children enrolled in Florida Healthy Kids	195,867	181,644	195,867	n/a
Number of children enrolled in Medikids	21,000	23,036	21,000	n/a
Number of children enrolled in Children's Medical Services Network	10,053	23,270	10,053	n/a
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%	1.39%	1.44%	1.44%
Average number of days between receipt of clean Medicaid claim and payment	15	8.9	15	15
Number of Medicaid claims received	145,101,035		145,101,035	n/a
Percent of new Medicaid recipients voluntarily selecting managed care plan	50%	53.8%	50%	n/a
Number of new enrollees provided with choice counseling	520,000	n/a	520,000	n/a

LRPP Exhibit II - Performance Measures and Standards

Department: AGENCY FOR HEALTH CARE ADMINISTRATION	Department No: 68000000

Approved Performance Measures (Words)	Approved Prior Year Standards FY 2008-09 (Numbers)	Prior Year Actual FY 2008-09 (Numbers)	Approved Standards for FY 2009-10 (Numbers)	Requested FY 2010-11 Standard (Numbers)
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	20%	18.2%	20%	Delete
Percent of women receiving adequate prenatal care	86%	79.3%	86%	90.0%
Neonatal mortality rate per 1000	5	5.3	5	5.0
Percentage of women with an Interpregnancy Interval (IPI) greather than or equal to 28 months.	50%	47.6%	50%	50%
Percent of eligible children who received an EPSDT screening	64%	70%	64%	90.0%
Number of children ages 1-20 enrolled in Medicaid	1,249,276	1,901,912	1,249,276	n/a
Number of children receiving EPSDT services	407,052	407,372	407,052	n/a
Number of hospital inpatient services provided to children	92,960	145,287	92,960	n/a
Number of physician services provided to children	6,457,900	8,116,552	6,457,900	n/a
Number of prescribed drugs provided to children	4,444,636	4,435,542	4,444,636	n/a
Number of hospital inpatient services provided to elders	100,808	105,198	100,808	n/a
Number of physician services provided to elders	1,436,160	1,303,365	1,436,160	n/a
Number of prescribed drugs provided to elders	15,214,293	1,235,945	15,214,293	n/a
Number of uninsured children enrolled in the Medicaid Expansion	1,227	2,339	1,227	n/a
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	20.00%	15.5%	20.00%	20.0%
Number of case months (home and community-based services)	550,436	561,878	550,436	n/a
Number of case months services purchased (Nursing Home)	619,387	511,380	619,387	n/a

LRPP Exhibit II - Performance Measures and Standards

Department: AGENCY FOR HEALTH CARE ADMINISTRATION	Department No: 68000000

Approved Performance Measures (Words)	Approved Prior Year Standards FY 2008-09 (Numbers)	Prior Year Actual FY 2008-09 (Numbers)	Approved Standards for FY 2009-10 (Numbers)	Requested FY 2010-11 Standard (Numbers)
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	20.00%	19.2%	20.00%	Delete
Percent of women and child hospitalizations for conditions preventable with good ambulatory care	20.00%	19.4%	20.00%	Delete
Number of case months services purchased (elderly and disabled)	1,877,040	1,902,612	1,877,040	n/a
Number of case months services purchased (families)	9,850,224	10,490,088	9,850,224	n/a
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%	1.9%	0%	Delete
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%	0.0%	4%	Delete
Percent of Priority I consumer complaints about licensed facilities and programs that are investigated within ~~48 hours~~ two business days.	100%	97.1%	100%	95.0%
Percent of accredited hospitals and ambulatory surgical centers cited for not complying with life safety, licensure, or emergency access standards	25%	21.8%	25%	Delete
Percent of validation surveys that are consistent with findings noted during the accreditation survey	98%	100.0%	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%	0.7%	0%	Delete
Percent of home health facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0%	0.1%	0%	Delete

LRPP Exhibit II - Performance Measures and Standards

Department: AGENCY FOR HEALTH CARE ADMINISTRATION	Department No: 68000000

Approved Performance Measures (Words)	Approved Prior Year Standards FY 2008-09 (Numbers)	Prior Year Actual FY 2008-09 (Numbers)	Approved Standards for FY 2009-10 (Numbers)	Requested FY 2010-11 Standard (Numbers)
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%	0.04%	0%	Delete
Percent of ambulatory surgical centers with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0%	0.2%	0%	Delete
Percent of hospitals that fail to report serious incidents (agency identified)	6%	1.16%	6%	Delete
Percent of complaints of HMO patient dumping received that are investigated*	100%	N/A	100%	Delete
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	2	N/A	N/A
Number of inquiries to the call center regarding practitioner licensure and disciplinary information**	30,000	9,952	30,000	Delete
Total number of full facility quality-of-care surveys conducted	7,550	6,450	7,550	7,550
Average processing time (in days) for Subscriber Assistance Program cases.	53	21	53	53
Number of construction reviews performed (plans and construction)	4,500	4,031	4,500	4,500

* There have been no complaints of HMO patient dumping received by this agency for several years. If any such complaints were to be received, they would be investigated.

