FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

CHARLIE CRIST
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
INTERIM SECRETARY

September 30, 2010

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

JoAnne Leznoff, Council Director
House Full Appropriations Council
221 Capitol
Tallahassee, Florida 32399-1300

David Coburn, Staff Director
Senate Policy and Steering Committee on Ways and Means
201 Capitol
Tallahassee, Florida 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 2011-2012 through Fiscal Year 2015-2016.

Sincerely,

Elizabeth Dudek
Interim Secretary

ED/cls

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

Visit AHCA online at AHCA.MyFlorida.com

Agency for Health Care Administration

FY 2011 - 2012
through
FY 2015 - 2016

Long Range Program Plan

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Agency for Health Care Administration's

Agency Management Team

Interim Agency Secretary ..... Elizabeth Dudek
(850) 412-4335

Chief of Staff ..... James McFaddin
(850) 412-3604

Acting Deputy Secretary for Health Quality Assurance ..... Molly McKinstry
(850) 412-4420

Deputy Secretary for Medicaid ..... Roberta Bradford
(850) 412-4000

Deputy Secretary of Operations ..... Karen Zeiler
(850) 412-3605

General Counsel ..... Justin Senior
(850) 412-3630

Inspector General ..... Peter Williams
(850) 412-3990

Director of Communications ..... Tiffany Vause
(850) 412-3620

Director of Legislative Affairs ..... Warren Moore
(850) 412-3612

Director of the Florida Center for Health Information and Policy Analysis ..... Elizabeth Eastman
(850) 412-3767

Chief Information Officer (Information Technology) ..... Scott Ward
(850) 412-4800

Health Quality Assurance Key Personnel

(Division of Health Quality Assurance)

Acting Deputy Secretary for Health Quality Assurance .....Molly McKinstry (850) 412-4420

- Assistant Deputy Secretary for Health Quality Assurance .....Vacant

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

Health Facility Regulation.....Jeff Gregg (850) 412-4340

Plans and Construction ..... Wayne Young (850) 412-4470

Managed Health Care .....Sue Conte (850) 412-4291

Long Term Care Services .....Molly McKinstry (850) 412-4420

Field Operations.....Polly Weaver (850) 412-4491

Area Offices **Field Office Managers**

Area 1/2 .....Barbara Alford (850) 412-4493
Area 3 .....Kris Mennella (386) 462-6232
Area 4 ..... Robert Dickson (904) 798-4513
Area 5/6 .....Pat Reid-Caufman (727) 552-1975
Area 7 .....Theresa DeCanio (407) 420-2530
Area 8.....Harold Williams (239) 335-1230
Area 9/10 .....Arlene Mayo-Davis (561) 381-5868
Area 11 .....Steve Emling (305)-593-3113

Health Care Services Key Personnel

(Division of Medicaid)

Deputy Secretary for Medicaid ..... Roberta Bradford (850) 412-4000

- Acting Asst. Dep. Secretary for Medicaid Operations Melanie Brown-Woofter (850) 412-4028
- Assistant Deputy Secretary for Medicaid Finance .....Phil Williams (850) 412-4008

Bureau .....**Bureau Chief**

Medicaid Contract Management..... Alan Strowd (850) 412-3450

Medicaid Health Systems Development .....Melanie Brown-Woofter (850) 412-4028

Medicaid Quality Management ..... Susan Whitmire (850) 412-4676

Medicaid Pharmacy Services .....Anne Wells (850) 412-4146

Medicaid Services ..... Beth Kidder (850) 412-4189

Medicaid Program Analysis..... Michele Morgan (850) 412-4075

Medicaid Area Offices ..... Fran Nieves (239) 335-1300

Area Offices	**Field Office Managers**
Area 1	Amber Vaugn 850-595-2300
Area 2a	Earnie Brewer 850-412-4002
Area 2b	Earnie Brewer 850-412-4002
Area 3a	Marilynn Schlott 386-418-5619
Area 3b	Marilynn Schlott 386-418-5619
Area 4	Lisa Broward 904-798-4200
Area 5	Don Fuller 727-552-1900
Area 6	Sue McPhee 813-350-4800
Area 7	Karen Monson 407-317-7851
Area 8	Fran Nieves 239-335-1300
Area 9	William Albury, 561-712-4400
Area 10	Rafael Copa 954-958-6500
Area 11	Rhea Gray 305-593-3000

Executive Direction, and Administration and Support Key Personnel

(Executive Direction, and Administrative Services)
http://ahca.myflorida.com/

Interim Agency Secretary .....Elizabeth Dudek (850) 412-4335

Chief of Staff .....James McFaddin (850) 412-3604

- Communications, and Multi-Media Relations
  Interim Communications Director.....Tiffany Vause (850) 412-3620

- Legislative Affairs
  Legislative Affairs Director.....Warren Moore (850) 412-3612

- Florida Center for Health Information and Policy Analysis
  Director ..... Beth Eastman (850) 412-3767

  Office of Data Collection, Data Quality, & Patient Safety.....
  .....Patrick Kennedy (850) 412-3757
  Office of Data Dissemination & Communication..... Beth Eastman (850) 412-3746
  Office of Health Policy and Research.....Heidi Fox (850) 412-3749
  Office of Health Information Exchange.....Christopher Sullivan, PhD (850) 412-3780

  Division of Operations
  Deputy Secretary..... Karen Zeiler (850) 412-3605

  Budget.....Michele Tallent (850) 412-3815
  Finance & Accounting.....Paula Shirley (850) 412-3820
  Human Resources..... James Haynes (850) 412-3900
  Support Services ..... Cathy McEachron (850) 412-3887
  Third Party Liability ..... Jennifer Barrett (850) 412-4137

- Division of Information Technology
  Interim Chief Information Officer .... Scott Ward (850) 412-4800

  Customer Service & Support ..... John Edwards (850) 412-4850
  Applications Development and Support ..... Ken Walker (850) 412-4855
  Information Technology Strategic Planning & Security ..... Scott Ward (850) 412-4844
  Enterprise Infrastructure .....Andrew Burgess (850) 412-4824

- General Counsel ..... Justin Senior (850) 412-3630

  Deputy General Counsel ..... Bill Roberts (850) 412-3630
  Chief Counsel for Medicaid..... Kim A. Kellum (850) 412-3630

Chief Counsel for Facilities Regulation and Managed Care ..... Thomas Hoeler (850) 412-3630
Chief Appellate Counsel ..... Tracy Cooper (850) 412-3630
Agency Clerk ..... Richard Shoop (850) 412-3630

- Inspector General ..... Peter Williams (850) 412-3990

Medicaid Program Integrity ..... Michael Blackburn (850) 412-3977
Internal Audit ..... Damon Rodriguez (Acting) (850)-412-3980
Investigations ..... Jerome Worley (850) 487-3990
HIPAA Privacy and Security Compliance ..... John Collins (850) 412-3986

Agency Mission and Goals

The mission statement establishes the reason for an Agency's existence. It succinctly identifies what the Agency does, why and for whom. The mission statement reminds everyone of the unique purposes promoted and served by the Agency.

OUR MISSION

Better Health Care for all Floridians

OUR 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

OUR 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 celebrate and share our ideas.

SECRETARY'S PRIORITIES

The Secretary's Priorities are drivers for setting performance standards, strategic direction and commitment of Agency resources. The following priorities should be considered during preparation of the Agency's Long Range Program Plan, and Legislative Budget Requests:

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

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

5. 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.

6. To make the Agency an employer of choice where employees believe their work is meaningful, opinions matter, efforts are recognized and that the workplace exemplifies the values of accountability, fairness, responsiveness and teamwork.

Agency Goals

Priority	Agency Goal	Goal Description	Program
1.	**Goal 1**	To combat fraud and abuse in the Florida Medicaid Program.	Administration and Support (Inspector General)
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 ensure that Medicaid beneficiaries get access to the services they need and have improved health outcomes.	Health Care Services (Division of Medicaid
4.	**Goal 4**	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)

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 (Division of Information Technology)

Agency Objectives

Office of the Inspector General

Goal 1: To combat fraud and abuse in the Florida Medicaid Program

Objective 1.A: To increase the amount of overpayments identified through detection activities at a rate of nine percent per year through FY 2015-2016.

Objective 1.B: To increase the amount of overpayments collected as a result of audits and investigations at a rate of nine percent per year through FY 2015-2016.

Objective 1.C: To increase the amount of overpayments prevented as a result of prevention activities conducted by MPI at a rate of five percent per year through FY 2015-2016.

Objective 1.D: To increase the number of referrals sent to Agency divisions and other state entities at a rate of seven percent per year through FY 2015-2016.

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 50 percent of all facility license renewal applications electronically via the Internet within five years.

Objective 2.B: To reduce the volume of Health Facility Regulation public record requests handled using Agency resources by 50 percent by FY 2015-2016.

Objective 2.C: To increase the number of additional lives covered by health insurance by 100,000 lives per year over each of the next five years.

Division of Medicaid

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

Objective 3.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 3.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 3.C: To slow the growth in long-term care expenditures by $528 million by converting a portion of the institutional care budget to community-based long-term care, by FY 2015-2016.

Objective 3.D: To increase beneficiaries reported satisfaction with access to specialty care services to 85 percent by FY 2014-2015.

Objective 3.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.

Florida Center for Health Information and Policy Analysis

Goal 4: 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 4.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, FloridaHealthFinder.gov from 485 days in FY 2005-2006 to a maximum of 126 days by FY 2015-2016. (The purpose of Objective 4.A is to promote streamlined and enhanced data processing functions (collection, auditing, certification, database upload, maintenance and dissemination) in a climate of growing production demands for faster consumer accessibility to high quality health data information.

Objective 4.B: To increase the average daily number of persons who visit FloridaHealthFinder.gov by 10 percent annually through FY 2015-2016.

Objective 4.C: To increase the number of prescriptions submitted electronically in Florida at a rate of 25 percent annually through FY 2015-2016.

Offices of Communications/Media Relations, and the Office of 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 2015-2016, 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.

Objectives 5.B: To increase the percentage of how often correspondence and media requests were responded to on time through fiscal year 2015-2016 to ensure the people of Florida are responded to in a timely matter.

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 allow technology to become a solution to streamlined business process improvements within the agency.)

Objective 6. B: By FY 2014-2015, 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 2015-2016 to achieve a 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 2015-2016.

Objective 6. E: To extend remote computing capabilities to 70 percent of appropriate users by FY 2015-2016 so that the Agency may continue to operate in the event of a disaster or pandemic.

Objective 6. F: By FY 2015-2016 to identify and secure 99 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 2015-2016 to be 75 percent complete in the development, piloting, and implementation of a comprehensive Information Technology Risk Management Program. The elements of the program will include (but not limited to):

- A classification of types of risks and lexicon of Agency-specific Program terminology;
- A methodology for identification of risks and development of associated mitigation strategies;
- Meaningful operational metrics and executive dashboard metrics;
- Policies and procedures for support of, and engagement with the Risk Management Program; and,
- A process for iterative Risk Management Program evaluation and evolution.

Agency Service Outcomes and Performance Projection Tables

Office of the Inspector General

Service Outcome Measure 1.A: Amount, in millions, of overpayments identified by the Agency for Health Care Administration

Service Outcome Measure Projection Table 1.A:

Baseline/Year FY 2006-2007	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015	FY 2015-2016
Projected amount, in millions, of overpayments identified by the Agency	9%	9%	9%	9%	9%
$35,700,000*	$43,796,924	$45,110,832	$46,464,157	$47,858,082	$49,293,824

**2008-2009 Report: The State's Efforts to Control Medicaid Fraud and Abuse*

Service Outcome Measure 1.B: Amount, in millions, of overpayments collected by the Agency for Health Care Administration

Service Outcome Measure Projection Table 1.B:

Baseline/Year FY 2003-2004	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015	FY 2015-2016
Projected amount of overpayments collected by the Agency	9%	9%	9%	9%	9%
$16,674,293	$31,148,721	$33,952,106	$37,007,795	$40,338,497	$43,968,961

Service Outcome Measure 1.C: Amount, in millions, of prevented overpayments to Medicaid providers (cost avoidance)

Service Outcome Measure Projection Table 1.C:

Baseline/Year FY 2008-2009	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015	FY 2015-2016
Amount, in millions, of overpayments prevented (cost avoided) by MPI detection and prevention activities	5%	5%	5%	5%	5%
$18,900,000	$21,879,113	$22,973,068	$24,121,722	$25,327,808	$26,594,198

Service Outcome Measure 1.D: Amount of referrals sent to the Department of Health, Florida Department of Law Enforcement, AHCA Division of Health Quality Assurance, AHCA Division of Medicaid, and the Medicaid Fraud Control Unit within the Office of the Attorney General

Service Outcome Measure Projection Table 1.D:

Baseline/Year FY 2007-2008	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015	FY 2015-2016
Amount of referrals that MPI will send to the Departments of Health, Florida Department of Law Enforcement, AHCA Division of Health Quality Assurance, AHCA Division of Medicaid, and the Medicaid Fraud Control Unit	7%	7%	7%	7%	7%
535	701	750	803	859	919

Division of Health Quality Assurance

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 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015	FY 2015-2016
Average annual number of renewal applications 8,649	0	1,730	3,460	5,190	6,920
Percent applications received via Internet 0%	0%	20%	40%	60%	80%

(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 Versa Regulation (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 and in the Agency's own Background Screening System, which was shut down August 1, 2010 in favor of electronic fingerprinting through numerous vendors. The Agency is making progress more slowly than originally anticipated with its "e-gateway" (web based) programming to implement on-line licensure applications due to a lack of available resources. However, if appropriate funding is secured in 2011, it is reasonable to expect the system will be implemented in late CY 2012 or CY 2013. Consequently, we anticipate an 80 percent e-renewal application rate by FY 2015-2016.)

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 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015	FY 2015-2016
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 2,942 in Fiscal Year (FY) 2009-2010 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 Versa Regulation 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 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015	FY 2015-2016
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

(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 Health Care Program, developed by Governor Crist. The other is the Florida Health Choices Corporation, designed by the Legislature. Both are now operational. Cover Florida Health Care is fully operational and Florida Health Choices Board has been established. These plans will be discussed further under Trends and Conditions as will the impact of the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Act, which requires nearly everyone to have health insurance by 2014.)

Division of Medicaid

Service Outcome Measure 3. A: Target weighted PMPM by State Fiscal Year

Service Outcome Measure Projection Table 3. A: Target Weighted PMPM by State Fiscal Year

Baseline/Year FY 2006-2007	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015	FY 2015-2016
Projected PMPM with 8% Growth $328.24	$446.56	$482.29*	$520.87*	$606.95*	$607.54*
Actual PMPM $269.89	$367.18	$396.55	$428.27	$462.53	$499.53

*Assumes Waiver is renewed for additional years

Service Outcome Measure 3. B: Percent of outcome measures maintained or improved in Medicaid's performance-based outcome indicators

Service Outcome Measure Projection Table 3. 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	12	12	20	20	20

Baseline/Year FY 2007-2008	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015
Number of outcome measures maintained or improved N/A	10	8	18	20	20
Percent of outcomes maintained or improved N/A	83%	67%	95%	100%	100%

Only 12 of the current "approved" measures are actual outcomes (i.e., performance measures). The 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.

Service Outcome Measure 3. C: Long-term care savings in millions over current projections

Service Outcome Measure Projection Table 3. C: Projected Long Term Care (LTC) Expenditures (in millions).

Baseline/Year FY 2005-2006	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015	FY2015-2016
Current LTC Projections $2,423	$3,114	$3,252	$3,395	$3,544	$3,700
Revised LTC Projections $2,294	$2,778	$2,872	$2,969	$3,069	$3,172
LTC Savings $129	$336	$380	$426	$475	$528

Table excludes Medicare nursing home crossover payments.

Service Outcome Measure 3. 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 3. D:

Baseline/Year FY 2005-2006	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015	FY2015-2016
Percent of MediPass patients that reported satisfaction with access to specialty care. 68%	61%	77%	80%	83%	85%

Service Outcome Measure 3. E: Number of services/programs available to low–income recipients that utilize principals of consumer driven care

Service Outcome Measure Projection Table 3. E: Services/programs with consumer directed incentives

Baseline/Year FY 2003-2004	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015	FY2015-2016
Services/programs with consumer directed incentives 1	3	3	4	4	4

Florida Center for Health Information and Policy Analysis

Service Outcome Measure 4.A: The average number of days between receipt of certified patient data and posting that data on the Agency's website, FloridaHealthFinder.gov

Performance Projection Table 4.A:

Baseline/ Year FY 2005-2006	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-15	FY2015-2016
Number of days from data receipt to posting on website 485	310	248	198	158	126
Percent decrease in days to post data on website 20 %	20 %	20 %	20 %	20 %	20 %

Service Outcome Measure 4.B: The average daily number of website visits to 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 FloridaHealthFinder.gov

Performance Projection Table 4.B:

Baseline/Year FY 2006-2007	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015	FY 2015-2016
Average number of sessions on website per day 3,107	4,550	5,005	5,505	6,055	6,661
Percent increase in the number of sessions begun per day 10%	10%	10%	10%	10%	10%

Service Outcome Measure 4.C: The number of new and refill prescriptions that are sent electronically as a percentage of all prescriptions

Performance Projection Table 4.C:

Baseline/Year FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015	FY 2015-2016
Number of Florida prescriptions that are sent electronically 1,974,486	2,750,000	3,500,000	4,250,000	5,125,000	5,875,000
Annual percent increase in number of E-Prescriptions	25%	25%	25%	25%	25%

The Office of Communications and Multi-Media Relations, and the Office of Legislative Affairs

Service Outcome Measure 5.A: Number of correspondence pieces tracked by the Agency's Correspondence Unit

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

Baseline/Year FY 2006-2007	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015	FY 2015-2016
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 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 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015	FY 2015-2016
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 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015	FY 2015-2016
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 5.B: The percentage of how often correspondence and media request are responded to on time

Service Outcome Measure Projection Table 5.B. (1):

Baseline/Year FY 2009-2010	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015	FY 2015-2016
Percent of correspondence responded to on time 85.8%	87.5%	89.25%	91%	92.8%	94.6%
Annual percent of increase 2%	2%	2%	2%	2%	2%

(The FY 2009-2010 baseline was selected as it was the first year the Communications Office began presenting how often correspondence was responded to on time to Agency management. This has played a significant role on how the Agency responds to requests.)

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

Baseline/Year FY 2009-2010	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015	FY 2015-2016
Percent of media requests responded to on time 80.26%	90%	91%	92%	93%	94%

(The FY 2009-2010 baseline was selected as it was the first year the Communications Office began presenting how often media requests were responded to on time to Agency management. This has played a significant role on how the Agency responds to requests. The 90 percent for FY 2011-2012 was selected because it came to the attention of the Communications Office that some staff were not previously using proper tracking methods in the FY 2009-2010. The Communications Office feels it can and should respond to media requests on time at least 95 percent of the time and will work to achieve this goal over the next five years.)

Service Outcome Measure 5.C: The number of constituent and legislative inquiries handled by the Legislative Affairs Office

Service Outcome Measure Projection Table 5.C:

Baseline/Year FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015	FY 2015-2016
Number of constituent and legislative inquiries handled by the Legislative Affairs Office 1024	1045	1065	1087	1108	1130
Annual percent of increase 2%	2%	2%	2%	2%	2%

The baseline data and five year projections are revised from last year's LRPP due to more accurate tracking. Current tracking now includes telephone calls too.

Service Outcome Measure 5.D: The number of legislative bills tracked and analyzed by the Office of Legislative Affairs

Service Outcome Measure Projection Table 5.D):

Baseline/Year FY 2006-2007	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015	FY 2015-2016
Number of legislative bills tracked and analyzed 148	151	154	157	160	163
Annual percent of increase 2%	2%	2%	2%	2%	2%

(The baseline data and five year projections are revised from last year's LRPP due to more accurate tracking.)

Information Technology

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 2010–2011	FY 2011–2012	FY 2012–2013	FY 2013–2014	FY 2014–2015	FY 2015–2016
20%	30%	50%	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 2010–2011	FY 2011–2012	FY 2012–2013	FY 2013–2014	FY 2014–2015	FY 2015–2016
98%	98%	99%	100%	100%	100%

Service Outcome Measure 6. C: Information Technology's annual retention rate

Service Measure Projection Table 6. C:

Baseline/Year FY 2010–2011	FY 2011–2012	FY 2012–2013	FY 2013–2014	FY 2014–2015	FY 2015–2016
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:

Baseline/Year FY 2010–2011	FY 2011–2012	FY 2012–2013	FY 2013–2014	FY 2014–2015	FY 2015–2016
99.99%	99.99%	99.99%	99.99%	99.99%	99.99%

(Mission critical network services are: enterprise E-mail, Active Directory, network firewalls and related systems, voice over IP (VOIP), and network shares/user shares. Downtime is needed and used to apply necessary network system maintenance.)