**The Department of Health now takes its own practitioner calls. These are no longer done by AHCA.

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%	N/A	N/A	N/A

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Staff Capacity
☐ Level of Training
☒ Previous Estimate Incorrect
☒ Other (Identify)
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: Using current estimating methods, the data are not available to calculate this percentage. Estimates provided several years ago did not address the correct population and were included in error.

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 since it cannot be calculated.

Office of Policy and Budget – July 2009

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%	N/A	N/A	N/A

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect
☒ Other (Identify)
Explanation: 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 replaced with a measure that more accurately reflects performance of this program.

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: **Agency for Health Care Administration**
Program: **Health Care Services**
Service/Budget Entity: **Children's Special Health Care/68500100**
Measure: **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%	N/A	N/A	N/A

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

Explanation: Performance results were based on self-reported surveys from parents/ guardians of children. It is difficult for parents/guardians to accurately remember whether all shots are up to date. This measure was 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 2009

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%	N/A	N/A	N/A

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect ☐ Other (Identify)
Explanation: 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 2009

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%	89.4%	(5.6%)	(5.9%)

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect ☐ Other (Identify)
Explanation: 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 non-Medicaid provider networks. Chief complaints 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 for the Medicaid population.

Office of Policy and Budget – July 2009

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	228,704	545	0.2%

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: 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 2009

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 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	181,644	(14,223)	(7.3%)

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

Office of Policy and Budget – July 2009

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 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	23,036	2,036	9.7%

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

Office of Policy and Budget – July 2009

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 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	23,270	13,217	131.47%

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

Office of Policy and Budget – July 2009

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%	1.39%	.05%	3.5%

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; 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 2009

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
15	8.9	(6.1)	(40.7%)

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect ☒ Other (Identify)
Explanation: Increasing numbers of electronically submitted claims as well as technology systems development have increased capability

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

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: 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 2009

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
145,101,035			

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

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

Explanation:
This measure does not measure program performance. 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 2009

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
20%	18.2%	(1.8%)	(9.0%)

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: 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 Agency is therefore seeking to drop the existing measures 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 2009

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%	79.3%	(6.7%)	(7.8%)

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: 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. Without outreach, it is difficult to reach all women who could benefit from Medicaid coverage during their pregnancy, particularly to get them into coverage at an early stage in the pregnancy.

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 2009

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
5.0	5.3	0.3	6.0%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect
☐ Other (Identify)
Explanation: 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 2009

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: Percentage of Women in Medicaid with an Inter-Pregnancy Interval (IPI) of 28 months or longer

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
50%	47.6%	(2.4%)	(4.8%)

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

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

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 2009

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 any 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%	70%	6%	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 Agency exceeded the approved standard.

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

Office of Policy and Budget – July 2009

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
1,249,276	1,901,912	652,636	52.4%

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

Explanation: The 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 2009

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure: Number of children receiving Child Health Check-up services – (EPSDT - federal)

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
407,052	407,372	320	0.08%

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: 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, service 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 2009

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	145,287	52,327	56.29%

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 2009

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
6,457,900	8,116,552	1,685,652	25.68%

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 2009

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	4,435,542	(9,094)	(0.20%)

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 2009

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
100,808	105,198	4,390	4.35%

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 andate.

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 2009

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	1,303,365	(132,795)	(9.25%)

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 2009

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	1,235,945	(13,978,348)	(91.88%)

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. In addition, the Standard has not been adjusted to account for Medicare Part D implementation.