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 2010–2011	FY 2011–2012	FY 2012–2013	FY 2013–2014	FY 2014–2015	FY 2015–2016
35%	42%	49%	56%	63%	70%

(The Agency's goal is to have 70 percent of its work force equipped to work remotely by 2015, as needed, in the event of a disaster or pandemic. Currently, 35 percent of the Agency's 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 PCs a year (or seven percent each year) are upgraded to a mobile computing platform, either through virtual PC technologies or hardware replacement (replacing PCs with laptops).

Service Outcome Measure 6. F: The percentage of Agency for Health Care Administration secured e-mail verified through e-mail encryption server reporting

Service Measure Projection Table 6. F:

Baseline/Year FY 2010–2011	FY 2011–2012	FY 2012–2013	FY 2013–2014	FY 2014–2015	FY 2015–2016
95%	96%	97%	98%	99%	99%

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 where possible (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 2010–2011	FY 2011–2012	FY 2012–2013	FY 2013–2014	FY 2014–2015	FY 2015–2016
20%	25%	50%	60%	70%	75%

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 2010-2011.)

Service Measure Projection Table 6. G (2):

Baseline/Year FY 2010–2011	FY 2011–2012	FY 2012–2013	FY 2013–2014	FY 2014–2015	FY 2016–2016
n/a	n/a	n/a	50%	75%	75%

(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.”)

(Risks prior-identified – a “risk prior-identified” is a risk identified in accordance with the Risk Management Program’s methodology *before* the risk becomes realized (if it is realized at all).

Linkage to Governor's Priorities

	Governor's Priorities	Agency's Goals that Support Governor's Priorities
1.	Protecting Our Communities	**Goal 1:** To combat fraud and abuse in the Florida Medicaid Program **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
2.	Strengthening Florida's Families	**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
3.	Keeping Florida's Economy Vibrant	**Goal 1:** To combat fraud and abuse in the Florida Medicaid Program **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
4.	Success for Every Student	**None**
5.	Keeping Floridians Healthy	**Goal 1:** To combat fraud and abuse in the Florida Medicaid Program **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 **Goal 3:** To ensure that Medicaid beneficiaries get access to the services they need and have improved health outcomes **Goal 4:**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 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	**None**

Linkage to Secretary's Priorities

	Secretary's Priorities	Agency Goals that Support Secretary's Priorities
1	To use taxpayers' resources as efficiently and effectively as possible and to safeguard those resources from fraud.	**Goal 1:** To combat fraud and abuse in the Florida Medicaid Program **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 **Goal 3:** To ensure that Medicaid beneficiaries get access to the services they need and have improved health outcomes
2	To ensure that patients in Florida's health care facilities are safe.	**Goal 1:** To combat fraud and abuse in the Florida Medicaid Program **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 **Goal 3:** To ensure that Medicaid beneficiaries get access to the services they need and have improved health outcomes **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
3	To ensure that Medicaid beneficiaries get access to the services they need and have improved health outcomes.	**Goal 1:** To combat fraud and abuse in the Florida Medicaid Program **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 **Goal 3:** To ensure that Medicaid beneficiaries get access to the services they need and have improved health outcomes

4	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 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 ensure that Medicaid beneficiaries get access to the services they need and have improved health outcomes **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
5	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 3:** To ensure that Medicaid beneficiaries get access to the services they need and have improved health outcomes **Goal 4:** 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 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
6	To make the Agency an employer of choice where employees believe their work is meaningful, opinions matter, efforts are recognized and that the workplace exemplifies the values of accountability, fairness, responsiveness and teamwork.	**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 **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

Trends and Conditions Statements

Office of the Inspector General

The purpose of the Office of the Inspector General (OIG) is to provide a central point for the coordination of, and responsibility for, activities that promote accountability, integrity, and efficiency within the Agency for Health Care Administration (Agency). This purpose is carried out, in part, by the work of the Bureau of Medicaid Program Integrity (MPI). The Florida Medicaid program is a $20.7 billion program with over 80,000 providers providing Medicaid services to more than 2.7 million recipients. Section 409.913, Florida Statutes and Title 42, Code of Federal Regulations (CFR) 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 is reduced to the minimum extent possible and to recover overpayments and impose sanctions as appropriate.

In the Medicaid program, the key indicator of fraud and abuse is overpayments. MPI is charged with preventing, finding, auditing and initiating the recovery of overpayments, as well as overseeing the integrity of the State's Medicaid program. In addition, the Bureau of MPI continues to ensure the Medicaid program is managed in accordance with state and federal mandates. To this regard they participated in the recent contract selection of a replacement Medicaid Fiscal Agent and were involved in the development and installation of an improved Florida Medicaid Management Information System (FMMIS). The Medicaid Fiscal Agent contract went live on July 1, 2008. The new contract requires the Fiscal Agent to make technical resources available to OIG/MPI that may be used to produce statistical information from complex Decision Support System (DSS) algorithms. These algorithms permit the Agency to identify violations of unbundling services, exceeding hour or age limit thresholds, etc. On November 1, 2008, the FMMIS/DSS system was populated with a complete history of paid claims data. MPI continues to work with the Medicaid Fiscal Agent to identify violations in the Medicaid program.

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

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

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

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 in a Medicaid federal audit program. Eight states are participating in this program (Florida, Illinois, Louisiana, New Jersey, New York, North Carolina, Texas, and Wisconsin).

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.

MPI's prevention, detection, and recoupment efforts continue to identify improper billing and fraudulent schemes in the Medicaid program. During FY 2008-2009, MPI prevention efforts resulted in cost savings of $18.9 million. Actual overpayments recovered total $50.3 million for the same fiscal year. In order to improve efforts, MPI continues to work closely with MFCU and other state entities through referrals. For FY 2009-2010, there were 198 referrals to the Medicaid Fraud Control Unit. Referrals to the Florida Department of Law Enforcement increased to 117. All referrals were up 60 percent to 894. See Figure 1-1 for a complete look of referrals from FY 2006-2007 through FY 2009-2010.

Figure 1-1

MPI Referrals				
Referrals	**FY 06-07**	**FY 07-08**	**FY 08-09**	**FY 09-10**
Department of Health	181	70	163	108
FL Department of Law Enforcement	1	13	40	117
AHCA Division of Health Quality Assurance	42	59	56	40
AHCA Division of Medicaid	82	48	60	67
Medicaid Fraud Control Unit	212	218	123	198
Others	44	127	118	364
Total	**562**	**535**	**560**	**894**

Every year, the Agency and the Medicaid Fraud Control Unit (MFCU) of the Office of the Attorney General submit a joint report to the Legislature titled, *The State's Efforts to Control Medicaid Fraud and Abuse*. This report contains the following:

- Number of cases opened and investigated each year;
- Sources of the cases opened;
- Disposition of the cases closed each year;

- Amount of overpayments alleged in preliminary and final audit letters;
- Number and amount of fines or penalties imposed;
- Any reductions in overpayment amounts negotiated in settlement agreements or by other means;
- Amount of final Agency determinations of overpayments;
- Amount deducted from federal claiming as a result of overpayments;
- Amount of overpayments recovered each year;
- Amount of cost of investigation recovered each year;
- Average length of time to collect from the time the case was opened until the overpayment is paid in full;
- Amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government;
- 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.

As a result of the cooperation between the Agency and MFCU, 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. In FY 2009-2010, the Agency sent 198 referrals to MFCU for investigation.

Combating fraud and abuse in the Florida Medicaid program is the Agency's highest priority. All divisions of the Agency work with the Medicaid Fraud Control Unit, the Department of Health, the Agency for Persons with Disabilities, the Centers for Medicare and Medicaid Services, law enforcement, and other agencies as needed. Regular meetings of the organizations involved help to ensure coordination and improve communication. The Agency will continue to work with local, state, and federal law enforcement and prosecutorial agencies to stop criminals, reduce fraud, and protect the integrity of the Florida Medicaid program. Current staffing levels may not be adequate to meet all the anticipated challenges we will encounter during the next five years covered by this Long Range Program Plan (LRPP). Additional staff will increase overpayments recouped and enhance return on investment.

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, MPI will use available resources in the most effective and efficient manner to focus on designated crisis locations and provider types. Medicaid Program Integrity will work collaboratively with other divisions in the Agency, as well as with other state and federal agencies. MPI will continue generating quality referrals by our field and detection units and will

continue to post Agency actions against health care providers on the health care fraud data Web site. Posting this information will facilitate the electronic exchange of health care fraud information between those agencies tasked with regulating health care providers. MPI will provide oversight for managed care by reviewing the compliance of various plans with applicable contract language, recommending enhancements to such contract language, and developing an audit program.

In general, we will strive to continue to increase prevention, detection, and recovery efforts. The following details the activities of prevention, detection, and recovery efforts.

Detection

The Data Detection Unit detects potential fraud and abuse in the Medicaid program. This unit is responsible for developing generalized analyses and providing programming support for other MPI units. They also facilitate provider self audits and coordinate Medicaid policy clarification requests. Data detection efforts are geared to detect violations through several detection methods. On the basis of apparent violations, investigations are conducted to determine whether overpayments exist. Recoveries of any overpayments are initiated or referrals to outside agencies are recommended. The Data Detection section utilizes various tools, resources and reports in an effort to identify Medicaid fraud and abuse activities. Detection efforts by MPI can be initiated by leads from complaints, other regulatory announcements or actions, incoming referrals, newspaper articles or advertisements, Explanation of Medicaid Benefits (EOMBs), leads from Medicaid, and the Medi-Medi partnership with the Medicare program. Data mining with internally developed advanced detection software and software supplied by the fiscal agent contractor are other sources used to detect fraud and abuse. Data detection and research units will continue to improve methodologies and tools for data analysis including reviewing possibilities of vendor assisted participation.

As part of their continued efforts to detect potential fraud and abuse in the Medicaid program, the data detection unit, MPI, and the Agency will contract with an outside vendor to provide additional comprehensive and generalized audits. The qualified vendor will provide post-payment identification and recovery of improper payments on behalf of the Florida Medicaid program. The selected vendor will identify Medicaid providers to be audited and will report back to the Agency with supporting documentation justifying those findings. Supporting documentation for each audit will be gathered from Medicaid Decision Support System (DSS) queries, and medical records supplied by providers. The detailed findings of the audits will be stored in the Agency's Fraud and Abuse Case Tracking System (FACTS). The vendor will be required to submit to the Agency a quarterly report summarizing the quality assurance activities and findings.

Prevention

Prevention efforts enhance the efficiency of the Medicaid Program in that detection, auditing and recovery of prevented overpayments become unnecessary. Stopping overpayments before they happen avoids recovery costs and allows those funds to be used as intended. Prevention efforts by MPI include the following:

- The use of prepayment reviews to identify improper claims and deny payment;
- Recommendations for termination of providers suspected of misusing the Medicaid program;

- The use of a provision of law that allows Medicaid to decline reimbursement for prescription drugs prescribed by practitioners who have been terminated from the Medicaid program;

- Site visits by field staff;

- Focused projects to address areas most susceptible to fraud and abuse that have a deterrent effect and that result in cost savings for the Medicaid program;

- EOMBs to recipients verifying receipt of services;

- Sanctions as appropriate under Rule 59G-9.070 Florida Administrative Code;

- Referrals to other regulatory and law enforcement entities that may result in restrictions on providers' abilities to continue to participate in the Medicaid program and that serve as a deterrent; and,

- Other measures that allow the Agency to better oversee its network of providers.

During FY 2008-2009, prevention efforts resulted in a cost savings of $18.9 million. The objective is to increase the costs avoided as a result of prevention efforts. Figure 1-2 illustrates the activities dedicated to Prevention Efforts during FY 2008-2009.

Figure 1-2

MPI Prevention of Overpayments (millions)				
Activity	**FY 05-06**	**FY06-07**	**FY 07-08**	**FY 08-09**
Prepayment Review	5.5	4.8	4.2	5.8
Termination of Providers	13.3	13.2	5.4	3.2
Focused Projects	11.4	5.0	9.8	2.6
Denial of Reimbursement for Prescription Drugs	5.9	0.8	0.5	0.3
Policy Changes	0.9	2.4	n/a	n/a
Site Visits	n/a	2.8	1.8	6.5
Fine Sanctions Imposed	0.3	0.4	0.1	0.5
Total	**$37.3**	**$29.4**	**$21.6**	**$18.9**

Recovery

Investigation and recovery efforts by MPI include comprehensive audits involving reviews of professional records, generalized analyses involving computer-assisted reviews of paid claims for compliance with Medicaid policies, paid claim reversals involving adjustments to incorrectly billed claims, focused audits involving reviews of certain types of providers in specific geographic areas, and referrals to MFCU and other regulatory and enforcement agencies.

Investigations into allegations and indications of violations of Medicaid policy fall into three categories:

- MPI-conducted audits,
- Paid claims reversals by MPI, and
- Vendor-assisted audits.

Figure 1-3 illustrates the amount, in millions, recovered during FY 2004-2005 through FY 2008-2009:

Figure 1-3

MPI Recovery of Overpayments (millions)					
Activity	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09**
MPI Audits(Collections by F&A)	$12.2	$16.3	$18.8	$14.9	$15.4
Paid Claims Reversals	1.5	0.9	0.7	0.5	0.3
TPL Contractor Asst. Claims Adj.	7.4	10.8	15.0	12.8	34.6
Total	**$21.1**	**$28.0**	**$34.5**	**$28.2**	**$50.3**

Next Steps

To improve the detection, prevention, and recovery of Medicaid overpayments due to fraud and abuse, the legislature passed Senate Bill 1986 during the 2009 Legislative Session which amended, in part, §§ 409.913, F.S.

Data Connectivity

New provisions added to §409.913, F.S. require the Agency to connect all databases that contain health care fraud information. Database connectivity is necessary to facilitate the electronic exchange of health information between state and federal entities. Pursuant to § 409.913 (38)(b), F.S., state entities that must be included within this strategic plan in addition to AHCA are the Department of Health, Department of Law Enforcement, and the Office of the Attorney General. The Agency will continue to look at database connectivity issues, collaborative efforts, the implementation of data integration for health care fraud information, the current issues in Medicaid fraud, strategies for fraud identification and prevention, and immediate and long range opportunities for database connectivity.

Fraud and Abuse Teams

In fall 2009, the Agency's Medicaid Quality Management Bureau, Project Management Unit, was assigned to work with the Office of the Inspector General to coordinate and assist in the implementation of Senate Bill 1986. (SB 1986**)** Many of the provisions took effect on July 1, 2009, and the Agency continued to improve its processes throughout this past fiscal year. To facilitate the implementation of the legislative changes, the Agency developed Fraud and Abuse Teams consisting of the following sub-committees:

Prevention Sub-Committee:

This sub-committee will continue to work with all ideas and suggestions regarding proposed changes in Medicaid policies and procedures, proposed changes to the provider enrollment agreement, provider site-visits, termination or denial of providers, provider education, and situations regarding the interpretation or implementation of Medicaid policies.

Detection Sub-Committee:

This sub-committee will continue to work with all ideas and efforts regarding the detection of fraudulent and/or abusive behavior regarding the claims process. The work will include the creation and checking of system edits, defining algorithms that identify outliers, analyzing data for aberrant billing practices such as up coding and unbundling, auditing providers, looking at fraud and abuse issues within Agency contracts, conducting pre-payment reviews and termination of providers.

MPI staff participates in this sub-committee. In addition to participating in fraud and abuse teams, the data detection unit will continue to utilize detection tools such as DSS Profiler, FMMIS, and Business Objects. This unit will also stay abreast of new technologies that may be used to enhance detection capabilities. This will involve engaging in conversations with vendors to implement and adopt state of the art detection tools such as neural networking capabilities.

Recoupment Sub-Committee:

This sub-committee will continue to work on various recoupment opportunities and processes to shorten the amount of time needed to collect identified overpayments, improve the percentage of identified overpayments collected, and identify new ways to enhance the Agency's recoupment efforts.

Protecting taxpayers from fraud and abuse in the Medicaid system is a team effort involving the entire Agency. Increasing cost avoidance through detection and prevention efforts and recovering overpayments will aide in achieving the goal of combating fraud and abuse in the Medicaid Program and creating better health care for all Floridians.

List of Potential Policy Changes Affecting the Agency's Budget Request or the Governor's Recommended Budget

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

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

Number	Identify Proposed Change	Describe Expected Results of Proposed Change	Describe Legislative Actions Required to Implement the Proposed Change
1	Authorizes the agency to sanction Medicaid providers for criminal convictions that we currently screen for during the application process.	Supports §409.913, FS in deterring fraud and abuse in the Medicaid program	Amend Florida Statute
2	Place Medicaid treating pharmacies under the same oversight regulation as other Medicaid provider types as defined by Florida Statutes.	This will eliminate conflicting language between §465.188, FS and §409.913, FS and to strengthen the Agency's efforts of deterring fraud and abuse within the Medicaid Program.	Repeal §465.188, F. S. to allow the use of statistically valid and legally upheld methodology when determining overpayments,

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

Number	Implementing Bill or Statute	Task Forces and Studies in Progress	Required / Expected Completion Date
1	s. 409.913, FS	Joint report AHCA and MFCU documenting effectiveness of efforts to control fraud.	Annually / January 1
2	s. 20.055(5)(h), FS	Schedules engagement for the upcoming fiscal year.	Annually / September 30
3	s. 20.055(7), FS	Summary of all activities within the Inspector General's office for the previous fiscal year.	Annually / September 30
4	1986 (2009 Legislative Session)	Implementation and coordination with AHCA, DOH, MFCU, APD, etc. (74 sections of bill) effective July 1, 2009 / development of Fraud Steering Committee / develop Strategic Plan for Data Connectivity	Bill effective July 1, 2009

Trends and Conditions Statement

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.

Stretching Resources in Tough Economic Times

From 2001 to 2009, total national health costs increased annually at an average rate of 10.2 percent. If that trend continues until 2019, health care costs for employers will rise 166 percent and the total health care spending in the U.S. will reach $4.4 trillion, consuming more than 20 percent of the gross domestic product of the United States. (Business Roundtable, Hewitt Report September 2009)

The impact of the recent nationwide recession and the possibility that it will be followed by a second recession—or double dip—does not bode well for government operations, particularly as these relate to regulatory processes. Depending upon which statistics one believes, Florida originally had either a $4.7 billion deficit or a $5.8 billion deficit projected for 2011. (State of Florida Long Range Financial Outlook Fiscal Year 2010-2011 through 2012-13; Center for Budget and Policy Priorities--Recession Continues to Batter State Budgets; Florida State Budget, Sunshine Review) However, the economy appeared to be improving in the first half of the 2010-2011 fiscal year, and a more recent report revealed that cautious optimism is taking hold, and while the shortfall will not be known until later this year, the results of the most recent estimating conference point to a smaller shortfall than previously thought. (See Florida Tax Watch August 2010 Budget Watch report)

The Agency has thus far met the need to tighten its fiscal belt by cutting programs perceived to be “luxury items”, i.e., those programs that, while beneficial, are not mandatory for quality health care provision, and by trimming regulations. Service cuts have included the nurse monitor program, an initiative originally developed in 2001 to help nursing homes and assisted living facilities meet regulatory compliance requirements; duplicative licensing for clinical laboratories that do only waived testing; and registration for utilization review agents. Elimination of state licensure for waived clinical laboratories means that these services no longer have redundant federal/state requirements to meet. Although the state is still responsible for ensuring that more than 13,000 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.

Additional efficiencies have been obtained through streamlining. During the 2010 legislative session, House Bill 7069 (Chapter 2010-114, Laws of Florida) passed requiring all background screening to occur using electronically obtained fingerprints and expanding the types of disqualifying crimes for those with direct access to residents/patients in health care facilities. Implementation occurred August 1, 2010. Since the bill also expanded the numbers of people who must be screened for employment in health care facilities, electronic fingerprinting using an approved vendor was seen as the only way to accommodate the new requirements. The Agency estimates the number of screenings will rise from a few more than 66,000 per year to more than 150,000 per year beginning August 1, 2010.

The Agency believes that resources can often be more appropriately "stretched" when state workers take on the responsibilities otherwise shouldered by private contractors. Responsibility for the revised direction is, in part, a function of technological change. 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 prepared a legislative budget request for FY 2010-2011 to bring the outsourced Complaint and Information Call Center back in-house using state workers. However, the legislature reduced the budget by the $133,486 in projected savings based on the existing contract amount. Consequently, a call center contract, though reduced in scope, remains in effect. 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 uses Voice Over Internet Protocol technology throughout its statewide operations. This permits establishment of a branched system without the high capital outlay expenditures originally associated with the telephone system. Nevertheless, until the division receives approval for additional positions, it cannot take advantage of its new telephone technology for this purpose.

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.

Staffing Shortages

Florida Trend indicates that Florida faces the third largest physician shortage in the nation and will need 63 percent more primary care physicians within 10 years to avoid that shortage. (Florida Trend) A recent article from the University of Central Florida indicates that twenty-eight states, including Florida, are pushing to expand the authority and responsibility that nurse practitioners have, due to the nation-wide shortage of doctors. (Nurses-Orlando Sentinel) Particularly when these occur in rural areas, shortages in the supply of physicians give rise to need for additional nurses with advanced degrees—Advanced Registered Nurse Practitioners—which are also in relatively short supply.

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)

Two April 2010 reports from the Florida Center for Nursing (FCN) detailed the size and characteristics of Florida's Licensed Practical Nurse, Registered Nurse and Advanced Registered Nurse Practitioner workforce as of January 2010. Results from the FCN study found significant growth in the supply of nurses in Florida, an increase which is described as undoubtedly created by the economic decline facing both Florida and the Nation. Among the conclusions of the report were:

- The number of RNs with an active license, Florida address, and eligibility to practice (the *potential* nurse workforce) increased by 11,512 from 2008-2010 – a growth rate of 3.3 percent annually. The number of LPNs with an active license, Florida address, and eligibility to practice increased by 2,919 from 2008-2010 – a growth rate of 2.7 percent annually.

- However, the net gain of 11,512 RNs masks much larger gains and losses from the nurse supply. The state actually gained more than 27,600 RNs over the two years, but it also lost nearly 16,200 RNs. Likewise, the net gain of 2,919 LPNs obscures the gain of more than 10,500 LPNs over the two years, but a concurrent loss of 7,615 LPNs. Conclusion: Even during a recession, retention in the state and profession remains a problem.

- The FCN estimated that about 85.5 percent of RNs (or 160,303) are actually working in the field of nursing in Florida. About 90 percent of ARNPs (or 11,335) are employed in nursing. The Center also estimates that about 83.3 percent of LPNs (or 48,185) are actually working in the field of nursing in Florida. They provide approximately 42,747 full-time equivalents (FTEs) of nursing labor, a large number of which are in long term care (15,718 FTEs).

- In 2010, 46.5 percent of the RN workforce and nearly 40 percent of the LPN workforce is over the age of 50 years and can be expected to retire during the next 15 years. In addition, the number of hours worked declines dramatically among those in the workforce aged 61 and older.

- Florida's geographic and demographic diversity mean that growth and adequacy of the nurse supply vary substantially across regions of the state. The South and Southeast regions experienced much lower rates of growth in RN supply over the past two years. The South and Southwest regions had the lowest number of employed RNs per 100,000 in population. The southern regions of the state experienced much higher rates of growth in LPN supply over the past two years. Even still, all three regions are below the statewide average in number of employed LPNs per 100,000 in population.

Even though the economic recession has eased the nursing shortage temporarily, the increased rate of growth in Florida's potential nurse workforce from 2008-2010 was almost entirely a result of increased new additions to the supply – not decreased attrition. The FCN expects the nursing shortage to return once the economy recovers. (See Full Report)

State agencies find themselves in stiff competition for staff with the facilities they regulate. To address the nursing shortage in Florida, hospital providers (the primary employers of nurses) offer competitive salaries and sign-on bonuses. Agency staff members are clearly prime candidates for facility positions since they not only possess clinical credentials and skills but also have regulatory expertise and can provide guidance to providers regarding regulatory compliance. Furthermore, staff members are required to complete comprehensive training while employed with the Agency, which represents an expenditure that is not recoverable. Survey staff members receive offers from health care providers that are often well above--sometimes even double--their current surveyor salaries.

As of June 29, 2010, the field offices where the majority of health quality assurance nurses are employed, had a 9.4 percent vacancy rate for registered nurses as compared to a 2.2 percent

vacancy rate for all other types of field office staff. This rate is considerably lower than last year's nurse vacancy rate, which was 12.7 percent. The rate for non-nursing staff is a bit higher than last year's rate of 1.7 percent. Nurse surveyor staff members are on call 24/7/365 and salaries are not commensurate with the level of their responsibility relative to what they would earn in other settings for that same level of responsibility. However, in times of economic downturn, the problem with recruitment is less likely to interfere with operations than when the economy is in good shape.

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 $44,399 annually. In addition, the median salary for contract nurses in the hospital setting is $45 per hour (over $93,000 annually). The most recent available U.S. Department of Labor statistics indicate that the median salary nationwide for a registered nurse is $62,450. (See U.S. Department of Labor Handbook for FY 2010-2011). Private sector benefits, including salaries and bonuses have surpassed what is available through the current state agency staffing/rate scheme.

Partially because salaries are not competitive and partly because responsibilities are extensive, the turnover rate for nurses in the field offices had been close to 20 percent every year since CY 1999. Probably due to the economic downturn, which tends to improve the Agency's ability to hire qualified staff, the nursing turnover rate for 2009/2010 was only 15.75 percent. (People First) Since the cost to train each new surveyor is approximately $12,000, a 15.75 percent turnover rate, year over year, yields an estimated annual non-recoverable cost of approximately $321,300 just to train new nurse surveyor staff members.

Long Term Care Facilities

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).

Florida's population potentially in need of long term care is significantly greater than that of other states. Our over-85 population is already 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 86.92 percent, down by 0.43 percent from the prior year. As of March 1, 2010, there were 79,437 licensed and 1,004 approved community nursing home beds in Florida. This represents a 0.05 percent statewide increase from the prior year. Medicaid occupancy for CY 2009 was 61.26 percent; six-month Medicaid occupancy was 62.06 percent during the period July 2009 through December 2009. Total occupancy for the second half of calendar year 2009 decreased by nearly 1.0 percentage point from 87.36 percent to 86.48 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 4.1 percent in the fourth 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 8.6 percent in the fourth quarter of CY 2009. While the progress for pressure ulcer reduction is not as dramatic as that for restraints, the data shown here represent 796 fewer people with pressure ulcers as of the end of CY 2009.

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 (Miami-Dade County). However, we have now expanded the initiative to other areas of the state. The Agency has partnered with the Florida Directors of Nurses Association, which is taking the lead to move this project 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 ten 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 2010-2011 is 617 FTE positions--one position less than the Division of Health Quality Assurance had in FY 2002-2003 after the Medical Quality Assurance function was transferred to the Department of Health. Two of those 617 positions are associated with new legislation, HB 945, passed during the 2010 Legislative session, which requires additional survey activities associated automated external defibrillators in certain assisted living facilities.(See Table 2-1) 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 42,187—an increase of more than 97 percent! (See Table 2-2)

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

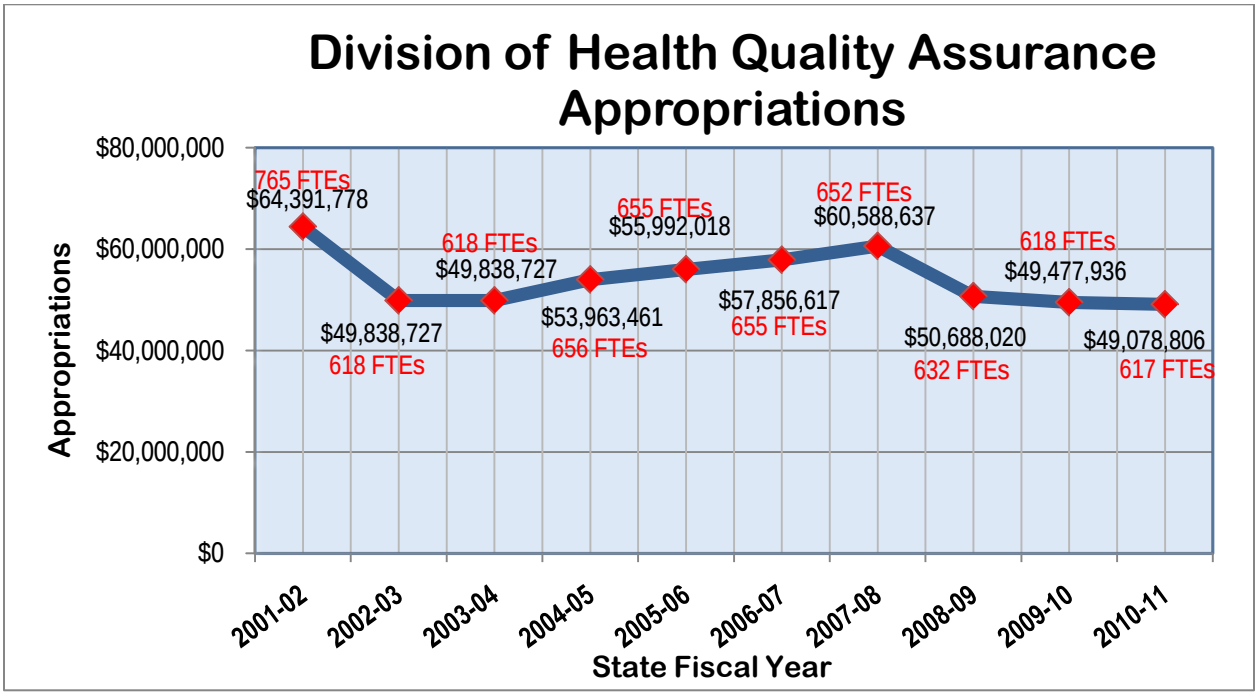
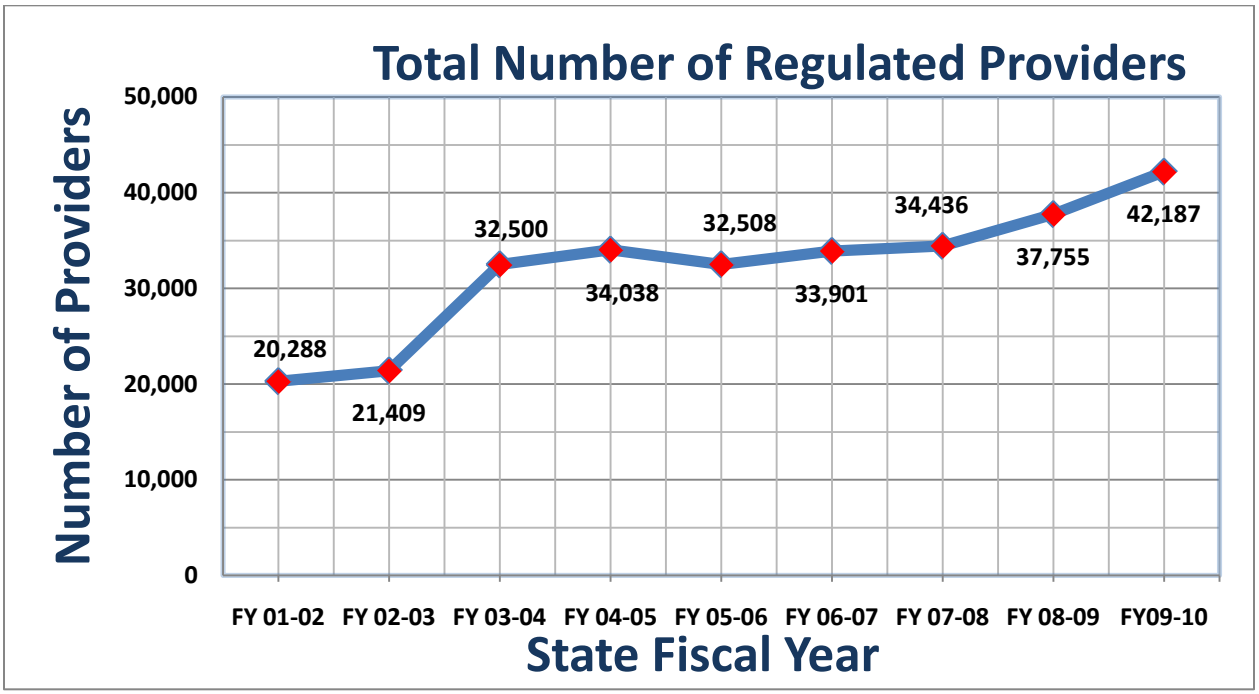


Table 2-2 - Total Numbers of Regulated Providers for State Fiscal Years 2001-2002 through 2009-2010



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.

One regulatory reduction affecting the Department of Health will also have an impact on the Agency: Effective July 1, 2010, House Bill 5311 eliminates the quarterly food sanitation inspections in nursing homes and hospitals that were conducted by the local County Health Department (CHD/DOH) staff. All other provider types will continue to be inspected quarterly for food sanitation. This means that the Agency will continue its normal business processes for inspection in both nursing home and hospitals; however due to language included in this bill the Agency will not be able to refer food sanitation issues to DOH, as DOH no longer has that authority.

The 2010 Legislature also passed legislation to require licensure of pain management clinics that will increase the number of clinics that must be licensed by the Agency. Pain management clinics not 100 percent owned by medical and osteopathic physicians must be licensed by the Agency for Health Care Administration as health care clinics under Part X, Chapter 400, Florida Statutes. This change is based on Senate bills that were incorporated into Chapter 2010-211, Laws of Florida.

In the CY 2010 legislative session, the Agency attempted to secure passage of additional regulatory reduction and fraud/abuse prevention provisions. The attempt was formalized into House Bill 1143, which was subsequently amended to become a highly controversial anti-abortion bill. Though House Bill 1143 passed in both houses of the Legislature, Governor Crist vetoed the legislation. The Division plans a further attempt at bill passage during the 2011 Legislative Session. Provisions will:

- Eliminate certified mail for license renewal reminder notices, saving about $56,000 annually.

- Allow additional accrediting organizations to be recognized for licensure of hospitals and ambulatory surgery centers.

- Simplify regulatory reporting requirements and make changes to licensing statutes that address uniform licensure for health care providers, including:

    - ✓ Inspections, classification of deficiencies and sanctions'
    - ✓ Complaint investigations
    - ✓ Provisional and inactive licenses
    - ✓ Electronic publication of documents and reports
    - ✓ Timeframes for reporting licensure changes
    - ✓ Financial information and bonds
    - ✓ Reporting bankruptcy, eviction or foreclosure
    - ✓ Remove references to Private Review Agents, registration requirements for which were repealed in 2009.

- Eliminate routine submission of licensure documents that are either reviewed during inspection, requested when needed, or no longer necessary.

- Align new AHCA nursing home staff training with federal qualifications

- Allow additional staffing in a nursing home outpatient clinic and streamline nursing home rules

- Modify the penalty for nursing homes for staffing to impose a fine of $1,000 when a nursing home that does not meet staffing ratios fails to self impose a moratorium.

- Clarify the requirement for hospice inpatient units to obtain a Certificate of Need.

- Clarify that portable service providers are subject to health care clinic licensure even though they do not deliver care at the clinic's location.

- Eliminate the Limited Nursing Services (LNS) specialty license type for assisted living facilities and allow a licensed nurse to provide limited nursing services in a standard licensed facility.

- Make several technical corrections to agency and organization names.

- Repeal obsolete and duplicative provisions in health care licensing and related statutes including expired reports and regulations.

- Allow an adult family care home to be operated by up to two people living in the home rather than just one individual.

- Clarify that a person may not provide services to more than two people in their own home without an AFCH license.

- Provide flexibility to AHCA for staffing the consumer call center. Provide 10 FTEs to bring the call center in house—which will cost no more than the existing contract.

- Clarify that AHCA inspection reports are not subject to legal challenge until penalties are imposed.

- Adopt selected federal standards for home health agencies for nursing supervision of home health aides and certified nursing assistants, provision of one service directly, patient rights, and delivery of services under contract.

- Adopt selected federal standards for intermediate care facilities for the developmentally disabled.

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 application processing. To handle these functions more efficiently and effectively, in late 2009, Health Quality Assurance established the Central Systems Management Unit (CSMU). Composed of staff from each of the licensure units, CSMU provides centralized intake for all mail, initial data entry processing for applications and checks, and front-end scanning for applications in all licensure units. Benefits CSMU include improved total processing time; insurance against lost applications and lost checks; and improved quality control over style and format for data entry. The CSMU tasks will transition as our online

application capability is implemented 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, which as of August 2010, begins with a vendor-based electronic fingerprinting requirement; a new document management system using Laser fiche technology; improvements in the Versa Regulation 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.

Progress Toward Online Licensure of Health Care Facilities

Computerization of the health facility licensure process is important for four reasons. First, it is an essential part of our effort to combat fraud and abuse in health care. Second, it has enabled and should continue to enable the Division to regulate a growing number of providers without adding staff. Third, it is creating a streamlined licensure process that will ultimately be faster and easier to complete and manage, with greater control for the providers and greater accuracy for the Agency. Fourth, it has enabled more reporting about Florida's regulated health care facilities for patients and families as well as other interested parties.

The computerization of the licensure process began in the late 1990s with the acquisition of the first automated licensure processing system (initially called FRAES). This system, now known as Versa Regulation, has undergone at least two major updates and continuous low-level revisions since that time. It has improved the documentation of every step of the licensure process for initial, renewal and change of ownership applications. In turn, this has improved the ability to manage the licensure process, ensuring greater compliance with statutes and rules on both the content of licensure applications and compliance with deadlines.

One of the benefits of the automated system is the ability to track individuals and organizations that have been excluded from Medicare, terminated from Medicaid, or found guilty of some other type of fraud. In the past, such individuals and organizations could easily have continued or re-established themselves as health care providers due to changes of ownership, corporate reorganizations or name changes. With automated information systems that track the controlling interests of all regulated providers, the Agency will improve its ability to deny or revoke licenses based on its ability to track the regulatory history of individuals and entities across provider types.

The automated licensure system is a significant investment that requires periodic appropriations by the legislature. Severe budget constraints in recent years have slowed progress toward a fully automated system that extends computerized capability to the regulated health care providers themselves. A FY 2011-2012 budget issue proposal has been submitted that request an appropriation to automate the submission of license applications and fees in a way that is integrated with the Agency's document management system as well as the accounts receivable systems. This will be a welcome development for many regulated providers, but it is critical in the fight against fraud and abuse and essential if we are to avoid adding Agency staff in an

industry that is not only growing, but churning with an increasing percentage of providers that open, close and re-open.

While the Agency has been expanding and refining the automated licensure system, we have also been improving and expanding the Agency information available on the Internet. Improved Internet capability has led to greater public reporting of information from the licensure system. FloridaHealthFinder.gov is the platform not only for detailed descriptive and contact information for all of our regulated providers, but also regulatory information such as the number and type of sanctions that have been imposed against licensees. This information has expanded greatly in the last several years and places the Agency at the national forefront in the amount of regulatory information that is available to the interested public.

Internet improvements also include development of the first instructional video that assists providers to complete licensure applications correctly. The homemaker-companion organization registration program was targeted because it is a relatively simple application and a significant percentage of applicants are unable to benefit from written instructions. In the future, the combination of internet-based video instruction and online, automated licensure applications will be essential to ensure accurate, timely processing of licensure applications.

The ultimate goal of a comprehensive, integrated, online licensure system is intra- and inter-departmental connectivity with other automated systems such as those used by Medicaid, Medicare, background screening, accounts receivable and practitioner regulation. The Agency has been moving steadily in this direction for the last decade but much work remains to be done.

Currently, about 65 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.