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 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 2009

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
1,227	2,339	1,112	90.63%

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 2009

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
20%	15.5%	4.5%	22.5%

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 2009

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	561,878	11,442	2.08%

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 2009

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
619,387	511,380	-108,007	-17.44%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect ☐ Other (Identify)
Explanation: The 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 2009

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
20%	19.2%	(0.8%)	(4.0%)

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: 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 2009

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
20%	19.4%	(0.6%)	(3.0%)

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: 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 2009

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
1,877,040	1,902,612	25,572	1.36%

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 2009

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	10,490,088	639,864	6.50%

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 2009

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0%	1.9%	Over	1.9%

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

Office of Policy and Budget – July 2009

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

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

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect ☒ Other (Identify)
Explanation: The Agency is committed to protecting its customers through the investigation of all reports of unlicensed activity followed by facility closure or facility compliance with applicable standards. As these facilities are closed or brought into compliance, there will be fewer instances of repeat unlicensed activities. A decrease in this measure demonstrates the Agency's commitment to ensuring quality of care and services through compliance with minimum standards. However, it is not a measure over which the Agency can exercise 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 is not a measure over which the Agency has ultimate control.

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

Office of Policy and Budget – July 2009

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Field Operations
Service/Budget Entity: Field Operations
Measure: Percent of Priority 1 consumer complaints about licensed facilities and programs that are investigated within two business days.

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
100%	97.11%	-2.89%	2.89%

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: Heavy workloads and short staffing prevented 100% compliance.

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

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☐ Other (Identify)
Recommendations: We believe that 100% compliance is a laudable goal, but not a realistic expectation in view of resource constraints.

Office of Policy and Budget – July 2009

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
25%	21.8%	3.2% Under	12.8% 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: 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 has ultimate control.

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.

Office of Policy and Budget – July 2009

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

Action:

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
98%	100.0%	2.0% Over	2.04% Over

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

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

External Factors (check all that apply):

- ☐ Resources Unavailable
- ☐ 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 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
- ☐ Personnel
- ☐ Technology
- ☒ Other (Identify)

Recommendations: The Agency is requesting that this measure be deleted.

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0%	0.7%	0.7% Over	0.7% Over

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: 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 provide limited nursing services from once a year to twice a year. However, the same problem exists with ALFs as with nursing homes. Although 0% is an admirable goal, it is not a reasonable expectation.

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

Explanation: The Agency has no control over whether there will be serious deficiencies in health care facilities. We can only site and require correction of these deficiencies.

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

Recommendations: The Agency is requesting that this measure be deleted.

Office of Policy and Budget – July 2009

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0%	0.1%	0.1% Over	0.1% Over

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

External Factors (check all that apply):
☐ Resources Unavailable
☐ 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. 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: The Agency is requesting that this measure be deleted.

Office of Policy and Budget – July 2009

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0%	0.04%	0.04% Over	0.04% Over

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

External Factors (check all that apply):
☐ Resources Unavailable
☐ 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. 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: The Agency is requesting that this measure be deleted.

Office of Policy and Budget – July 2009

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0%	0.2%	0.2% Over	0.2% Over

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

External Factors (check all that apply):
☐ Resources Unavailable
☐ 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. 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: The Agency is requesting that this measure be deleted.

Office of Policy and Budget – July 2009

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0%	3.8%	3.8% Over	3.8% Over

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

External Factors (check all that apply):
☐ Resources Unavailable
☐ 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. 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: The Agency is requesting that this measure be deleted.

Office of Policy and Budget – July 2009

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 ☐ 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%	0*	0*	0*

* There have been no such complaints for the past 6 years.

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

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:

We have not received any complaints of HMO patient dumping.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☐ 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 6 years.

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation
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:
None required. Performance requirement was met.

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:
Eliminate this performance measure. It is not meaningful.

Office of Policy and Budget – July 2009

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

Action:

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
N/A	2	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:
There is no standard for this performance measure. It merely reflects the number of such complaints received.

External Factors (check all that apply):

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

Explanation: Not applicable.

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

☐ Training ☐ Technology
☐ Personnel ☐ Other (Identify)

Recommendations:
Eliminate the performance measure. It is not meaningful.

Office of Policy and Budget – July 2009

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation
Measure: Number of calls 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	9,952	(20,048)	67%

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 Department of Health now has its own call center. As of 5/1/09 the Department is taking its own calls about practitioner licensure and disciplinary information.

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 Department of Health has its own call center.

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

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

Recommendations: Delete this measure. No longer applicable.

Office of Policy and Budget – July 2009

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

Action:

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
7,550	6,450	1,100 Under	14.57% 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 Agency has no control over the numbers of facilities that either desire licensure or that no longer wished to be licensed and discontinue operations. The total number of surveys conducted each year will fluctuate with the total number of licensed facilities.

External Factors (check all that apply):

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

Explanation: The number of surveys fluctuates with the number of facilities that are licensed.