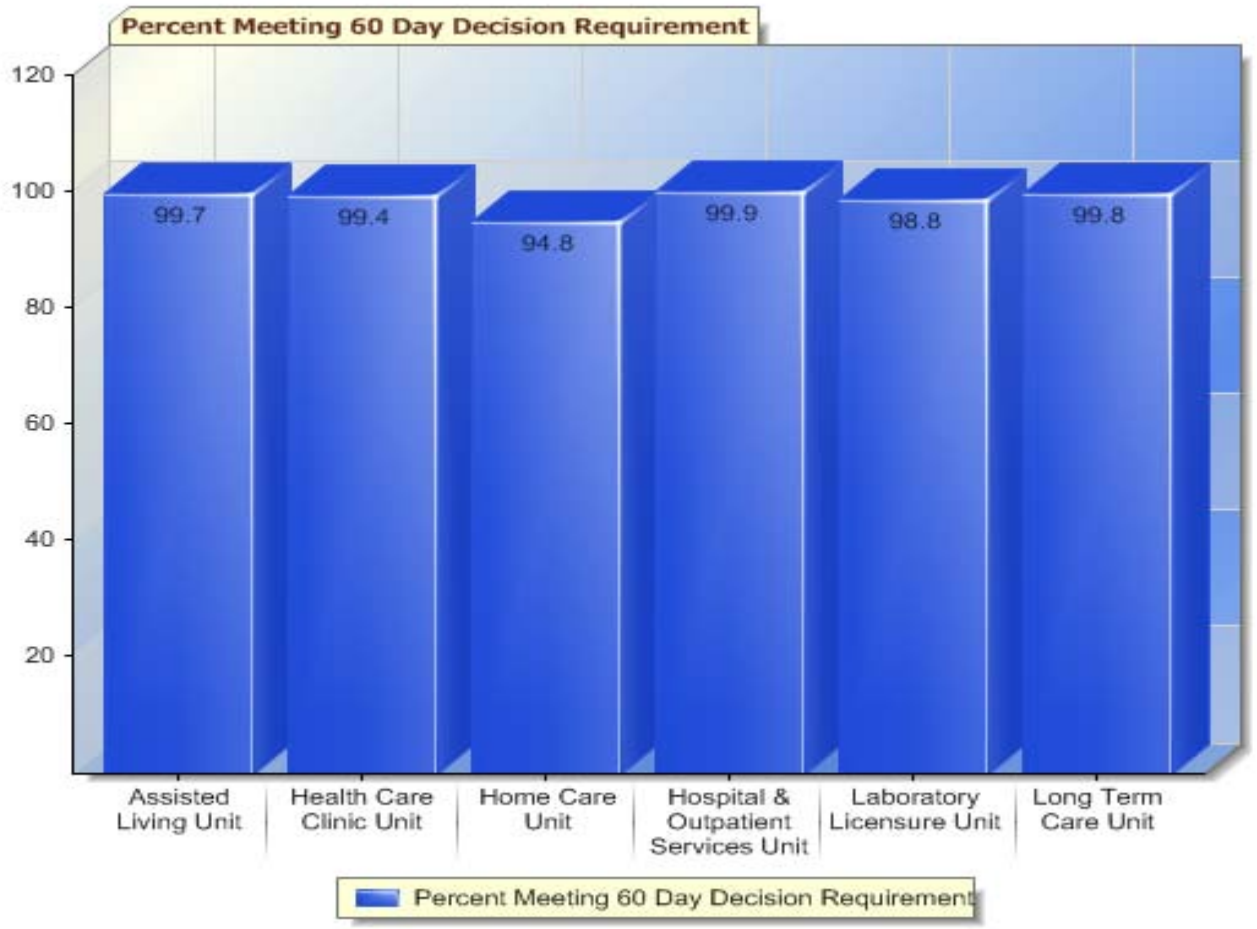
Since only about 35 percent of applications are submitted correctly the first time, the Agency believed its application needed further clarification and perhaps less detail. Consequently, in addition to working toward online applications, the Division reduced and clarified the verbiage in the license application itself. Lack of adequate resources has delayed the online application process as the programming will require additional legislative budget requests unlikely to be approved during times of economic stress. However, eventually combined with the online application process, this simplified application should serve to stretch existing resources further to accommodate the burgeoning numbers of providers.

In the interim, and because an online application system is technologically resource intensive, our Laboratory Licensure unit worked on an intermediate step to permit licensure applications as online, writable PDFs. This means the applicants can type information directly into the licensure applications online; save the files to their own computers so they can fill them out over a period of time; and print them, sign them, enclose checks and submit them to the Agency. Laboratory staff members have already reported that the legibility of applications being received with this process is substantially improved. We anticipate that other units will be following in the footsteps of this pilot project.

As shown in the graph below, most of the units are now 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), statutory compliance ranges from 94.8 percent to 99.9 percent for the fiscal year ended June 30, 2010.

Table 2-3 – State Fiscal Year 2009-2010--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



Customer Service Satisfaction

One might assume that the Agency's philosophy of doing more with existing or reduced resources would have resulted in dissatisfaction among consumers of Agency licensure services. However, based upon consumer satisfaction surveys conducted in state fiscal year (SFY) 2009 as compared with 2010, increased dissatisfaction does not appear to have been the case. As Table 2-4 demonstrates, consumer satisfaction actually increased between SFY 2009 and SFY 2010.

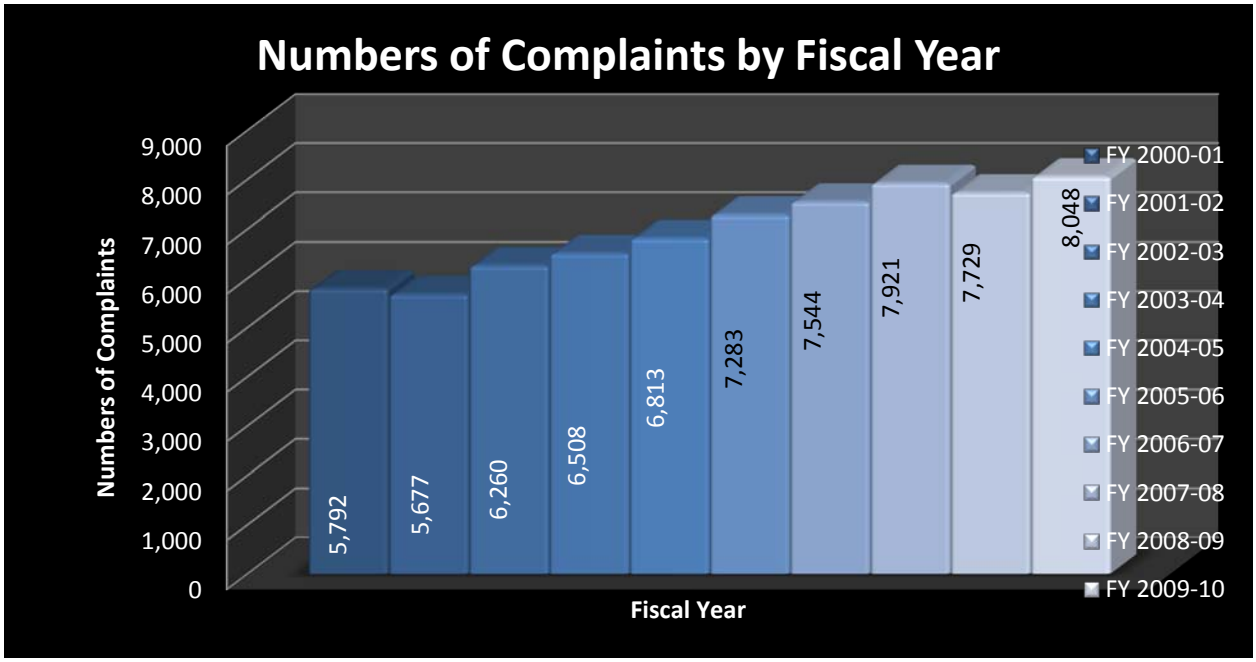
Table 2-4 – Consumer Satisfaction with the Licensure Application Process and Staff Assigned to that Process

Combined Licensure Customer Service Survey Results - Summary SFY 2009	Very Satisfied/ Satisfied	Neither Satisfied Nor Dissatisfied	Very Dissatisfied/ Dissatisfied
Overall satisfaction with Agency staff	84.79%	4.53%	10.68%
Overall satisfaction with the Agency website	87.66%	9.00%	3.35%
Overall satisfaction with the Agency Application	79.49%	9.47%	11.05%
Overall satisfaction with Agency staff	91.53%	3.24%	5.23%
Overall satisfaction with the Agency website	90.05%	7.71%	2.24%
Overall satisfaction with the Agency Application	80.47%	10.47%	9.07%

Consumer Complaint Trends

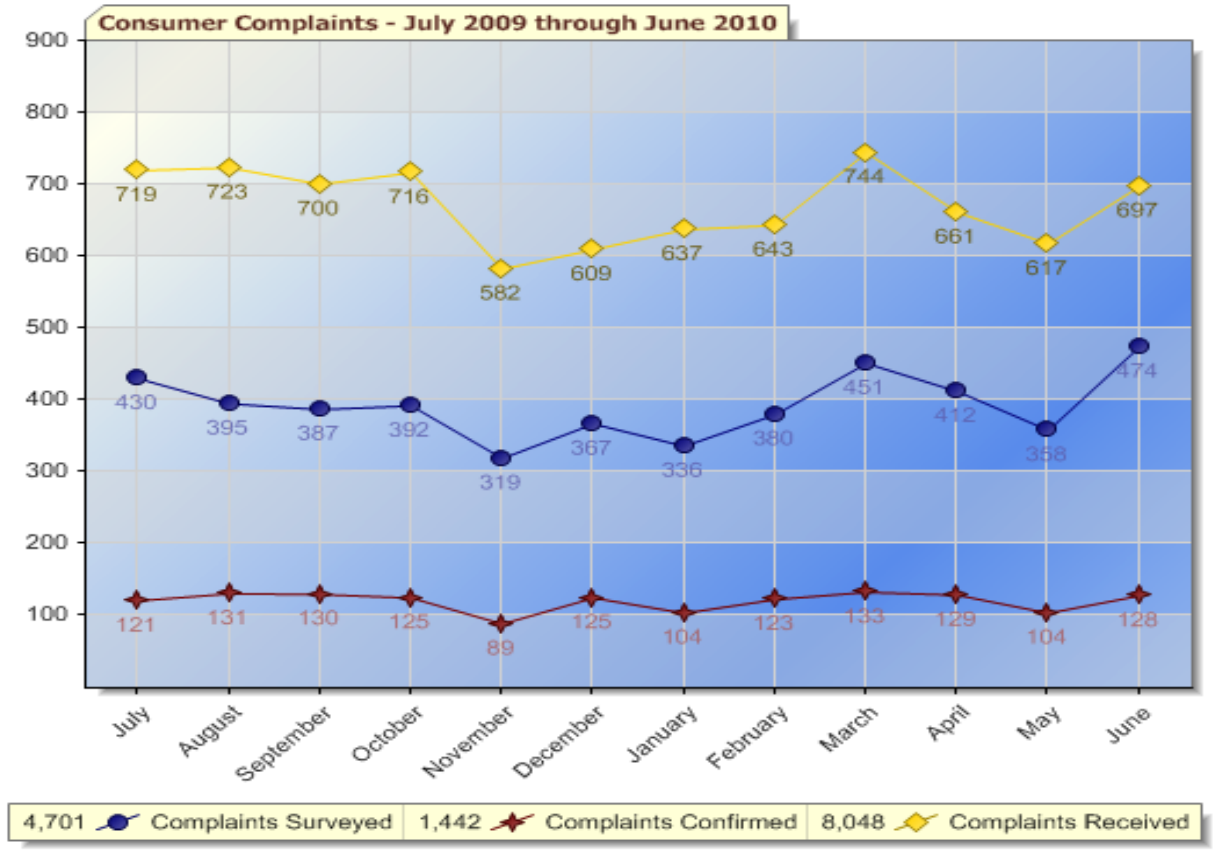
Consumer complaints about health care facilities trended upward for nine of the last ten years, not necessarily because there were more problems in health care facilities, but often because consumers are more capable of using the Internet to obtain information than in the past. Complaints coming into the Division for review and potential investigation have increased substantially over the past 10 years, rising from 5,792 in FY 2000-2001 to 8,048 in FY 2009-2010, an increase of nearly 39 percent over the 10-year period.(See Table 2-5) 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 2-5 - Number of Consumer Complaints Against Health Care Facilities
Fiscal Years 2000-2001 through Fiscal Year 2009-2010



Not all complaints are investigated, as the chart for Fiscal Year 2009-2010 will show (See Table 2-6). 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 2-6 - Number of Complaints Received, Surveyed and Confirmed State Fiscal Year 2009-20010



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 are 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: AHCA Docs. Such 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 improve consumer information and will link these documents to the appropriate resources, consolidating multiple pieces of information into a single location on the Agency Web site. 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

Legislative Changes

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 restrictions were added by this legislation to prevent fraud and abuse by health care providers.

However, one very important provision among those restrictions was not renewed effective July 1, 2010. This was the provision that precluded the Agency from approving initial licenses and changes of ownership (CHOWS) in any county where there is at least one active home health agency (HHA) and fewer than 1,200 people aged 65 or over for each agency. Other provisions of Senate Bill 1986 were implemented successfully in 2009 and 2010, including the following:

- 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.

- Additional grounds for license denial or revocation based on convictions, guilty or no contest pleas to felonies under Chapter 409 (social & economic assistance) Chapter 418 (fraud) Chapter 893 (drug abuse) and similar federal statutes unless offense/conviction was more than 15 years prior to the application.

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

- Additional felony offenses relating mostly to fraud or similar transgressions on background screening requirements.

The best way to prevent fraud and abuse not only of the financial systems associated with health care, but also of the patients entrusted to facilities, is to prevent criminals from getting into the system in the first place. Legislation passed during the 2010 session consolidated all background screening requirements under Chapter 408, F.S., and deleted background screening requirements in each provider authorizing statute. Requirements for screening were also expanded as follows:

Level 2 screening (National check requiring fingerprints)

- Any person seeking employment who may provide personal care or services directly to clients, or have access to client's living areas, personal property or funds.

- Any contractor who provides personal care or services directly to clients.

- Level 2 is still required for:
  - Administrators & Financial Officers
  - A controlling interest (owner, officer, board member) if the Agency has reason to believe the person has been convicted of a disqualifying offense

- New persons being hired or contracted on or after August 1, 2010 must have been screened
  - They cannot work in a probationary capacity pending screening results
  - They must have received exemption from disqualification

- Persons already hired or under contract as of July 31, 2010 or earlier who have already been screened as level 1 must be re-screened for level 2 over a five-year period ending July 31, 2015.

Agency Activities to Implement Senate Bill 1986

The Division devoted significant resources to the Fraud and Abuse Prevention in 2010. Deputy Secretary for Health Quality Assurance Elizabeth Dudek led the effort to implement provisions of Senate Bill 1986. For the fiscal year ended 6/30/10, 65 home health agency applicants were denied renewal licensure and 21 existing licenses were revoked. Fines for survey deficiencies were imposed against 137 home health agencies. Fines for failure to submit quarterly reports were filed in 687 cases and 82 fines were levied for failure to have a director of nursing and to notify the Agency of that failure within 30 days. Medicare and Medicaid review the Division's quarterly reports of home health agencies; consequently, sharing of information helps Medicare prevent fraud as well. Improved financial reviews of initial and change of ownership applications have led to 33 denials in the cases of health care clinics, eight denials of home medical equipment providers, and 127 denials of home health agencies that would otherwise have worked their way through licensure and into the Medicaid system. We have also increased information sharing between the Health Care Clinic Unit and the private insurance industry to combat fraudulent billing.

In addition, the Office of Field Operations made fifty referrals to Medicaid Program Integrity during the fiscal year ended June 30, 2010.

Financial Reviews

Another mechanism for preventing fraud and abuse at the front end of an application is the proof of financial ability to operate (PFA) requirement. As indicated by Table 2-7, there was an expansion of formal PFA reviews in 2010.

Table 2-7 - Financial Reviews Received and Completed in State Fiscal Years 2009 and 2010

Applications	FYE 2010		FYE 2009	
	Received	Completed	Received	Completed
ALF	0	0	4	4
CCRC Extension	4	4	6	5
Clinic	609	606	NA	NA
CON Reviews	28	28	22	29
Condition Compliance	0	0	0	0
Expedited CON	2	2	4	3
Gold Seal	22	25	7	7
Home Health	475	471	672	653
Home Medical Equip.	246	243	50	46
Hospice	2	2	3	3
ICF/DD CHOW	0	0	3	3
Nurse Registry	101	99	107	101
Nursing Home CHOW	42	37	89	75
Pat. Comp. Fund	9	8	22	20
PPEC	4	4	3	3
Other*	83	83	54	54
Total	**1,627**	**1,612**	**1,046**	**1,006**

Note the significant change from FY 2009 (1,006) to FY 2010 (1,612) in the numbers of financial reviews conducted. While PFA requirements cannot prevent all potentially bad actors from obtaining licenses, they can diminish the chances that those who cannot afford to be in the business of health care-and would thus be more apt to take fraudulent advantage of the system--are denied access. We estimate that about 10 percent of the PFAs reviewed are denied for applicants having insufficient financial resources to run their programs.

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. Senate Bill 1986, passed in 2009, mandates use of the ESS by all hospitals, nursing homes, assisted living facilities and others that provide residential treatment and services. As of June 2010, 4,334 facilities had enrolled. Participation percentages range from a low of 43 percent for VA hospitals to a high of 100 percent for inpatient hospices, with 86.7 percent of all facilities of all types required to participate enrolled. Those 669 licensed providers that had not enrolled as of the beginning of the 2010 hurricane season were sent notices of intent to sanction and are subject to sanctions of $500 each.

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 June 2010, there were 38 licensed Health Maintenance Organizations (HMOs).

The following statistics are based on data available for these 38 HMOs. Data show enrollment in Florida's HMOs had declined from 4.5 million in CY 2001 to 3.6 million by December 2009 (based upon the most recent available AHCA and OIR Data Reports). Well Care had the largest market share with 496,609 enrollees, including the two Medicaid plans HealthEase and Staywell, followed by Humana with 483,477 enrollees and Aetna with 473,746. HealthEase generally reports separate enrollment figures to the Agency and OIR, although they are wholly owned subsidiaries of the same parent organization.

The CY 2009 change in enrollment reflected a change in the profitability of Florida's HMOs. The Office of Insurance Regulation reports that the HMOs had profits of $575 million for calendar year 2009.

As of December 2009, 20 of the HMOs offered commercial managed care, 27 provided a Medicare product and 17 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 929.000 in July 2009 to 1.1 million in July 2010. (AHCA internal reports) HealthEase and Staywell, both product lines of WellCare, had the largest market share with 362,279 enrollees or 35 percent of the total, despite the company leaving the Medicaid Reform pilot project areas.

Medicaid HMOs reported operating losses of $31 million in CY 2009 compared to $66.7 million operating profit in CY 2008 for the Medicaid product line only. The consolidated HMO operating

income for the 17 Medicaid HMOs over all product lines increased from $246 million in CY 2008 to $343 million in CY 2009.

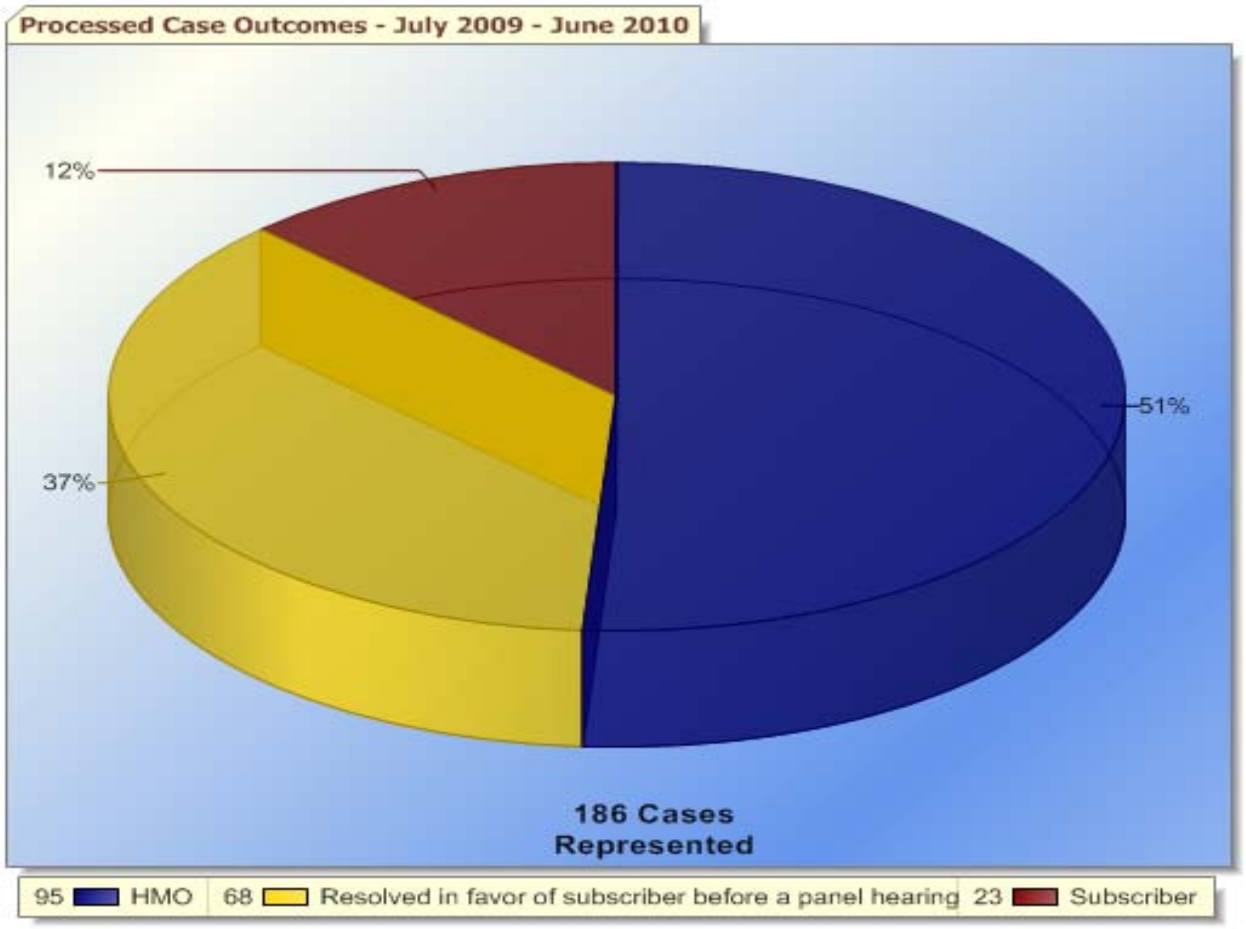
Since implementation of the mandatory requirement for placement of most Medicaid patients in MediPass or in managed care plans (Section 409.9122, F.S.), the Agency has been concerned with the issue of assessing care quality in commercial and Medicaid managed care plans and MediPass. The Agency has collected 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 2009-2010, this program reviewed more than 506 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.

During fiscal year 2010 – 2011 the Agency will begin phasing in the use of encounter data for premium or capitation rates for Medicaid capitated plans contracting with the Agency. The availability of encounter data will allow Medicaid Program Integrity to review this data just as it does fee for service data to look for potential areas in which fraud and abuse might occur. Encounter data can also be used to determine utilization of services which will assist the Agency in developing network adequacy standards based on actual use.

As shown in Table 2 - 8 below, about 49 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.

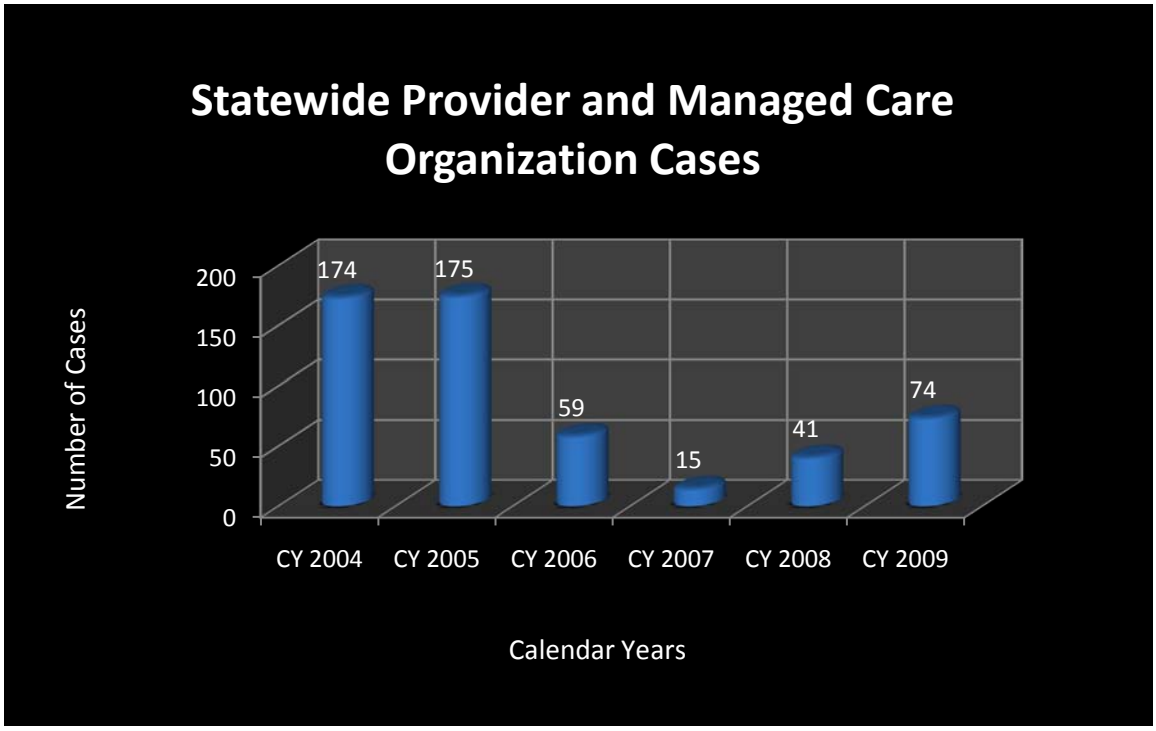
Table 2-8: Subscriber Assistance Programs — Outcomes of Processed Cases for State Fiscal Year 2009-2010



In addition to the Subscriber Assistance Program, the Agency has a call center to register HMO complaints. However, emphasis shifted from the Agency 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. Initially successful as a review option, it appears that the cases sent to Maximus were trending downward and have now recovered some of their upward momentum, as indicated by Table 2-9.

Table 2-9: Statewide Provider and Managed Care Organization Dispute Resolution Cases for Calendar Years 2004 through 2009



Of the 74 cases processed in CY 2009:

- Four providers submitted incomplete information and the cases were returned;
- Three cases were not accepted by Maximum because the cases did not meet the eligibility requirements;
- Eleven cases were withdrawn by Maximus because payment was received for the disputed services;
- One case was withdrawn by Maximus because the claim did not meet the minimum amount in controversy requirement;
- Six cases were withdrawn by Maximus because they were not within the contractor's jurisdiction;
- One case was withdrawn at the provider's request;
- Thirteen cases were accepted for full review and are still pending;
- Two cases completed the review process and a final order is still pending;
- Twenty-six cases completed the review process and a final order was issued; and

- Seven cases were still pending the review process.

Resolving the Problem of Un-Insurance

The number of uninsured individuals in the U.S. increased from 45 million to 45.7 million between CY 2003 and CY 2007. By CY 2009, the number had risen to 46.3 million (CDC—Health Insurance Coverage). The continued high unemployment rate further increased this trend in 2010. An estimated 25 million additional 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.) It is small wonder such under-insurance and un-insurance statistics exist given that insurance premiums increased 131 percent from 1999 to 2009, while worker earnings only increased by 38 percent against inflationary increases of 28 percent. Both single and family premiums more than doubled during that 10-year period, with the former rising from an average of $2,196 to $4,824 and family premiums rising on average from $5,791 to $13,375. Participation has also shifted from conventional insurance plans to managed care plans during that decade. A quarter of the U.S. population is now enrolled in health maintenance organizations. (Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2009) (Kaiser 2009 Healthcare Study - Employer Health Benefits 2009 .

Florida tackled the problem of un-insurance first. 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)

The Cover Florida Health Care Access Program (Cover Florida) was implemented and as of June 30, 2010, covered 6,219 people. Senate Bill 2534 (Chapter 2008-32, Laws of Florida). Cover Florida is intended to provide low cost insurance for individuals through private insurers. Four of the original six companies are still participating, including Blue Cross Blue Shield of Florida, United Health Care, JMH and FHCP.

Currently, the two Insurance companies with the largest shares of health insurance in Florida are Blue Cross and Blue Shield of Florida, with approximately 30 percent of the Florida Market and Aetna, which controls about 15 percent of the health care insurance market in the state. (Florida Trend)

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 is expected to 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 Corporation is fully functional, however, there are not yet any plans enrolled and the marketplace has not been established.

What a difference a year makes!

Last year, the news was full of questions about what Florida should do to resolve the problems of un-insurance and underinsurance. Once each year, a report from the Centers for Disease Control presents insurance coverage rates for selected states. The early release statistics for 2009 were published on June16, 2010. In 2009, the percentage of persons who were uninsured at the time of interview among the 20 largest states ranged from 3.7 percent in Massachusetts to 24.6 percent in Texas. Florida had the second highest rate of un-insurance at 19.3 percent. Given Florida's most recent population statistic of 18,537,569 (U.S. Census Bureau as of July 2009), that translates into roughly 3,578,000 uninsured Floridians.

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA, Public Law 111-148**, (**Patient Protection and Affordable Care Act**)** also known as "Health Care Reform") into law. It was followed by another law, the Health Care and Education Reconciliation Act of 2010 These new laws create many changes for the health care market place. Florida officials have calculated that the health-care laws passed by Congress in 2010 could add nearly 1.8 million uninsured residents to the state's Medicaid and Children's Health Insurance Program rolls by 2019. In dollar terms, these additional covered lives would add nearly $8 billion annually to the cost of these programs, of which more than $1.2 billion would be paid by the state.

Lockton, Inc., the world's largest, privately owned, independent insurance broker recently published an article dealing with strategic planning for health insurers. The article dealt with various perspectives for strategic planning in light of the 2010 passage of the Patient Protection and Affordable Care Act (PPACA), noting that the business and economic environment is straining their business models, leading to mergers and partnerships, with many providers leaving the medical profession, especially in primary care and nursing. Consumers, employers and government are exerting pricing pressure on payers while payers face increasing costs related to technology, legislation, adverse selection and increased transparency. Buyer loyalty to insurance companies is down, fraud and abuse are up and the public image of health insurance companies is suffering. (Lockton—Your 2011 Health Plan Decisions)

By 2019, under PPACA, 2,521,000 Florida residents will gain coverage. (*Health Coverage in Florida: How Will Health Reform Help? Families USA, March 2010*) If that prediction becomes reality, we believe the goal of 500,000 additional insured Floridians by 2015-2016 may require an increase in potential covered lives. It should be noted, however, that Florida, 20 other states, the National Federation of Independent Businesses and two individuals are suing the federal government to overturn the law on the basis that it is an unconstitutional usurpation of states' rights. Oral arguments in this case are scheduled for September 2010.

While insurance may be expanded to more people in Florida, some believe that employers will opt for less choice and lower quality insurance in order to reduce costs. (See New York Times, 7/18/10) In addition, there is some evidence that more Floridians are buying their own health care coverage as a result of new offerings, health care reform and loss of employer coverage. (South Florida Business Journal 7/16/10)

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	During the 2010 legislation session, the Florida Legislature eliminated funding of $133,486, but did not give the Agency the 10 FTE positions necessary to bring the call center in house. Consequently, the call center remains under contract. A new contract must be negotiated and in place effective January 1, 2011.
3.	Moving toward online licensure for health care providers	Online licensing	Project will include full implementation of online licensing for HQA for 29 provider types, including online payment, integration with document management, web portal for providers to submit applications, check status, and update licensure information between license renewals. Solution will provide single sign-on capability to providers to have one user account for multiple online systems, email notifications for reminders and deadlines, requests for additional information (omissions). Integration with all Agency fees, assessments, overpayments, fines to facilitate full collection before licenses are issued. Three year project: total $5,161,600 = 1,751,600 FY 2011-2012 + 2,322,800 FY 2012-2013 + 1,087,200 FY 2013-2014.

Number	Potential Policy Changes	Legislative Budget Requests (LBR) Affected	Impact on Agency Policy if LBR Request is not Approved
4.	Additional Counties to be added to Medicaid pilot expansion will require addition managed care FTEs.	Medicaid Pilot Expansion	Two positions are being requested in the event that expansion of Medicaid Reform (1115 (b) waiver program) is authorized by the legislature. The 2 positions are pay grade 24 analyst positions. Should these positions not be funded the Agency will have difficulty in monitoring contract and statutory compliance of Medicaid plan contractors.
5.	Expand background screening capability by obtaining grant funds	Background Screening Expansion	The Agency has applied for a Centers for Medicare and Medicaid Grant to implement additional background screening enhancements and cover additional provider types. One of the most important enhancements will include a rap-back system that will be paid for with fees from the providers and individuals screened and will allow the agency and providers to obtain new information whenever new arrests occur after an individual has already been screened. Funds will support AHCA and the Florida Department of Law Enforcement. The grant period is 10/1/10-9/30/12. A budget request was submitted to the LBC for September 2010 meeting for $1,387,042 for funding 10/1/10-06/30/11. An LBR will also be required for FY 2012-2013 for $85,062.

Number	Potential Policy Changes	Legislative Budget Requests (LBR) Affected	Impact on Agency Policy if LBR Request is not Approved
6.	Call Center and Call Group license funding	Complaint and Information Call Center and Call groups	The Agency is considering bringing the division's complaint and information call center in house using existing vacant FTEs as necessary. This will require additional license payments for software necessary to set up a call pool using Cisco Systems phones that are already standard for the Agency. Other units that get many phone calls can also benefit from this software licensure. The licenses have a non-recurring cost of $1,500 per person. However, there will be a recurring cost of 20 percent of the licensure cost each year for maintenance. To cover all the call groups we need to implement, including CSMU, the Home Care Unit, the Lab Unit, the ALF Unit and the Call Center will require 88 licenses for a total one- time cost of $132,000 plus a recurring cost of $26,400 per year.

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

Number	Changes in Current Programs	Statutory Reference	Changes in Current Services	Changes in Current Activities	Substantive Legislative Action Required to Support Changes
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 1995 codes.	429.41(1)(a)	None	None	Statutory change
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 currently limited to the Consumer Price Index (inflation) Pursuant to 408.805, F.S.; licensing fees must cover Agency costs.	408.805, F.S.	None	None	Statutory changes

Number	Changes in Current Programs	Statutory Reference	Changes in Current Services	Changes in Current Activities	Substantive Legislative Action Required to Support Changes
5	Adopt selected Federal standards for ICF-DDs.	Ch 400, Part VIII	None	None	Statutory Change
6	Adopt selected Federal standards for home health agencies.	Ch 400, Part III	None	None	Statutory Change
7	Accreditation requirement for home medical equipment providers.	Ch 400, Part VII	None	None	Statutory Change
8	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
9	Eliminate certified mail for Agency notices	408.806(2)9d), F.S.	None	None	Statutory Clarification
10	Eliminate routine submission of certain 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
11	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
12	Exempt homemaker-companion agencies under contract with APD from AHCA registration.	400.509(1)	None	None	Statutory Change
13	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
14	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
15	Connect all licensure inspection and life/safety fees to the license application so all are assessed and collected at the same time.	408.805 F.S.	None	None	Statutory Clarification
16	Eliminate the exemption for certain prepaid capitated Medicaid contractors from licensure.	Ch 641, Parts I and II, F.S.	None	None	Statutory Change
17	Eliminate the Limited Nursing Services (LNS) designation for assisted living facility licensure.	429.07, 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
18	Align payment of annual health council assessments with licensure applications to eliminate separate provider billings	408.033, F.S.	None	None	Statutory Change
19	Align requirement for advance closure notice with new federal (Affordable Care Act) requirements for nursing homes	400.18, F.S.	None	None	Statutory Change
20	Protect the names of consumers who file complaints against licensed facilities	119.071, F.S.	None	None	Statutory Change
21	Clarify that when required, an inspection is a required part of a “complete” application	408.806, 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
22	Require PPECs to have playgrounds for children Eliminate a section related to a rule that no longer exists for physical plan requirements	400.914, F.S. 400.915, F.S.	Changes licensure requirements for PPECs	None	Statutory Change
23	Adopt CLIA certification standards for toxicology labs	112.0455, F.S.	Eliminates state licensure of toxicology labs	None	Statutory Change
24	Require licensed clinical labs to submit copies of their federal CLIA certificates or applications for the same as part of their state licensure applications.	Chapter 483, 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
25	Eliminate Home Medical Equipment provider inspections except when these are for complaints.	400.933, F.S.	Eliminates inspections, except for complaint investigations	None	Statutory Change
26	Consolidate branches of home health agencies under parents rather than separately licensing them.	400.471, F.S.	Streamlines licensure process	None	Statutory Change
27	Permit revocation of ECC and LNS licenses at the time of survey rather than waiting until license renewal. Clarify that only registered nurses can perform assessments in ALFs	429.07, F.S. 429.26, F.S.	Streamlines licensure process	None	Statutory Change Statutory Clarification

Number	Changes in Current Programs	Statutory Reference	Changes in Current Services	Changes in Current Activities	Substantive Legislative Action Required to Support Changes
28	Eliminate certain requirements associated with nursing home paperwork and survey training	Chapoter 400, Part II F.S.	Regulatory reduction	None	Statutory Change
29	Make hospital emergency requirements consistent with federal EMTALA requirements.	395.1041 F.S.	Regulatory reduction	None	Statutory Change
30	Replace registration of homemaker companion organizations with a licensure program for personal care programs	Chapter 400, Part III	Changes requirements for homemaker companion organizations	This is an entirely new licensure program.	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, 2011
2.	s. 408.7057(2)(g)2., F.S.	Annual Report on the Cases of the Statewide Managed Care Dispute Resolution Program	February 1, 2011
3.	s. 400.191(2), F.S.	Nursing Home Guide Quarterly Report	February 15, May 15, August 15 and November 15, 2011
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, 2011
5.	S 429.19 F.S.	Assisted living facilities report of fines of $5,000 or more for violation of state standards	July 30, 2011
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. 483.26, F.S.	Technical Advisory Panel (laboratory)	Ongoing meetings. Recent meeting details may be found at the following hyperlink: AHCA: Laboratory Unit
9.	s. 627.4236, F.S.	Bone Marrow Transplant Advisory Panel	A meeting is scheduled for Friday, October 8, 2010 in Tallahassee

Trends and Conditions Statement

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 **(**59G**:** Medicaid **-** Florida Administrative Rules, Law, 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 Chapter 20, 216 393, 395, 400, 408, 409, 440, 626 and 641, F.S. Medicaid must meet federal standards or obtain a federal waiver to receive federal financial participation in the program. Although rates of federal participation vary each year, 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 2009, the U.S. Census Bureau estimated Florida's population to be approximately 18.537 million, making it the fourth most populous state in the nation. Projections indicate that Florida will become the third most populous state by Calendar Year (CY) 2025; its growth rate has been among the fastest in the nation for decades.

As of July 1, 2009, Florida had the highest percentage (17.4 percent) of elderly residents in the nation. As the baby–boom generation begins reaching retirement age in the next few years and substantial numbers of retirees relocate to Florida, 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 2009-2010, Medicaid served 2.736 million beneficiaries and paid claims to approximately 80,000 providers. With a budget of nearly $20.7 billion in FY 2010-2011, 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. It is the largest source of federal funding for the state. Medicaid caseloads in FY 2009-2010 were more than 60 percent higher than a decade ago. The caseload increased by nearly 10 percent in FY 2009-2010 over the prior fiscal year and is projected to increase in FY 2010-2011 by more than nine percent compared to FY 2009-2010. The recent increase reflects external factors not within the Medicaid program's control, especially the rapid downturn in the economy in fiscal years 2008-2010 and the resulting unemployment rate statewide of almost 12 percent.

In the last ten years, expenditures in the Medicaid program grew from almost $9 billion in FY 2000-2001 to $20.7 billion projected in FY 2010-2011, 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 ($3.3 billion), Nursing Home Care ($2.75 billion), Prescription Services ($1.6 billion) , Low Income Pool ($1.1 billion),

Supplemental Medical Insurance ($1.0 billion), Home/Community Based Services ($1.0 billion), Hospital Outpatient Services ($969 million), and Physician Services ($938 million).

During FY 2009-2010, the Florida Medicaid Management Information System (MMIS) received full federal certification from the Centers for Medicare & Medicaid Services (CMS). The certification allows Florida to receive the maximum federal funding of 75 percent for the operation of the system.

MEDICAID SERVICES

Medicaid Pilot Program

Florida's Medicaid pilot program, created in Section 409.91211, F.S., with the passage of Senate Bill (SB) 838 (CS/CS/SB 838) during the CY 2005 Florida Legislative Session, authorized the Agency to seek a demonstration project waiver (pursuant to Social Security Act §1115) to create a statewide initiative for a more efficient and effective services delivery system that would enhance quality of care and beneficiary outcomes in the Florida Medicaid program. The Agency received approval of the 1115 waiver from Centers for Medicare and Medicaid Services on October 19, 2005, and authority to implement the program with the passage of House Bill (HB) HB 3B during the Florida Special Legislative Session in December 2005. They will also enjoy better health through education and increased health literacy. The Medicaid pilot program is designed to transform the Medicaid program by empowering Medicaid beneficiaries to take control of their health care by providing more choices for beneficiaries, and improving health through health literacy and incentives and bringing about healthy behaviors. The major components of Medicaid Reform are:

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

During the initial phase of implementation, beneficiaries in the children and families, and the aged and disabled 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 2009-2010, 11 Medicaid pilot health plans had been contracted in Broward County. In Duval County, five plans were contracted and in Baker, Clay, and Nassau counties, two plans were contracted. Total enrollment in all plans was 261,243.

The current Medicaid Reform Waiver expires June 30, 2011. The Florida Legislature directed the Agency to request a three year extension of the waiver to ensure it remains active and current. The Agency submitted the extension request June 30, 2010 to federal CMS. Updates on Medicaid pilot program and a copy of the request may be found at:

http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml

Expansion of the Reform program into new geographic areas or substantial changes to the waiver will require Legislative authorization.

Source: Medicaid Health Systems Development, Medicaid Program Analysis, and Medicaid Choice Counseling 'Florida Medicaid Reform: Draft annual report for FY 2008-2009.

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 72 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. Title XXI enrollment decreased in 2008 due to transitional complications with Florida Healthy Kids Corporation's third party administrator. Since July 2006, Title XXI enrollment has increased 30 percent from 196,674 in July 2006 to 255,742in July 2010. The total KidCare enrollment as of July 2010 was 255,742, including 28,044children in MediKids.