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

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

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

Office of Policy and Budget – July 2009

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 Subscriber Assistance Program 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	21	32 Under	60.17% 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

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure: Number of Construction Reviews Performed

Action:

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
4,500	4,031	469 Under	10.42%

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

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

Explanation:

External Factors (check all that apply):

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

Explanation: Due to economic recession the number of submittals has temporarily declined

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

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

Recommendations: None

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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 2009

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 2009

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 Diptheria, Tetanus, and Pertussis (DTaP), 3 polio, and 1 Measles, Mumps, and Rubella (MMR) [4/3/1]) by two years of age. It also evaluates the statewide coverage rates for the 4/3/1/3/3 series of 4 DTaP, 3 polio, 1 MMR, 3 Influenza (Hib), and 3 hepatitis B vaccines.

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

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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, whether they've had one in the previous six months, and are completely unfamiliar with the Guidelines. In addition, the timing of appropriate visits varies by age group meaning that an accurate determination of adherence to guidelines cannot be determined regardless of whether the parent answers the survey positively or negatively.

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. The lack of a visit within the last 6-months does not indicate a lack of adherence to guidelines for all age groups.

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

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Action (check one):

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

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

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

For this measure, the standard reflects the percentage of caregivers 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.

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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 2009

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 2009

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 2009

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 2009

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 2009

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 2009

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 2009

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 2009

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 2009

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 2009

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure: Percent of women with an inter-pregnancy interval (IPI) of 28 months or more.

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 Healthy Start program targets at least 24-28 months between pregnancies for improved pregnancy outcomes, and on average, Florida Medicaid has been well above that target for several years. Under the current measure, the average overstates the interval and hides the true frequency of births with less than the ideal interval. More than 50% of all births in Florida, and in Florida Medicaid have an interval of less than 28 months. The measure is being changed to more accurately track improvements in this area.

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: 50% of women in Medicaid with an IPI of at least 28 months.

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 2009

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 2009

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 2009

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 2009

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 2009

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 2009

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Action (check one):

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

Proposed Change to Measure:
The Agency is requesting that this output (count) measure 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 2009

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Action (check one):

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

Proposed Change to Measure:
The Agency is requesting that this output (count) measure 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 2009

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 2009

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Action (check one):

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

Proposed Change to Measure:
The Agency is requesting that this output (count) measure 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 2009

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

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

Proposed Change to Measure:
The Agency is requesting that this output (count) measure 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 2009

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 2009

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 2009

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 2009

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 2009

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 2009

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 2009

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 2009

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. – Delete measure
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☐ Backup for performance measure.

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

Survey deficiency data are maintained in the federal Automated Survey Processing Environment (ASPEN) and centrally collected. The number of facilities is obtained from Florida Regulatory and Enforcement System (FRAES).

Validity:
The Agency is committed to acting decisively and pursuing more aggressive penalties for poorly performing facilities. Data collected for this outcome enable the Agency to determine how well facilities are performing, 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 2009

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. – Delete measure
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☐ Backup for performance measure.

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

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

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

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

Reliability:
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 types of facilities. 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 that 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 2009

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

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 priority code 1. These are considered the very serious complaints that the Call Center receives. 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 priority 1 consumer complaints that are investigated within two business days comes from a series of computations. First, compute the length of time the priority 1 complaint is received to when it is investigated. The length of time is calculated by subtracting the Received Date from the Survey Start Date. Second, from the listing of complaints, determine how many complaints have a length of time that is two or fewer business days. Third, the percent is computed by dividing the total number of complaints with a length of time of two or fewer business days by the total number of priority 1 complaints.

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.

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. – Delete measure
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☐ Backup for performance measure.

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 2009

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. – Delete measure
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

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

The Joint Commission 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 Joint Commission 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 Joint Commission survey utilizing a decision matrix developed by Health Standards and Quality/Field Operations staff and makes 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 Joint Commission 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 2009

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. – Delete measure
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☐ Backup for performance measure.

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

Survey deficiency data are maintained in the federal Automated Survey Processing Environment (ASPEN) and centrally collected. The number of facilities is obtained from Florida Regulatory and Enforcement System (FRAES).

Validity:
The Agency is committed to acting decisively and pursuing more aggressive penalties for poorly performing facilities. Data collected for this outcome enable the Agency to determine how well facilities are performing, 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 2009

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 agencies 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. – Delete measure
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☐ Backup for performance measure.

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 deficiency data are maintained in the federal Automated Survey Processing Environment (ASPEN) and centrally collected. The number of facilities is obtained from Florida Regulatory and Enforcement System (FRAES).