In July 2003, in response to over-enrollment, new 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

coordinating outreach activities. In July 2009, the Florida Legislature passed KidCare administrative simplification legislation which made the KidCare application and renewal process easier for families. Florida Healthy Kids Corporation also worked closely with the Department of Children and Families to streamline the transition to the Title XXI programs for children losing Medicaid coverage. These simplification changes have resulted in an 11.8 percent enrollment increase from July 2009 to July 2010. Based on the January 2010 KidCare Social Services Estimating Conference (SSEC) enrollment and expenditure projections, the Florida Legislature appropriated sufficient funding. Based on the increased enrollment projections and expenditures from the July 2010 KidCare SSEC, KidCare may face a $.7 million General Revenue deficit. Congress reauthorized the Children's Health Insurance Program in April 2009, allocating $68.9 billion to the states through September 30, 2013. Florida's federal allocation is sufficient to meet state fiscal year (SFY) 2010-2011 enrollment and expenditure projections.

Source: Florida KidCare Enrollment Reports, 2004 through 2010; 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; The Children's Health Insurance Program Reauthorization Act of 2009**.**

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 3.E.). The Agency has done a remarkable job in controlling long-term care costs given its large existing elderly population coupled with a 60 percent growth rate over the last decade for individuals age 85 and older who are more likely to need nursing home assistance. Florida is ranked 36th 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 3.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, August 2010

Developmental Disabilities

The Agency has been particularly successful in serving individuals with developmental disabilities in the community. As of July 2010, there were 29,945 individuals over the age of three being served through four home and community based waiver programs for persons with the following disabilities: mental retardation with 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 approximately 19,000.

The Agency also administers the Familial Dysautonomia (FD) Waiver for individuals diagnosed with FD, an extremely rare developmental disability. Consumer enrollment began July 2006. There are currently eight individuals enrolled.

Behavioral Health Services

The Medicaid program is an important element of the mental health treatment system in Florida. 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 authorized the Agency to establish prepaid mental health plans (PMHPs) for individuals enrolled in MediPass. During FY 2006-2007, the Agency expanded PMHPs statewide, with the exception of the counties in which the Medicaid Reform pilot has been introduced. The PMHPs have responsibility, within their AHCA areas, for providing the Medicaid community mental health benefits.

In 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 managed care or 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. The benefits of having a child welfare system managed by a single vendor are improved access, continuity, and quality of care.

During the 2010 legislative session language relating to the children in Area 10 was modified to permit the development of a specialty plan for this population. This specialty plan is designed to coordinate and integrate behavioral and physical health services. The Agency anticipates enrolling the children into this specialty plan prior to July 1, 2011.

The Agency received approval for the fourth renewal request for the 1915(b) (4) waiver authorizing the Statewide Inpatient Psychiatric Program (SIPP) for Medicaid recipients under the age of eighteen. 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. Various Agency initiatives have reduced the average length of stay in SIPP facilities, which has resulted in a significant cost savings and improved treatment outcomes. SIPP serves approximately 1,100 children and adolescents each year. 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 the FMHI in their 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 matching funds for county-funded services. 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.

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, became required for all home health services statewide in fall 2009. Pilot projects, authorized through the 2009 session's CS/CS/CS/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**: On July 1, 2010, the Agency implemented a comprehensive care management pilot project for home health services in Miami-Dade County. This program includes face-to-face assessments of patients 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 is being conducted through a qualified quality improvement organization.

- **Pilot Project for Telephony Home Health Services Delivery Monitoring and Verification**: The Agency competitively procured a vendor which, starting July 1, 2010, verifies through a voice-identification telephone check in and checkout system that home health workers were in the patient's home. Home health agencies must submit claims electronically through the vendor's system, ensuring that only services for which there are verified check ins and check outs can be billed.

The increased utilization review provided through implementation of CS/CS/CS/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.

The Agency 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 inpatient health organizations (health maintenance organizations and provider service networks, including the Medicaid pilot reform health plans, the specialty plans for recipients with HIV/AIDS and for children with chronic conditions,; prepaid mental health plans; the statewide child welfare prepaid mental health plan; the statewide inpatient psychiatric program; 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.

The Agency continues to contract with a quality improvement organization to provide an independent quality assessment/improvement program for its Developmental Disabilities Home and Community Based Services Waivers. 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 are expected to result in continued improvements in this area.

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**,** 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, the Agency plans to continue listening to 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.

Source: Bureau of Medicaid Services, August 2010

Pharmacy

Innovations to Promote Evidence-Based Medicine (Objective 3.F)
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:

ePrescribing Support

EmPowerRx (Background)

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. A real-time data feed to make the Medicaid eligibility information; PDL information; and individual patient prescription history available to all Medicaid prescribers statewide was implemented in July 2010. This advanced technology solution augments the efforts of the Electronic Prescribing Advisory Panel that was created by the Legislature in CY 2007. Section 408.0611 F.S. requires the Agency to establish an informational clearinghouse on the Agency's website; 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 3.A.)

Prescribed Drug Cost Containment Measures

A report published in November, 2009 by the AARP Public Policy Institute noted that wholesale prices for the brand-name medications most commonly used by Medicare beneficiaries increased an average of 9.3 percent between October 2008 and September 2009, a period when there was no inflation and, in fact, other consumer prices actually dropped.[1] The report further notes that generic drug prices declined 10.6 percent during the same period.

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

[1] Rx Watchdog Report, Comparative Measures of Price Change for Prescription Drugs and Other Goods, November 2009

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. During FY 2009-2010, the Pharmacy Benefit Management (PBM) contractor continued to improve systematic electronic solutions to reduce the time and expense of paper-based prior authorization procedures, and in appropriate circumstances offer 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. During FY 2009-2010, the Area Office pharmacists continued their assigned activities to support the ongoing statewide contract for medication therapy management initiative. Refinements in the program have focused the clinical staff on performing audits to support the waiver programs, and handling prior authorizations at the Agency level for medical appeals and a targeted population of medications requiring complex clinical review.

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 2009-2010, population-based interventions continued to be 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 Lists through interface with provider's electronic medical records systems. This goal was achieved in July 2010.

2. Develop an improved method of capturing National Drug Code (NDC)-level information on claims for physician administered drugs to allow more effective invoicing for manufacturer rebates. This goal was achieved in July 2010.

3. Collaborate with other agencies to develop contingencies in the event of elimination of funding for the Florida MEDS-AD 1115 waiver. The Bureau of Pharmacy services worked with Agency legal staff; the Department of Children and Family Services; and the Center for Medicare and Medicaid Services to define the contingency plan to manage a loss of funding and simultaneously define an extension of the MEDS AD Waiver should funding be restored. Fortunately, funding was restored, and the Waiver is in the process of being renewed.

4. Improve the automatic claim system edits to integrate diagnosis data with drug claims. The Bureau of Pharmacy Services successfully implemented an automated prior authorization process to streamline approval of branded anticonvulsants for recipients with seizure disorders. The process does not require prescribers to fax paperwork. Instead the point-of-sale pharmacy screens medical diagnosis codes in a recipients medical claims file and compares the codes to the prescription refill history. Recipients who meet the automated criteria can automatically receive a branded anticonvulsant as long as the physician requests it. Recipients taking anticonvulsants for medical reasons other than seizures receive generic medications. The Bureau of Pharmacy Services plans to expand this capability to other therapeutic drug categories.

5. Improve patient safety through refined automatic system edits (quantity limits; dose limits; duration of therapy) for specific therapeutic classes. The Bureau of Pharmacy Services implemented a significant number of point-of-sale system edits in FY 2009-2010. Successful projects included limits on numbers of prescriptions per month for all controlled substances. Within the controlled substance project, mandatory dose and quantity limits were implemented, as well a structured prior authorization for prescribers to document medical necessity of patients who exceed the standard requirements. Accommodations for cancer and sickle cell patients were built into the processes.

6. Continue to eliminate paper-based processes through electronic indexing and filing of records. In FY 2009-2010, administrative support staff were assigned to scan paper based prior authorization records and miscellaneous paper in various staff offices to the shared drive. This effort will continue, and the goal will be reduce the burden of paper in all staff offices and clear the file cabinets of paper-based prior authorization forms. The Bureau is working with the PBM to route the fax line into an imaging queue so that staff can work prior authorizations (Pas) electronically. This will greatly reduce the Bureau's expenses for copy paper and toner.

7. Develop a web-based prior authorization system for physician-administered drugs. Completion of goal number two above was required prior to development of this functionality. The Bureau of Pharmacy Services will now proceed with research to determine the design and programming required for this system capability.

List of All Task Forces and Studies in Progress

NUMBER	IMPLEMENTING BILL OR STATUTE	TASK FORCES AND STUDIES REQUIRED BY FY 2010-2011 LEGISLATION	BUREAU ASSIGNED
1.	CS/CS/SB 1484 (Chapter 2010-144 LOF)	Directs Medicaid to begin process of extension of the Section 1115 waiver (reform) and requires monthly reports to the Legislature	Health Systems Development
2.	CS/CS/SB 1484	Directs Medicaid to appoint a technical advisory panel in the study and development of intergovernmental transfer distribution methods and provide a report to the Legislature and Governor by January 1, 2011.	Medicaid Program Analysis
3.	CS/CS/SB 1484	Creates and name Medicaid as part of the Medicaid and Public Assistance Fraud Strike Force within the Dept. of Financial Services and report annually by October 1st to the Legislature and Governor.	AHCA Secretary

List of Potential Policy Changes Affecting the Agency's Budget Request or the Governor's Recommended Budget

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

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

Number	Identify Proposed Change	Describe What's Expected of Proposed Change	Describe Legislative Actions Required to Implement the Proposed Change
	None		

Trends and Conditions Statement

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 support consumers in health care decision making. The Agency's consumer oriented website, FloridaHealthFinder.gov, was developed in support of the Florida Center's mission to provide accurate and timely health care information to the public, and 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, including hospital inpatient records, and ambulatory and emergency department's records, provide accurate and timely health care information to consumers, policy analysts, administrators, and researchers in order to evaluate cost, quality, and access to care. (See Figures 1 and 2) The Florida Center is highly regarded throughout the nation as a primary resource for state health care data.

As such, this data is used extensively to display health outcome and pricing information on FloridaHealthFinder.gov. Due to the collection of this data in a more timely and efficient manner, the Florida Center is able to meet the objective of reducing the amount of days between processing and posting the data. Included in the process improvements are: paperless data collection; enforcement; facility outreach; quality assurance activities; new rule implementation; improved website for submitting facilities, as well as the Guide to Submitting Inpatient and Ambulatory Discharge Patient Data (Data Guide).

In 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 number of e-prescriptions sent to pharmacies across Florida. The desired outcome is for this percentage to increase at a rate of 25 percent per year. (See Objective 4.C)

The Florida Center's long range plan contains the promotion of the exchange of secure, privacy-protected health care information, electronic prescribing, the adoption of electronic health records among providers, and the use of personal health records by 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 responsible for the implementation of a statewide health information exchange plan and administration of the Medicaid program's electronic health records incentives program.

Additionally, the Florida Center will continue to be responsible for collecting adverse incident reports from hospitals, ambulatory surgery centers, health maintenance

organizations, nursing homes, and assisted living facilities. The Florida Center will work closely with facilities and regulatory agencies to assure that corrective actions have been implemented.

Over the next five years the Florida Center's long range plan includes continued work with the State Consumer Health Information and Policy Advisory Council as well as its workgroups including the Data Standards and Transparency Steering Committee; the Health Information Exchange Coordinating Committee; the Legal Work Group and the State Electronic Prescribing Advisory Panel to meet our objectives. The Florida Center will also continue to pursue grant opportunities.

Meeting our goals and objectives fulfills the Agency's mission of making available transparent health care data and information so consumers are able to make informed choices about their health care.

The Office of Data Collection, Data Quality, and Patient Safety

The Agency is directed to collect patient-level data by §408.061, Florida Statutes. As the Florida Center is charged with disseminating health care data to help Floridians make informed choices about their care, this data collection is one of the most important functions performed in the Florida Center. Accurate, timely, and unbiased data are also essential to the accurate modeling and understanding of Florida's health care system. To that end, the Florida Center collects data on every patient discharge from all licensed acute care hospitals, ambulatory surgical centers and emergency departments.

Patient Data Collection: A Brief Synopsis of the Process

Patient data is collected electronically via the Internet in accordance with Chapters 59E-7 and 59B-9, Florida Administrative Code. Facilities submit data reports quarterly.

The submitted data are checked for errors by a custom-designed computer program. Reports detailing any identified inconsistencies in the data are sent to the reporting facility for correction and verification. Following appropriate facility action, the corrected data are processed again. The process repeats until the data are determined to be error-free.

At this point a final report is sent to the facility for final review and certification. In the certification process, the facility's Chief Executive Officer or Chief Financial Officer signs and returns an attestation vouching for the data's accuracy. Once the data have been certified they are added to the main database where they are available for use.

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.

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 on each patient discharged from approximately 277 acute care Florida facilities, including long-term care

hospitals, rehabilitation hospitals, short-term psychiatric hospitals, and long-term psychiatric hospitals. The number of hospital inpatient discharge records submitted has increased each year from 2,386,661 in CY 2002 to 2,606,164 records in CY 2009.

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

Each reported discharge record includes patient demographics, admission information, medical information, discharge information, and charge data. Patient demographics include 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 are required to provide a unique identification number for each record along with the patient's Social Security number, and an infant linkage identification number. The hospital's Agency for Health Care Administration (AHCA) identification 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 database contains "same-day surgery" data on reportable patient visits to approximately 435 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 but each facility submits quarterly reports under a unique Agency-assigned identification number. 3,071,154 ambulatory patient records were collected in CY 2009.

Ambulatory surgery facilities are required to report every visit 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 and Social Security numbers.

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.

Comprehensive inpatient rehabilitation reporting (initiated in 1993), which was previously limited to freestanding facilities, is no longer a separate companion to the hospital inpatient database. Rehabilitative inpatient reporting will include rehabilitation distinct part units in acute care hospitals and data from the freestanding facilities which will be included as part of inpatient data reporting. There were 19,224 rehabilitation patient records collected for 2009.

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

In 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. These regulations require 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. Evaluation and management (E&M) codes are reported in order to indicate the level of seriousness of each patient's condition.

Data elements collected from EDs 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. Each report is electronically transmitted by the facilities to the Agency via a secure Internet data submission system.

6.5 million Emergency department records were collected in 2009.

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 www.FloridaHealthFinder.gov website. This can only be achieved through the increasingly timely collection and posting of quality data. Meeting our goals and objectives fulfills the agency's mission of better health care for all Floridians.

The Data Collection unit continues to model processes and workflows in order to improve the current method of collecting and processing patient data. This process mapping has allowed data collection staff to achieve a more effective and efficient business model. These efforts paid off in CY 2009 with the Florida Center's Data Collection Unit achieving record levels of data with more than 95 percent of the data filed "on time."

The following efforts also assist the Florida Center in meeting objective 4.A; to shorten the length of time required to process and post certified patient data on FloridaHealthFinder.gov.

Paperless Data Collection

The Data Collection Unit completed its paperless initiative in 2009 whereby the use of paper has been essentially eliminated from the data collection and processing workflow. This process improvement involved rendering all communications with submitting facilities electronic in format. This allowed the Florida Center to save significant amounts of time for Agency and facility staff. In 2009 alone, the paperless data collection initiative saved the Agency more than $80,000 in paper and filing space.

Enforcement

During 2009 the Florida Center reinstated enforcement of fines for facilities that fail to 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 to comply with submission deadlines as possible. While relatively few facilities have been fined, the initiative has been an integral part of the Data Collection Unit's success in raising on-time percentages to record levels.

Facility Outreach

Perhaps the most important outgrowth of the Data Collection Unit's process improvement efforts has been the establishment of the Facility Outreach Program. With the implementation fines for late submitters the Agency concurrently began to offer facilities "hands-on" help getting their data submitted correctly. 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 outreach program 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;
- Identifying the resources available to mitigate/improve deficient areas;
- Collaboratively constructing a recovery plan to reestablish reporting currency; and
- Monitoring progress through regular status review calls.

Quality Assurance

The Florida Center is also continuing to expand its commitment to quality assurance through measuring the performance of individual processes and comparing them over time against specific goals and benchmarks. The Data Collection Quality Assurance program is increasingly supported by automated reports of system-based measurements that can then be used to focus Florida Center resources more efficiently, yielding the greatest process improvement results.

New Rule

In 2008, the Agency initiated rule promulgation in order to update both the Inpatient and Ambulatory/Emergency Department data collection rules which will assist in meeting objective 4.A. The rules were effective beginning January 1, 2010. The new inpatient rule expands data collection elements and includes a new data set to capture rehabilitative services performed in general acute care hospitals. The Ambulatory rule includes the addition of new data elements to estimate the ED length of visit time. Both data collection rules align collected data elements with current Uniform Bill (UB-04) mandates while at the same time reducing the submission from six months to five.

The rules will enhance the utility of the data collected by providing information on rehabilitative services statewide and providing information to address Emergency Department (ED) utilization. Data Collection staff will continue to reach out to facilities to help them manage the changeover to the new rules' reporting environment. It is the Data Collection Unit's goal to complete the changeover with as little a drop in on-time performance as possible.

New Data Collection Website

The new rule will require reporting facilities to undertake significant system and staff changes. At the same time "old rule" reporting requirements will remain in effect as long as two years for data resubmissions. So for the near term there will be two sets of rules governing patient data reporting. It is vital, therefore, to make sure the Agency is able to provide reliable, helpful information on these reporting requirements in an easy-to-understand way. To that end in 2009 the Data Collection Unit completely re-vamped its website to enable users to locate information of interest quickly on schemas, rules, data guides, etc. Initial feedback from reporting facilities was overwhelmingly positive.

Data Guide

To further assist facilities, the Data Collection Unit produced the Guide to Submitting Inpatient & Ambulatory Discharge Patient Data (Data Guide). The Data Guides (now including a "new rule" version) draw upon years of questions, comments, and requests that have been received by the Agency's staff. They represent a commitment to helping facilities with the complex task of filing discharge data. The Data Guides help facilities clearly understand what data to file, when to file it, and how it should be filed. It is the Data Collection Unit's intent that every facility should be able to confidently submit data with a minimum of time and error. The Data Guides are available at: http://www.ahca.myflorida.com/schs/data.shtml.

Figures (4-1) and (4-2) provide a visual comparison for the historical volume of data collected.

Figure 4-1 Trend in Number of Patient Record Collection

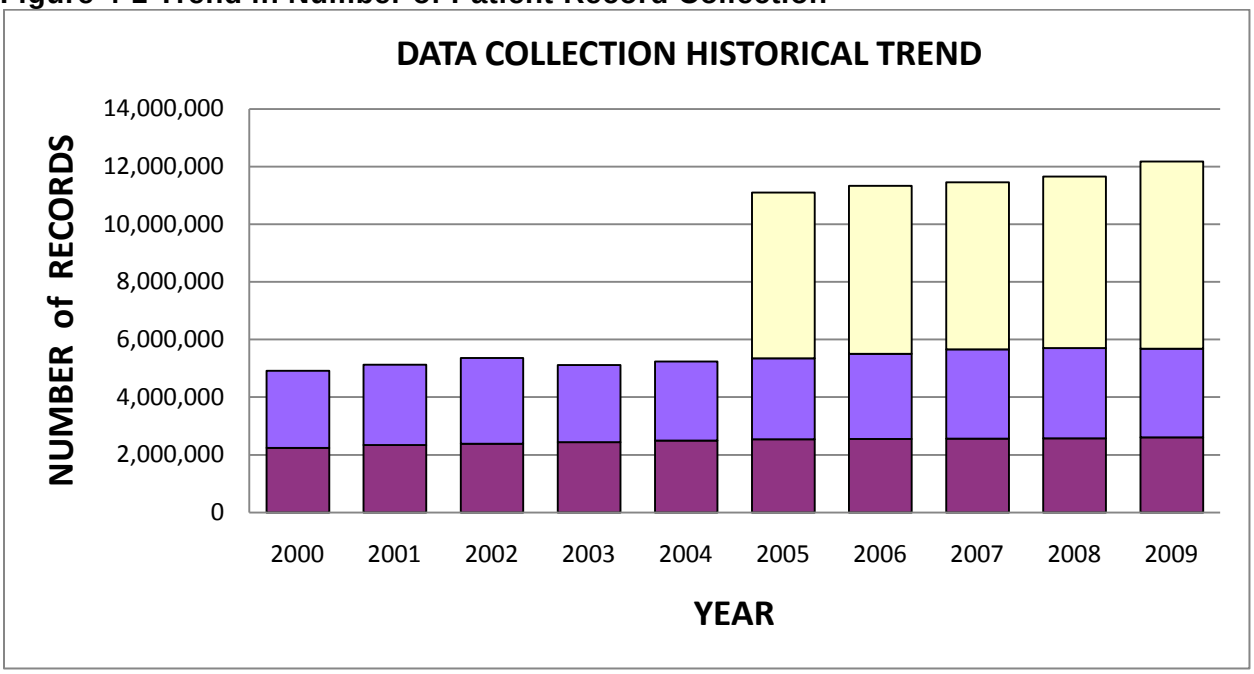


Figure 4-2 Five Year Record Collection Projection

Fiscal Year Record Type	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015	FY 2015-2016
Hospital Inpatient	3,179,789	3,274,228	3,371,472	3,471,604	3,567,487
Ambulatory Surgery	3,860,446	4,059,258	4,268,309	4,488,126	4,692,315
Emergency Department	6,499,903	6,707,899	6,922,551	7,144,072	7,355,501
TOTAL Records	13,540,138	14,041,385	14,562,332	15,103,802	15,615,303

Risk Management and Patient Safety

In 2008, adverse incident reporting for Assisted Living Facilities and Nursing Homes was assigned to the Florida Center, joining hospital adverse incident reporting in a single office for the first time. The Office of Risk Management and Patient Safety (RMPS) is now focusing on improving customer service and providing facilities with patient safety best practices. Priority has been assigned to changing the Agency's relationship with facility risk managers from adversarial to collegial. Staff are also working to streamline incident reporting across all facility types and to encourage the use of electronic reporting.

One of the most notable initiatives in this effort has been the significant reduction in the number and volume of reports that RMPS is requiring from facilities. Thanks to a new on-line submission system that debuted in 2009, facilities can now submit statutorily-required annual risk management reports by simply uploading existing facility reports instead of having to recreate them for the Agency. Just this one change has reduced reporting requirements for facilities by an average of more than two weeks. RMPS is also working with the Bureau of Information Technology to design a new web-based adverse incident reporting system that will further speed reporting while reducing the facilities' administrative burden.

Increased report automation will also help the Agency leverage the reports into usable data and provide it back to the facilities. It is hoped this data will then provide material support to facility-level patient safety programs, making them more effective.

The Office of 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, FloridaHealthFinder.gov. This website was created in the fall of 2007 when FloridaHealthStat.com and FloridaCompareCare.gov were consolidated.

FloridaHealthFinder.gov includes a variety of information to assist consumers and professionals, with their medical needs and searches for information. In addition, the

website provides Florida consumers with information about health care services, charges, and quality of care. It provides health outcomes and/or pricing information for pharmaceuticals, physicians, health care facilities, and health plans. The website provides 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, FloridaHealthFinder.gov exemplifies transparency in health care by providing consumers easy access to health care data.

This Office fulfills numerous data requests and provides customers with technical assistance to address their specific health care data needs. In order to fill these data requests the Florida Center utilizes a variety of database sources such as acute-care hospital, ambulatory surgery center, emergency department, comprehensive rehabilitation, and hospital financial data.

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. Additional functions of the Office of Data Dissemination and Communication includes providing technical assistances to consumers requesting de-identified patient data, customized ad hoc reports and other requested information.

Data Dissemination Requests

Typically, data requests that come directly into the Office of Data Dissemination and Communication fall into the following categories:

- requests for de-identified data (limited data set);
- requests for standard reports;
- requests for ad hoc reports;
- requests for publications; and
- requests for other information.

Requests for data are processed upon written request and may be submitted to the Office of Data Dissemination and Communication via mail, fax, or e-mail. Customers are required to complete a Limited Data Set Data Use Agreement form in order to receive access to de-identified patient data.

Information on the data available and prices for data are listed in the Data Catalog and Price List; however, prices for ad hoc reports are estimated based on the time required to complete the report. Completed customer orders are mailed after payment is received. Federal, state, or municipal government agencies are not charged.

A detailed log is maintained for tracking purposes. Monies received are handled through the Bureau of Finance and Accounting within the Agency for Health Care Administration (Agency). Copies of requests, checks, invoices, and fax receipts are kept on file for each customer.
More information on ordering data is available at FloridaHealthFinder.gov.

The FloridaHealthFinder.gov Website

FloridaHealthFinder.gov continues to garner national recognition as a leader in health care transparency and in 2009 received the (NAHDO) 2009 Innovation in Data Dissemination Award. The inaugural award was created by the NAHDO Board of Directors to recognize the importance of effectively communicating health data to the public.

The FloridaHealthFinder.gov website was established to help consumers make 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 Multimedia Health Encyclopedia and Symptom Navigator.

The website provides performance data for 150 selected medical conditions and procedures in Florida's short-term acute care hospitals and ambulatory (outpatient) surgery centers. The data includes volume and charges, and for inpatient care includes length of stay, readmission rates, mortality rates, infection rates, and complication rates with a separate section for pediatric patients. Other available comparison tools on the website include:

- Health Plan comparison for member satisfaction, coverage areas, and quality of care;
- Comparison of Hospice Providers through the results of the Family Evaluation of Hospice Care survey based on the experience of families whose loved one received hospice care;
- Nursing Home comparison for services, range of charges, and other information as well as quality of care inspection reports; and
- Prescription Drug Price comparison at Florida pharmacies for the most commonly used prescription drugs.

During 2009 there were many enhancements/additions to the www.FloridaHealthFinder.gov website. Among those were a hospice comparison tool, multimedia encyclopedia, RSS Facility Feed Builder, and enhancements to the existing facility/provider locator tool as described below.

The ADAM multimedia encyclopedia is an enhanced version of the health encyclopedia previously located on the website. It provides users with the tools to research a disease or condition, lookup a symptom, learn about a test, and prepare for surgery or a procedure. It offers over 3,900 unique articles covering conditions, procedures, treatments, surgeries, tests and more. It also includes over 3,000 illustrations, diagrams and photos and over 80 multimedia videos to give visitors information in the format they're seeking.

This interactive tool also includes Care Points that feature over 300 topics covering the most common health issues, like gallbladder removal, spine surgery, cancer, and heart failure. Care Points are designed to help patients become more active participants in their care, both before and after their doctor visits. Care Points cover four clinical areas where patients need information the most. They provide easily accessible patient education about discharge information, pre-operative information and instructions, self care information, as well as suggested questions to ask their doctor.

The Facility/Provider Locator was expanded in 2009 to include more search options and to provide additional information on the facility/provider profile pages. A user can now search by name, street address, zip code, Agency for Health Care Administration number, license number, administrator or chief executive officer, owner, and/or emergency actions. Depending on the facility/provider type, advance search options might include: bed type, specialty license, service area, special programs and services, certification status, and other options.

Examples of some of the additional information now available on the profile pages include:

- Inspection Reports,
- The types and numbers of beds at assisted living facilities, hospitals, nursing homes, residential treatment facilities, and other facility types (where applicable),
- Service areas (counties) served by home health agencies, hospices, nurse registries, and homemaker/companions as well as the listing of satellite offices for home health agencies and hospice providers,
- Hospital listings now include the Chief Executive Officer; links to hospital websites (when available); specialty programs and services; and accreditations,
- Specialty licenses for assisted living facilities and
- Medicare and Medicaid Certification for home health agencies.

Another new feature added to the Web site in 2009 is the Really Simple Syndication (RSS) Facility Feed Builder. This RSS feed capability allows visitors access to facility data and information on request without any restrictions. These feeds provide timely data updates in one prominent location.

www.FloridaHealthFinder.gov: Florida Consumers, Researchers and Professionals

FloridaHealthFinder.gov includes two major sections/tabs, “Florida Consumers” and “Researchers and Professionals”.

“Florida Consumers” tab users can utilize the comparison tools described earlier. In addition consumers can locate health care facilities and providers through Facility Locator and its Profile Pages. The Florida Consumers side also includes a Medical Help Resources link where uses can find a list of programs for uninsured or under-insured Floridians as well as social service referrals for low-income individuals and families. Additional information on the consumers’ page includes Brochures and Guides, as well as information on Emergency Care, Medicaid, Senior Health, and more. New information and tools added in 2009 include the Florida Medicaid Information Network, RSS Facility Feed Builder, AHCA News and Announcements, the Medicaid Expenditures by Provider Category, the Hospital Financial Data Book, and Website Tutorials.

The “Researchers and Professionals” tab allows specialized data queries that require users to have some knowledge of medical coding and terminology. With the interactive tools users can pull health care data on Florida hospitals, ambulatory surgery centers and emergency departments.

The Inpatient Facility Query allows a user to search by diagnosis and procedure codes and 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. The Emergency Department data can be queried 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 a query will return the most recently available four quarters (one year) of data. Note that only principal diagnoses and procedures are used. Queries using secondary diagnoses and procedures must be ordered from the Office of Data Dissemination and Communication.
The Researchers and Professional page also includes information about ordering data, quick data summaries, the State Health Data Directory, research studies, a link to the Florida Medicaid Health Information Network, and other information.

FloridaHealthFinder.gov - Next Steps

To increase the average daily number of persons who visit FloridaHealthFinder.gov by 10 percent annually through FY 2015-2016 (to meet objective 4.B), the website will be enhanced with physician volume as another resource for consumers and thus increase traffic to the website. The physician data published will be total volume for total hip and total knee replacements. The results will be displayed by provider and by facility utilizing one year of hospital inpatient data. Data for physicians with less than ten procedures combined for total knee and total hip replacements will be suppressed. The physician data will be linked to other related FloridaHealthFinder.gov data such as volume, charges, length of stay, readmissions, and educational information provided through ADAM. This initiative was recommended by the State Consumer Health Information and Policy Advisory Council in June 2010.

The Florida Center will continue utilizing the Data Standards and Transparency Committee, a sub-committee of the State Consumer Health Information and Policy Advisory Council, to continue the promotion and enhancement of FloridaHealthFinder.gov.

Community Outreach and Education

E-mail requests from the public received through FloridaHealthFinder.gov are responded to by staff from the Office of Data Dissemination and Communication. Included are requests for data, 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 2009, the Florida Center responded to 2,063 requests for information as compared to 1,706 requests in 2008.

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 FloridaHealthFinder.gov website. In 2009 this included participation in 20 events, including health fairs, employee benefit fairs, and conferences. The Office did mailings of FloridaHealthFinder.gov pamphlets and bookmarks to hospice providers, County Health Departments, medical libraries, universities, and other state agencies. Outreach and promotion also included an announcement in the Florida Hospital Association newsletter, a link to

FloridaHealthFinder.gov posted on several health care websites, and a full page ad in the State of Florida Open Enrollment Benefits Guide.

In the next five years, staff will continue to develop ideas for outreach through an Internal Communications Team charged with preparing a long range program plan and marketing strategies for increasing visits to the FloridaHealthFinder.gov website. This internal team will work 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 will 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.

Consumer Awareness Series

The Consumer Awareness Series is directed by §408.05(5) (a), Florida Statutes, and includes brochures to assist the public in making well-informed health care decisions. The brochures are available in English and Spanish. They can be ordered by calling the Agency's Call Center and are also available on FloridaHealthFinder.gov. They contain general information on a health care topic as well as a resource directory for further information. In 2009, 110,076 brochures were distributed. Of these, 81.4 percent were in English (89,689) and 18.5 percent were in Spanish (20,387). The Florida Center will continue our long range planning efforts of providing brochures to the public.

Office of 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 for Health Care Administration. Reports produced by this office are available at 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.

The Office of Health Policy and Research has been assigned the lead on the implementation of the Medicaid Electronic Health Record Incentive Program. Section 4201 of The American Recovery and Reinvestment Act (ARRA) of 2009 establishes and funds incentives for the adoption and use of certified electronic health records (EHRs) through Medicaid payments. The federal Centers for Medicare and Medicaid Services (CMS) and the State's Medicaid program will provide oversight, as directed in ARRA. Information on this initiative is discussed under Florida Center Health Information Exchange Initiatives. More information is also available at www.fhin.net.

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 reported data includes annual statewide quality measures gathered by health plans. 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 (HEDIS) and compare the quality of services provided by health plans across all health plan product lines. Quality indicator reporting by health plans began in 1999.

Consumer Assessment of Healthcare Providers and Systems

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program is a public-private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care. Commercial health plans report CAHPS data directly to the Florida Center. Companies complete a separate set of surveys for HMO plans and for preferred provider organization (PPO)/indemnity plans. HMO plans report all items from the CAHPS survey, while PPO plans report eight specified CAHPS items in addition to the supplemental items. In 2010, there were a total of 18,771 completed surveys.

In order to meet objective 4.B, which is to increase the average daily number of person who visit FloridaHealthFinder.gov by 10 percent annually, the Agency will continue to provide consumers a *Compare Health Plans* link on FloridaHealthFinder.gov, which displays comparative information about benefits and performance of health plans throughout Florida. The *Compare Health Plans* portion of the website includes comparative information on plan performance measures, member satisfaction survey data, and county coverage areas for all managed care and most PPO/indemnity health plans in Florida. These continued efforts will help the Florida Center meet our goal to increase the availability of transparent health care data and information so that consumers are able to make informed choices about their health care.

Emergency Department Report

The Emergency Department Report fulfills the requirements of §408.062 (1) (i), Florida Statutes, which mandates that the Agency publish 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.

These efforts help the Florida Center meet our goal to increase the availability of transparent health care data and information so consumers are able to make informed choices about their health care.

Health Care Expenditures Report

The Health Care Expenditures Report, a report on health care expenditures in Florida, is 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. These efforts help the Florida Center meet our goal by increasing the availability of transparent health care data and information so consumers are able to make informed choices about their health care.

Health Care Cost and Utilization Project (HCUP)

The Florida Center submits facility discharge and visit data to the Health Care Cost and Utilization Project as administered by the federal Agency for Healthcare Research and Quality (AHRQ). This project rolls up discharge data from 38 states, creating a 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.

Healthcare Cost and Utilization Project (HCUP) national databases, which includes Florida's data, includes the following databases: 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. The Florida Center has also 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.

MyFloridaRx.com

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 most commonly used prescription drugs in Florida. The data set was enhanced in 2010 to provide pricing information on 150 of the most commonly used prescription drugs. Prior to this, pricing information was provided for 100 drugs. This

website assists in our goal of providing transparent health care data and information so consumers are able to make informed choices about their health care.

State Consumer Health Information and Policy Advisory Council

This Office 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 §408.061 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 FloridaHealthFinder.gov website.

Through the use of committees and technical workgroups, the Advisory Council members and Florida Center staff have developed and implemented the Advisory Council's Long Range Plan. The committees and technical workgroups, as of August 2010, include: Data Standards and Transparency Committee, Health Information Exchange Coordinating Committee, and the Health Information Exchange Legal Work Group. The Health Information Exchange Coordinating Committee is facilitated by the Office of Health Information Exchange within the Florida Center. Staff and committee members will meet annually to update and revise the goals and objectives previously defined. Further information about the Advisory Council and the technical workgroups is available at: http://ahca.myflorida.com/SCHS/chis.shtml.

The long range goals and measurable objectives of the State Consumer Health Information and Policy Advisory Council are detailed below:

Goal 1: Improve and streamline Florida Center data collection

A. Complete and roll-out new data collection web page.

B. Complete internal AHCA computer systems that will allow the Agency to process data submitted in accordance with the new data collection administrative rules 59B-9 and 59E-7 by April 1.

C. Complete the processing of first quarter 2010 data with little to no decrease in data currency (percentage of facilities completing their data submission by certification deadline).

D. Complete the roll-out of – and transition to – an updated data rules validator (referred to internally as the "auditor") by the end of the year.

E. Finalize specific updates to the data collection rules and formally initiate rule updates by the end of the year.

Goal 2: Promote FloridaHealthFinder.gov

A. Increase number of visits from 1.35 million in 2009 to 1.75 million in 2010.

B. Increase the annual number of visits to Compare Hospitals and Ambulatory Surgery Centers by 15 percent.

C. Increase the annual number of visits to Compare Health Plans by 15 percent.

Goal 3: Improve FloridaHealthFinder.gov

A. Continue to make the website more user friendly and enhance navigation.

B. Add physician volume information on hip and knee replacements.

C. Post performance measures within 8-10 weeks of the final certification date.

Goal 4: Display physician data on the FloridaHealthFinder.gov website

A. Provide consumers with an easy access point to information on Hip and Knee Replacements.

B. Provide consumers with physician volume for Hip and Knee Replacements to allow for comparison by December 2010.

Goal 5: Pursue statewide Health information Exchange opportunities for the State, consistent with national initiatives funded through the American Recovery and Reinvestment Act of 2009

A. Issue an Invitation to Negotiate and select the HIE Vendor to build the state health information exchange infrastructure for the "network of networks." An HIE vendor will be selected by November 1, 2010.

B. Identify early adopters (e.g. hospital systems, provider networks, clinics, RHIOs, county health departments) to participate health information exchange roll-out in 2011. Six to eight early adopter HIE Participation Agreements will be completed.

C. Increase the percent of pharmacies and percent of physicians within the state that are actively engaged in electronic prescribing.

D. Complete the State Medicaid Health Information Technology Plan that will provide a comprehensive plan for the participation of Florida Medicaid providers in health information exchange. Submit to CMS for approval in January 2011.

Medicaid Health Information Network and Personal Health Records

In 2009, the Agency for Health Care Administration (Agency) entered into a two year no-cost contract with Availity® Health Information Network, LLC to develop a secure Web portal designed to give providers patient specific claims-based information, along with patient eligibility and benefit look-up capabilities. On November 19, 2009, the Agency launched this Medicaid claims-based electronic health record that is now available for Medicaid treating providers. It is called the Florida Medicaid Health Information Network, powered by Availity (Florida Medicaid HIN). Further information on the Florida Medicaid HIN is provided under Florida Center Health Information Exchange Initiatives.

HealthTrio LLC was engaged via a subcontract to provide the personal health record (PHR) for Medicaid recipients. The first target population for the PHR is new mothers with children. The record allows 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.

The PHR with individualized data is expected to become available in late 2010. 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.

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 assist users find data sources with links to more information if available, and provide current contact information. The responsible data administrator can be contacted for more detailed information regarding available data. The State Health Data Directory is available at 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.

The Office of Health Information Exchange

In 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 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 2009 Legislative Session, §408.051, Florida Statutes, was created by SB 162. This legislation, also titled the Florida Electronic Health Records Exchange Act, provides the following key provisions related to health information exchange:

- 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.

- Amended §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.

- Amended §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.

Health Information Exchange Coordinating Committee (HIECC)

In December 2007, the Agency established the Health Information Exchange Coordinating Committee 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, which sunset in 2009, 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.

Florida Center Health Information Exchange Initiatives

The health information technology initiatives of the Florida Center, listed below, are being implemented as a result of our statutory directives and the related provisions and programs of the Health Information Technology for Economic and Clinical Health Act. (HITECH) of 2009. In May 2009, Governor Charlie Crist designated the Agency for Health Care Administration as the entity to lead Florida's use of federal grant funding for health information initiatives and recognized the HIECC's role in advising the Agency.

Florida's Health Information Exchange Plan

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 Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009 provides Florida with the ability to substantially further our efforts.

The Agency submitted a grant application to the Office of the National Coordinator for Health Information (ONC) to develop Florida's statewide health information exchange in October 2009. The grant is made available through the State Health Information Exchange Cooperative Agreement Program. The purpose of the program is to facilitate and expand the electronic movement and use of health information among organizations according to national recognized standards.

The Agency received its Notice of Award on March 15, 2010. Total federal funding awarded for the four-year period is $20.7 million. The total four-year project budget is an estimated $23.5 million required matching contributions of $2.8 million. A $1 for every $10 match in 2011, a $1 for every $7 match in 2012, and a 25 percent match thereafter is required in the HITECH Act which may be private or public sources.

In the FY 2010-2011 budget authorizing funding, the Legislature directed the Agency to issue an invitation to negotiate (ITN) by July 15, 2010, to create a Florida Health Information Exchange Infrastructure. The Agency is to contract with a vendor who can demonstrate the expertise to design and create a statewide infrastructure for health information exchange through an integrated solution leveraging the ongoing federal investments to ensure meaningful use. The Legislature provided spending authority of $9,456,329 to expend in year one of the program.

The Agency issued the ITN on July 15, 2010. The Agency also submitted its plan for the use of funds, the Florida Health Information Exchange Report, to the Legislature on August 1, 2010.

Medicaid Electronic Health Record Incentive Program

The Agency will administer the Medicaid Electronic Health Record Incentive Program that will provide incentive payments to Medicaid providers in implementing and using electronic health record systems. The Agency's proposed Planning-Advanced Planning Document (P-APD) was approved by the Centers for Medicare and Medicaid Services on February 9, 2010.

Planning activities include an environmental scan and developing Florida's State Medicaid Health Information Technology Plan (SMHP). The SMHP will include an implementation plan for the Medicaid Electronic Health Records Incentive Program. North Highlands has been selected by the Agency for Health Care Administration as the awarded vendor for AHCA RFQ No. 09/10-RFQ-002, "Consulting Services for the Development of the State Medicaid Health Information Technology Plan."