Validity:
The Agency is committed to acting decisively and pursuing more aggressive penalties for poorly performing facilities. Data collected for this outcome enable the Agency to determine how well facilities are performing, 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 2009

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 or welfare of the public

Action (check one):

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

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

Survey data are maintained in the Florida Regulatory and Enforcement System (FRAES) and centrally collected. FRAES has the capability to capture serious deficiencies for home health agencies. The data are pulled from FRAES and reviewed by the Central Systems Management 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 facilities are performing, 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 2009

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. – Delete measure
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☐ Backup for performance measure.

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

Survey data are maintained in the Florida Regulatory and Enforcement System (FRAES) and centrally collected. FRAES has the capability to capture serious deficiencies for home health agencies. The data are pulled from FRAES and reviewed by Central Systems Management 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 facilities are performing, 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 2009

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. – Delete measure
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☐ Backup for performance measure.

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

Survey data are maintained in the Florida Regulatory and Enforcement System (FRAES) and centrally collected. FRAES has the capability to capture serious deficiencies for home health agencies. The data are pulled from FRAES and reviewed by Central Systems Management 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 facilities are performing, 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 2009

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Action (check one):

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

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

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

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

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

Office of Policy and Budget – July 2009

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 2008/09.

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 2009

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Action (check one):

☒ Requesting revision to approved performance measure. Delete 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. All are investigated.

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 2009

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Action (check one):

☒ Requesting revision to approved performance measure. Delete 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 standard is based on 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 2009

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. Practitioner calls are no longer taken by the AHCA call center, so information can no longer be obtained for this measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☐ Backup for performance measure.

Data Sources and Methodology:
Call center staff members input data by call as they respond to phone calls. Calls are tracking in the computer as customer services representatives input their transactions. Tallies from all call center staff are compiled daily and weekly by the call center manager. The monthly statistics are compiled in the same fashion using programming and software available to the call center. Year to date reports are also provided monthly.

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

Reliability:
The numbers are gathered daily, weekly and monthly by the call center manager and stored in the computer system. The call center manager reviews the statistics for obvious inconsistencies. The call center contract manager monitors calls and reviews data to ensure that calls are appropriately allocated to the correct categories of facility calls, professional calls and HMO calls. Only the inquiries associated with professional calls are allocated to the practitioner regulation function.

Office of Policy and Budget – July, 2009

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. – Delete measure
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☐ Backup for performance measure.

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

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

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

Office of Policy and Budget – July 2009

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, 2009

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, 2009

LRPP 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
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

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

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

Measure Number	Approved Performance Measures for FY 2008-09 (Words)		Associated Activities Title
21	Number of children receiving EPSDT services		Physician Services ACT4230
			Early Periodic Screening Diagnosis & Treatment ACT4260
			School Based Services ACT4310
			Clinic Services ACT4330
22	Number of hospital inpatient services provided to children		Hospital Inpatient ACT4210
			Therapeutic Services for Children ACT4310
23	Number of physician services provided to children		Physician Services ACT4230
			Therapeutic Services for Children ACT4310
24	Number of prescribed drugs provided to children		Prescribed Medicines 4220
			School Based Services ACT4320
25	Number of hospital inpatient services provided to elders		Hospital Inpatient -Elderly and Disabled/fee for service ACT4010
			Prescribed Medicines- Elderly and Disabled/fee for service ACT4020
			Physician Services-Elderly and Disabled/fee for service ACT4030
			Hospital Insurance Benefit-Elderly and Disabled /Fee for service ACT4140
26	Number of physician services provided to elders		Physician Services-Elderly and Disabled/fee for service ACT4030
			Supplemental Medical Insurance-Elderly and Disabled/fee
			for service ACT4050
			Prescribed Medicines- Elderly and Disabled/fee for service ACT4020

Measure Number	Approved Performance Measures for FY 2008-09 (Words)		Associated Activities Title
27	Number of prescribed drugs provided to elders		Prescribed Medicines- Elderly and Disabled/fee for service ACT4020
28	Number of uninsured children enrolled in the Medicaid Expansion		Purchase MediKids Program Services ACT5110 Purchase Children's Medical Services Network Services ACT5120 Purchase Children's Medical Services Network Services ACT5130
	Medicaid Long Term Care - 68501500		
29	Percent of hospitalizations for conditions preventable with good ambulatory care		Nursing Home Care ACT5020 Home and Community Based Services ACT5030 Capitates Nursing Home Diversion Waiver ACT5060
30	Number of case months (home and community-based services)		Home and Community Based Services ACT5030 Capitates Nursing Home Diversion Waiver ACT5060
31	Number of case months services purchased (Nursing Home)		Nursing Home Care ACT5020 Other ACT5070

Measure Number	Approved Performance Measures for FY 2008-09 (Words)		Associated Activities Title
	Medicaid Prepaid Health Plan - 68501600		
32	Percent of hospitalizations for conditions preventable by good ambulatory care		Prepaid Health Plans Elderly and Disabled ACT1620 Prepaid Health Plans - Family ACT1650
33	Percent of women and child hospitalizations for conditions preventable with good ambulatory care		Prepaid Health Plans - Family ACT1650
34	Number of case months services purchased (elderly and disabled)		Prepaid Health Plans Elderly and Disabled ACT1620
35	Number of case months services purchased (families)		Prepaid Health Plans - Family ACT1650
	Health Care Regulation - 68700700		
36	Percent of nursing home facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020

Measure Number	Approved Performance Measures for FY 2008-09 (Words)		Associated Activities Title
37	Percent of investigations of alleged unlicensed facilities and programs that have been previously issued a cease and desist order, that are confirmed as repeated unlicensed activity		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
38	Percent of Priority I consumer complaints about licensed facilities and programs that are investigated within 48 hours		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
39	Percent of accredited hospitals and ambulatory surgical centers cited for not complying with life safety, licensure or emergency access standards		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
40	Percent of validation surveys that are consistent with findings noted during the accreditation survey		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
41	Percent of assisted living facilities with deficiencies that pose a serious threat to the health, safety or welfare of the public		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
42	Percent of home health facilities with deficiencies that pose a serious threat to the health, safety or welfare of the public		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020

Measure Number	Approved Performance Measures for FY 2008-09 (Words)		Associated Activities Title
43	Percent of clinical laboratories with deficiencies that pose a serious threat for not complying with life safety, licensure or emergency access standards		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
44	Percent of ambulatory surgical centers with deficiencies that pose a serious threat to the health, safety or welfare of the public		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
45	Percent of hospitals with deficiencies that pose a serious threat to the health, safety or welfare of the public		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
46	Percent of hospitals that fail to report serious incidents (agency identified)		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
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

Measure Number	Approved Performance Measures for FY 2008-09 (Words)		Associated Activities Title
50	Number of inquiries to the call center regarding practitioner licensure and disciplinary information		Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
51	Total number of full facility quality-of-care surveys conducted		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
52	Average processing time (in days) for Statewide Provider and Subscriber Assistance Panel cases		Subscriber Assistance Panel ACT7130
53	Number of construction reviews performed (plans and construction)		Plans & Construction ACT7080

AGENCY FOR HEALTH CARE ADMINISTRATION

SECTION I: BUDGET	FISCAL YEAR 2008-09 OPERATING	FIXED CAPITAL OUTLAY
TOTAL ALL FUNDS GENERAL APPROPRIATIONS ACT	16,161,955,269	0
ADJUSTMENTS TO GENERAL APPROPRIATIONS ACT (Supplementals, Vetoes, Budget Amendments, etc.)	811,089,484	0
FINAL BUDGET FOR AGENCY	16,973,044,753	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 *	1,745,604	673.76	1,176,117,429	
Prepaid Health Plans - Families *	8,974,020	149.11	1,338,157,245	
Elderly And Disabled/Fee For Service/Medipass - Hospital Inpatient * Number of case months Medicaid program services purchased	432,053	2,875.24	1,242,256,706	
Elderly And Disabled/Fee For Service/Medipass - Prescribed Medicines * Number of case months Medicaid program services purchased	432,053	1,799.13	777,320,178	
Elderly And Disabled/Fee For Service/Medipass - Physician Services * Number of case months Medicaid program services purchased	432,053	717.31	309,916,462	
Elderly And Disabled/Fee For Service/Medipass - Hospital Outpatient * Number of case months Medicaid program services purchased	432,053	496.19	214,378,281	
Elderly And Disabled/Fee For Service/Medipass - Supplemental Medical Insurance * Number of case months Medicaid program services purchased	294,512	2,659.53	783,262,401	
Elderly And Disabled/Fee For Service/Medipass - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	82,133	104.36	8,571,746	
Elderly And Disabled/Fee For Service/Medipass - Patient Transportation * Number of case months Medicaid program services purchased	432,053	154.06	66,562,453	
Elderly And Disabled/Fee For Service/Medipass - Case Management * Number of case months Medicaid program services purchased	432,053	211.78	91,500,222	
Elderly And Disabled/Fee For Service/Medipass - Home Health Services * Number of case months Medicaid program services purchased	432,053	126.26	54,551,588	
Elderly And Disabled/Fee For Service/Medipass - Therapeutic Services For Children * Number of case months Medicaid program services purchased	82,133	215.41	17,692,175	
Elderly And Disabled/Fee For Service/Medipass - Hospital Insurance Benefit * Number of case months Medicaid program services purchased	262,852	404.16	106,233,561	
Elderly And Disabled/Fee For Service/Medipass - Hospice * Number of case months Medicaid program services purchased	432,053	460.87	199,120,239	
Elderly And Disabled/Fee For Service/Medipass - Private Duty Nursing * Number of case months Medicaid program services purchased	82,133	1,427.96	117,282,640	
Elderly And Disabled/Fee For Service/Medipass - Other * Number of case months Medicaid program services purchased	432,053	1,262.35	545,401,206	
Women And Children/Fee For Service/Medipass - Hospital Inpatient * Number of case months Medicaid program services purchased	759,006	1,148.29	871,559,477	
Women And Children/Fee For Service/Medipass - Prescribed Medicines * Number of case months Medicaid program services purchased	759,006	324.25	246,108,325	
Women And Children/Fee For Service / Medipass - Physician Services * Number of case months Medicaid program services purchased	759,006	526.26	399,431,170	
Women And Children/Fee For Service / Medipass - Hospital Outpatient * Number of case months Medicaid program services purchased	759,006	564.29	428,299,768	
Women And Children/Fee For Service / Medipass - Supplemental Medical Insurance * Number of case months Medicaid program services purchased	801	178,690.31	143,130,937	
Women And Children/Fee For Service / Medipass - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	601,547	170.67	102,666,624	
Women And Children/Fee For Service / Medipass - Patient Transportation * Number of case months Medicaid program services purchased	759,006	71.48	54,255,022	
Women And Children/Fee For Service / Medipass - Case Management * Number of case months Medicaid program services purchased	759,006	14.51	11,013,115	
Women And Children/Fee For Service / Medipass - Home Health Services * Number of case months Medicaid program services purchased	759,006	163.97	124,457,130	
Women And Children/Fee For Service / Medipass - Therapeutic Services For Children * Number of case months Medicaid program services purchased	759,006	69.65	52,865,537	
Women And Children/Fee For Service / Medipass - Clinic Services * Number of case months and Medicaid program services purchased	759,006	111.30	84,475,241	
Women And Children/Fee For Service / Medipass - Other * Number of case months Medicaid program services purchased	759,006	492.00	373,430,684	
Medically Needy - Hospital Inpatient * Number of case months Medicaid program services purchased	18,366	16,044.25	294,668,688	
Medically Needy - Prescribed Medicines * Number of case months Medicaid program services purchased	18,366	5,862.97	107,679,331	
Medically Needy - Physician Services * Number of case months Medicaid program services purchased	18,366	2,334.57	42,876,793	
Medically Needy - Hospital Outpatient * Number of case months Medicaid program services purchased	18,366	2,354.35	43,240,008	
Medically Needy - Supplemental Medical Insurance * Number of case months Medicaid program services purchased	4,044	2,307.68	9,332,265	
Medically Needy - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	3,385	131.97	446,716	
Medically Needy - Patient Transportation * Number of case months Medicaid program services purchased	18,366	125.82	2,310,830	
Medically Needy - Case Management * Number of case months Medicaid program services purchased	18,366	88.15	1,618,970	
Medically Needy - Home Health Services * Number of case months Medicaid program services purchased	18,366	74.33	1,365,193	
Medically Needy - Therapeutic Services For Children * Number of case months Medicaid program services purchased	3,385	10.43	35,296	
Medically Needy - Other * Number of case months Medicaid program services purchased	18,366	54,377.18	998,691,278	
Refugees - Hospital Inpatient * Number of case months Medicaid program services purchased	4,885	390.17	1,905,963	
Refugees - Prescribed Medicines * Number of case months Medicaid program services purchased	4,885	85,285.25	416,618,453	
Refugees - Physician Services * Number of case months Medicaid program services purchased	4,885	513.58	2,508,823	
Refugees - Hospital Outpatient * Number of case months Medicaid program services purchased	4,885	249.49	1,218,753	
Refugees - Patient Transportation * Number of case months Medicaid program services purchased	4,885	6.20	30,271	
Refugees - Case Management * Number of case months Medicaid program services purchased	4,885	7.88	38,490	
Refugees - Home Health Services * Number of case months Medicaid program services purchased	4,885	26.87	131,261	
Refugees - Therapeutic Services For Children * Number of case months Medicaid program services purchased	599	1.01	606	
Refugees - Other * Number of case months Medicaid program services purchased	4,885	250.15	1,222,002	
Nursing Home Care * Number of case months Medicaid program services purchased	73,348	33,920.73	2,488,017,780	
Home And Community Based Services * Number of case months Medicaid program services purchased	66,009	15,135.40	999,072,793	
Intermediate Care Facilities For The Developmentally Disabled - Sunland Centers * Number of case months Medicaid program services purchased	818	142,380.11	116,466,926	
Purchase Medikids Program Services * Number of case months	23,389	2,463.20	57,611,760	
Purchase Children's Medical Services Network Services * Number of case months	23,270	5,272.51	122,691,367	
Purchase Florida Healthy Kids Corporation Services * Number of case months	181,644	1,605.57	291,642,730	
Certificate Of Need/Financial Analysis * Number of certificate of need (CON) requests/financial reviews conducted	1,798	995.99	1,790,786	
Health Facility Regulation (compliance, Licensure, Complaints) - Tallahassee * Number of licensure/certification applications	26,577	543.84	14,453,568	
Facility Field Operations (compliance, Complaints) - Field Offices Survey Staff * Number of surveys and complaint investigations	42,072	1,074.40	45,202,141	
Health Standards And Quality * Number of transactions	2,472,014	1.64	4,044,251	
Plans And Construction * Number of reviews performed	4,031	1,580.13	6,369,495	
Managed Health Care * Number of HMO and workers' compensation arrangement surveys	350	10,326.73	3,614,356	
Organ And Tissue Donor * Number of donor designations	2,021,898	0.03	52,661	
Background Screening * Number of requests for screenings	59,845	14.90	891,698	
Subscriber Assistance Panel * Number of cases	552	1,787.21	986,541	
Health Facilities And Practitioner Regulation - Medicaid Choice Counseling * Number of new enrollees provided choice counseling	334,088	8.02	2,678,878	
TOTAL			16,021,545,283	

SECTION III: RECONCILIATION TO BUDGET	
PASS THROUGHS	
TRANSFER - STATE AGENCIES	
AID TO LOCAL GOVERNMENTS	
PAYMENT OF PENSIONS, BENEFITS AND CLAIMS	
OTHER	927,612,224
REVERSIONS	23,887,310
TOTAL BUDGET FOR AGENCY (Total Activities + Pass Throughs + Reversions) - Should equal Section I above. (4)	16,973,044,817

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:

The Agency's LRPP uses many terms and acronyms that are unique to AHCA. Please add to the list of terms and acronyms as appropriate:

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 September 30 of the subsequent fiscal year. Certified forward amounts payables and encumbrances are certified forward at the end of the 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.

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.

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.

CIO - Chief Information Officer

CIP - Capital Improvements Program Plan

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.

EOG - Executive Office of the Governor

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

FCO - Fixed Capital Outlay

FFMIS - Florida Financial Management Information System

Fixed Capital Outlay: Real property (land, buildings including appurtenances, fixtures and fixed equipment, structures, etc.), including additions, replacements, major repairs, and renovations to real property which materially extend its useful life or materially improve or

change its functional use. Includes furniture and equipment necessary to furnish and operate a new or improved facility.

FLAIR - Florida Accounting Information Resource Subsystem

F.S. - Florida Statutes

GAA - General Appropriations Act

GR - General Revenue Fund

Indicator: A single quantitative or qualitative statement that reports information about the nature of a condition, entity or activity. This term is used commonly as a synonym for the word "measure."

Information Technology Resources: Includes data processing-related hardware, software, services, telecommunications, supplies, personnel, facility resources, maintenance, and training.

Input: See Performance Measure.

IOE - Itemization of Expenditure

IT - Information Technology

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

LAN - Local Area Network

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

LBC - Legislative Budget Commission

LBR - Legislative Budget Request

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

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

L.O.F. - Laws of Florida

LRPP - Long Range Program Plan

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

MAN - Metropolitan Area Network (Information Technology)

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.

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.

PBPB/PB2 - Performance-Based Program Budgeting

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.*

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.

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.

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.

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

Service: See Budget Entity.

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

STO - State Technology Office

SWOT - Strengths, Weaknesses, Opportunities and Threats

TCS - Trends and Conditions Statement

TF - Trust Fund

TRW - Technology Review Workgroup

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

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

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

WAN - Wide Area Network (Information Technology)