The 2010 Legislature provided the Agency with $5,912,752 to contract as needed with independent consultants and vendors to develop implementation plans and to implement the Medicaid Electronic Health Records Incentive Program in FY 2010-2011.

This program is overseen by the Centers for Medicare & Medicaid Services (CMS) and State Medicaid agencies. The purpose is to support the costs for acquiring and implementing certified electronic health records (EHRs). Eligible Medicaid providers may receive up to 85 percent of allowable costs for EHR technology and support services capped at $85,000 over six years. The incentives are 100 percent federally funded. Planning for and administering the program is 90 percent federally funded. Eligible entities include Medicaid providers, including eligible professionals (physicians, nurse mid-wives and nurse practitioners) where 30 percent of patients are Medicaid eligible, 20 percent for pediatricians, and providers in federally qualified health centers, and rural health clinics whose patient volume is 30 percent needy individuals, acute care hospitals with not less than 10 percent Medicaid eligible patient volume, and children's hospitals which have no volume requirements. The state is required to provide adequate program oversight and pursue initiatives to encourage the adoption of certified EHRs to promote health quality and exchange of health information.

Regional Extension Centers

The purpose of Regional Extension Centers is to assist health care providers in the adoption, implementation and effective use of certified EHR technology. Funds will be used for training and technical assistance as well as dissemination of best practices.

The Agency supported the efforts of Florida stakeholders applying for funding to establish Regional Extension Centers and drafted letters of support for the four Florida applicants. The announcement of the first round of awards was received in February 2010 with the award of $8.5 million to Health Choice Network. The announcement of the second round of awards was in April 2010. The University of Central Florida's College of Medicine received $7.6 million; the Community Health Centers Alliance, Inc. (CHCA) received $10.9 million; and the University of South Florida received $6 million.

During 2010, the extension center representatives have been meeting monthly to discuss the best way to work together and with the Agency. The regional extension centers will assist the Agency in its administration of the Medicaid EHR incentives program through mutual cooperation. The regional extension centers will also facilitate HIE through education and outreach related to the adoption of electronic health records.

Electronic Prescribing

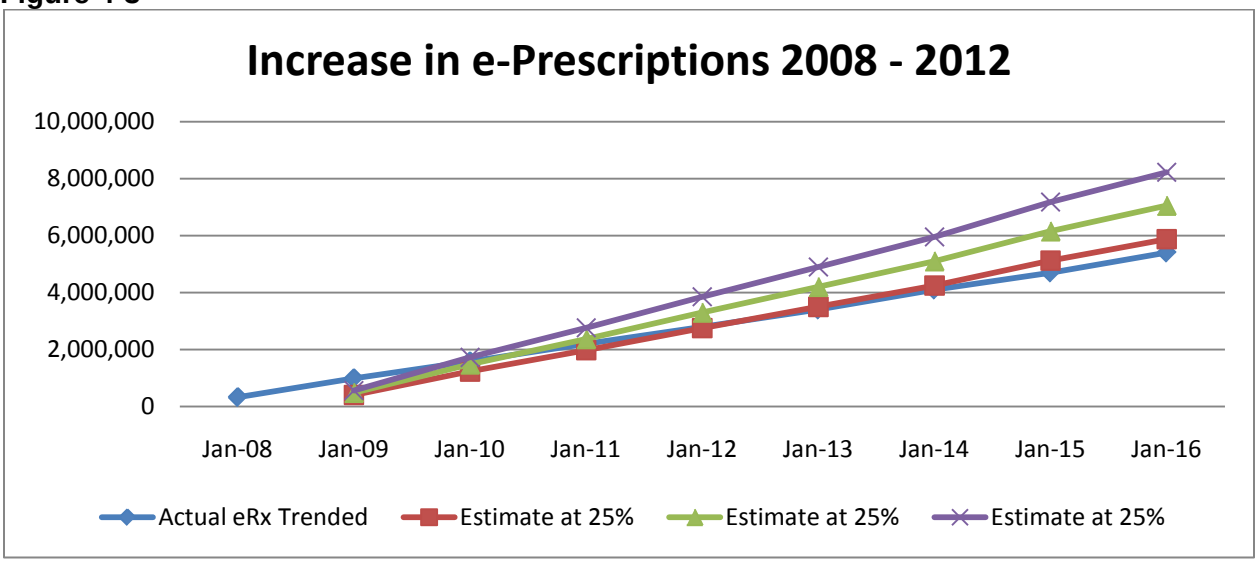
Section 408.0611, Florida Statutes, directs the Agency to collect information on the benefits of electronic prescribing (e-prescribing) and e-prescribing software and disseminate that information through the Agency's website. The law states that the Agency is to collaborate with stakeholders to create an e-prescribing clearinghouse and coordinate with private sector e-prescribing initiatives. The Legislature directed the Agency to prepare an annual report on the progress of e-prescribing implementation in Florida which is in line with our objective to increase the number of prescriptions submitted electronically in Florida.

The Annual E-Prescribing Report provides information on trends in e-prescribing adoption in Florida through calendar year 2009. The e-prescribing metrics track the volume of electronic prescriptions, medication information requests and pharmacies that accept e-prescriptions statewide and by metropolitan areas. Data from year 2009 indicate that Florida is continuing to show growth of e-prescribing transactions and is ranked among the top 20 states for e-prescribing by Surescripts - The Nation's E-Prescription Network. . In the second quarter of

2010, 17 percent of prescriptions in Florida were sent electronically, up from 1.6 percent in 2007, 4.3 percent in 2008, and 14.4 percent at the end of 2009.

Two important factors likely to increase e-prescribing adoption is the availability of Medicare incentives for e-prescribing that began in 2009 under the Medicare Improvements for Patients and Providers Act (MIPPA) and is extended under the Health Information Technology for Economic and Clinical Health Act (HITECH), and the opportunity to coordinate outreach efforts through HITECH funded programs. In order to meet our objective 4.C, it is important that Florida capitalize on these opportunities to accelerate e-prescribing in 2011 through greater educational outreach and participation of Florida Medicaid. Figure 4-3 shows the anticipated increase in the number of prescriptions e-prescribed through 2012.

Figure 4-3



Universal Patient Authorization for Health Information Exchange

During the 2009 Legislative Session, the legislature passed Senate Bill 162 Florida Electronic Health Records Exchange Act creating the new §408.051, Florida Statutes, which removes many of the legal barriers to meaningful health information exchange and directed the Agency to develop a standard form for patient authorization. Working with stakeholders, the Agency developed two universal patient authorization forms for the use or release of a patient's identifiable health record. The forms were incorporated by reference in the rule which was adopted July 2010. The rule and forms are located at 59B-16 Florida Administrative Code. A question and answer document explaining the purposes and use of the forms and the new rules and forms will be available at www.FHIN.net.

The Agency is also participating in multi-state activities to extend the use of standard patient authorization forms and facilitate interstate HIE.

Children's Health Insurance Program Reauthorization Act (CHIPRA)

In February 2010, the Agency received a grant award of $11.3 million to the State of Florida and Illinois to improve health care quality and delivery systems for children enrolled in Medicaid and the Children's Health Insurance Program (CHIP). The Medicaid and CHIP agencies in Florida and

Illinois will use the CHIPRA grant to improve health outcomes for children by enhancing access to information for use by providers, consumers, and state agencies and undertaking new quality improvement activities in their Medicaid and CHIP programs.

The Agency will work in collaboration with other agencies such as the Department of Health, providers, consumers, advocates, the HIECC, and other stakeholders, seek to leverage current state-wide HIE infrastructure-building efforts to improve quality of care for children.

Broadband Infrastructure

In November 2007, the Federal Communication Commission awarded $9.6 million to the Big Bend Health Care to build a health care network in the Florida Panhandle. This consisted of a gigabit fiber optical network connecting nine rural hospitals and a broadband wireless network connecting not-for-profit clinics in the rural counties of the Panhandle.

Beginning in 2009, the Agency has worked together with the Department of Management Services, Florida Department of Education, Workforce Florida, Florida State University, and Regions of Critical Economic Concern, to draft grant proposals in the areas of Broadband Infrastructure, Sustainable Adoption, and Mapping as funded via the Recovery Act. The Agency will continue to work with awardees to provide connections to health care facilities across the state.

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 Medicaid electronic health records adoption incentives	Medicaid Electronic Health Records Incentive Program	Continued inefficiencies and medical errors.
2.	Expand Health Information Exchange Infrastructure	State HIE Cooperative Agreement Program	Lack of coordination in health care transitions.

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.	Coordinate standards for electronic health information exchange.	Amend § 408.051, F.S.	N/A	The Agency will work with advisory groups to facilitate health information exchange.	Establish specific statutory authorization for consolidation of advisory groups.
3.	Require clinical labs providing greater than 5percent of reported Florida Medicaid clinical laboratory claims to report clinical laboratory results data weekly to the Agency	Amend § 408.061 (2), F. S.	N/A	The Agency will collect and make clinical lab results available to treating providers through its health information exchange.	Establish statutory authority to promulgate rules to require the reporting of laboratory results data.

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.	January 1: 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: Annually
4.	§ 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. However, in June 2010 this was increased to 150 on MyFloridaRx.com.	Annually
5.	§ 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: Annually
6.	§ 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.	January 1: Annually

Number	Implementing Bill or Statute	Task Forces and Studies In Progress	Required/ Expected Completion Date
7.	§ 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
8.	§ 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: Annually
9.	§ 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
10.	§ 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.	Ongoing
11.	§ 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
12.	§ 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
13.	§ 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: Annually

Number	Implementing Bill or Statute	Task Forces and Studies In Progress	Required/ Expected Completion Date
14.	§ 408.05 (4) (a) (7), F.S.	Maintain detailed information on data maintained by other local, state, federal, and private agencies in order to advise those who use the center of potential sources of data which are requested but which are not available from the center. This is available in the State Health Data Directory on FloridaHealthFinder.gov.	Annually

Trends and Conditions Statement

The Offices of 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 website 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. (Objectives 5.A)

As described, personal contact makes up a significant portion of the core mission and the job duties for the offices under the Division of Communications and Legislative Affairs. This important point should be taken into consideration when viewing the service outcome measures of this document.

The Communications Office strives to be efficient and responsive to all requests. In an effort to ensure that the Agency and the Communications Office remain responsive to people of Florida, new service outcome measures have been added to achieve the Communication Office goals. These new measures include the percentage of how often correspondence and media requests were responded to on time. (Objectives 5.B)

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.

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, Studies in Progress

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

Trends and Conditions Statement

Division of 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 on 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 continues to age, 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 continued to be 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, 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.

Goal 6 and its corresponding objectives provide direct support for all other agency goals and have as their core the importance of providing quality health care to Floridians (see Figure 6-1).

Figure 6-1: Map of Division Objectives to Agency Priorities

Agency Priorities	Division of Information Technology Objectives
To use taxpayers' resources as efficiently and effectively as possible and to safeguard those resources from fraud.	Objective 6. A – Cost Reduction/Efficiency Objective 6. F – Data Security Objective 6. G – Risk Management
To ensure that patients in Florida's health care system are safe.	Objective 6. D – Infrastructure Availability Objective 6. E – Business Continuity
To ensure that Medicaid beneficiaries get access to the services they need and have improved health outcomes.	Objective 6. D – Infrastructure Availability Objective 6. E – Business Continuity
To ensure that the Agency treats providers as partners in the effort to provide better health care and that they are treated fairly.	Objective 6. B – Customer Service
To ensure that all health care consumers are empowered with the 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.	Objective 6. A – Cost Reduction/Efficiency Objective 6. B – Customer Service Objective 6. D – Infrastructure Availability Objective 6. E – Business Continuity Objective 6. F – Data Security Objective 6. G – Risk Management
To make the agency an employer of choice where employees believe their work is meaningful, that their opinions matter and their efforts are recognized.	Objective 6. C – Staff Retention

Strategic Planning, Vision, Oversight

The Agency's executive management team strongly supports the use of technology as an effective tool in furthering the Agency's overall goals and objectives. The Division of Information Technology functions as a partner in Agency strategic planning and vision creation.

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 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. AHCA-celerate has been leveraged as the Agency's governance vehicle as well. The consolidation of information technology efforts within the Division of Information Technology will facilitate the identification of duplicative efforts and purchases that are at cross purposes with Agency 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 AHCA-celerate Agency Management Team Committee and its division-level partner, the AHCA-celerate Strategy Team (AST), and their associated 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 AHCA-celerate Agency Management Team Committee and the AST are:

- The continued 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.

- Voice-Over-Internet-Protocol (VOIP) Phone services installation replacing an over 10 year old analog-based phone system. VOIP services allow for utilization of "contact centers" that are planned to replace costly out-sourced call-centers.

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

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

AHCA-celerate Agency Management Team Committee and the AST 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, 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 AHCA-celerate Agency Management Team Committee and the AST 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 (AHCA-celerate Agency Management Team Committee and the AST) to align all information technology initiatives with the ongoing mission of the Agency.

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 AGENCY 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 legislation at a federal level and state level;
- 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:

- **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.
- **FTC.** The Federal Trade Commission (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 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.

The Agency, overall, continues to be 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 at the Agency 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.

Finally, the most significant factor affecting the Agency'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. State of Florida budget restraints are furthering the difficulty of retaining and hiring capable long term the Agency IT staff.

The Agency is at a very real risk of losing IT 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 the Agency'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.

Statutorily Required AHCA Primary Data Center Relocation

By July 2012, a legislatively mandated state data center consolidation is expected where a state designated primary data center, either the State Shared Resource Center (SSRC) or Northwood Shared Resource Center (NSRC) is expected to house the current AHCA primary data center currently located in Building 3, of the Ft. Knox Business Center campus. Great care regarding the move must be focused on risk analysis, federal statutory compliance and any Agency budget costs that increase because of the move.

Great amounts of transition planning will need to be completed before this delicate data center move by the Agency takes place. The Florida Agency for Enterprise Information Technology (AEIT) is assisting AHCA where the organization can in planning coordination but much of the responsibility is left with the Agency. A Legislative Budget Request (LBR) will be placed by the Agency once the costs are known.

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 faster speeds. The objective states clearly the Division's fervent support of the Agency and its mission, and the Division's goals. When accomplished, this objective 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 IT services of an organization becomes inefficient and unreliable.

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

Number	Potential Policy Changes	Reference LRPP Goals	Legislative Budget Request (LBR)	Impact on Agency Policy if LBR is Not Approved
1.	Awaiting State Primary Data Center Transition Plan cost analysis (late Sept. 10). The Transition plan will influence our current LBR.	Objective 6. A – Cost Reduction/Efficiency Objective 6. B – Customer Service Objective 6. D – Infrastructure Availability Objective 6. E – Business Continuity Objective 6. F – Data Security Objective 6. G – Risk Management	TBD	Additional transitional costs for moving the Agency Primary Data Center will have to be absorbed by normal AHCA Fiscal Year budget.

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
None					

List of All Task Forces and/or Studies in Progress

Number	Bill Cite	Task Forces and Studies Required by FY 2009 –2010 Legislation	Agency Staff Assigned	Action Required Due Date
None				

Performance Measures and Standards - LRPP Exhibit II

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 2009-10 (Numbers)	Prior Year Actual FY 2009-10 (Numbers)	Approved Standards for FY 2010-11 (Numbers)	Requested FY 2011-12 Standard (Numbers)
Program: Administration and Support		**Code: 68200000**		
Administrative costs as a percent of total agency costs	0.11%	0.12%	0.11%	0.19%
Administrative positions as a percent of total agency positions	11.45%	11.18%	11.45%	10.65%
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%	26.2%	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%	89.7%	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%	93.0%	95%	95.0%
Total number of children enrolled in Kidcare	228,159	280,632	228,159	N/A
Total number of children enrolled in Florida Healthy Kids	195,867	222,331	195,867	N/A
Number of children enrolled in Medikids	21,000	35,260	21,000	N/A
Number of children enrolled in Children's Medical Services Network	10,053	23,041	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%	1.50%	1.44%	2.00%
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	156,083,703	145,101,035	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 2009-10 (Numbers)	Prior Year Actual FY 2009-10 (Numbers)	Approved Standards for FY 2010-11 (Numbers)	Requested FY 2011-12 Standard (Numbers)
Percent of new Medicaid recipients voluntarily selecting managed care plan	50%	N/A	50%	N/A
Number of new enrollees provided with choice counseling	520,000	N/A	520,000	N/A

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%	16.5%	20%	Delete
Percent of women receiving adequate prenatal care	86%	54.0%	86%	90.0%
Neonatal mortality rate per 1000	5	4.8	5	5.0
Percentage of women with an Interpregnancy Interval (IPI) greather than or equal to 28 months.	50%	27.6%	50%	50%
Percent of eligible children who received an EPSDT screening	64%	71%	64%	90.0%
Number of children ages 1-20 enrolled in Medicaid	1,249,276	2,117,062	1,249,276	N/A
Number of children receiving EPSDT services	407,052	851,416	407,052	N/A
Number of hospital inpatient services provided to children	92,960	146,389	92,960	N/A
Number of physician services provided to children	6,457,900	9,696,267	6,457,900	N/A
Number of prescribed drugs provided to children	4,444,636	5,015,577	4,444,636	N/A
Number of hospital inpatient services provided to elders	100,808	109,303	100,808	N/A
Number of physician services provided to elders	1,436,160	2,392,400	1,436,160	N/A
Number of prescribed drugs provided to elders	15,214,293	1,324,200	15,214,293	N/A
Number of uninsured children enrolled in the Medicaid Expansion	1,227	N/A	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%	20.30%	20.00%	20.0%
Number of case months (home and community-based services)	550,436	537,733	550,436	N/A
Number of case months services purchased (Nursing Home)	619,387	510,660	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 2009-10 (Numbers)	Prior Year Actual FY 2009-10 (Numbers)	Approved Standards for FY 2010-11 (Numbers)	Requested FY 2011-12 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%	17.9%	20.00%	20.00%
Percent of women and child hospitalizations for conditions preventable with good ambulatory care	20.00%	19.2%	20.00%	20.0%
Number of case months services purchased (elderly and disabled)	1,877,040	163,788	1,877,040	N/A
Number of case months services purchased (families)	9,850,224	532,007	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%	2.00%
Percent of hospitals with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0%	8.7%	0%	4.00%
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%	4.00%
Percent of Priority I consumer complaints about licensed facilities and programs that are investigated within ~~48 hours~~ two business days.	100%	99.5%	100%	98.0%
Percent of accredited hospitals and ambulatory surgical centers cited for not complying with life safety, licensure, or emergency access standards	25%	11.6%	25%	25.00%

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 2009-10 (Numbers)	Prior Year Actual FY 2009-10 (Numbers)	Approved Standards for FY 2010-11 (Numbers)	Requested FY 2011-12 Standard (Numbers)
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%	0.5%	0%	2.00%
Percent of home health facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0%	0.0%	0%	1.00%
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%	0.29%	0%	1.00%
Percent of ambulatory surgical centers with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0%	3.4%	0%	4.00%
Percent of hospitals that fail to report serious incidents (agency identified)	6%	1.40%	6%	6.00%
Percent of complaints of HMO patient dumping received that are investigated*	100%	N/A	100%	N/A
Percent of complaints of facility patient dumping received that are investigated	100%	100%	100%	100%
Number or complaints of facility patient dumping received that are investigated	N/A	1	N/A	N/A
Number of inquiries to the call center regarding practitioner licensure and disciplinary information**	30,000	N/A	30,000	N/A
Total number of full facility quality-of-care surveys conducted	7,550	6,470	7,550	7,550
Average processing time (in days) for Subscriber Assistance Program cases.	53	43	53	46
Number of construction reviews performed (plans and construction)	4,500	4,564	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 II - Performance Measures and Standards

Department: AGENCY FOR HEALTH CARE ADMINISTRATION	Department No: 68000000

Approved Performance Measures (Words)	Approved Prior Year Standards FY 2009-10 (Numbers)	Prior Year Actual FY 2009-10 (Numbers)	Approved Standards for FY 2010-11 (Numbers)	Requested FY 2011-12 Standard (Numbers)
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%	0.5%	0%	2.00%
Percent of home health facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0%	0.0%	0%	1.00%
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%	0.29%	0%	1.00%
Percent of ambulatory surgical centers with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0%	3.4%	0%	4.00%
Percent of hospitals that fail to report serious incidents (agency identified)	6%	1.40%	6%	6.00%
Percent of complaints of HMO patient dumping received that are investigated*	100%	N/A	100%	N/A
Percent of complaints of facility patient dumping received that are investigated	100%	100%	100%	100%
Number or complaints of facility patient dumping received that are investigated	N/A	1	N/A	N/A
Number of inquiries to the call center regarding practitioner licensure and disciplinary information**	30,000	N/A	30,000	N/A
Total number of full facility quality-of-care surveys conducted	7,550	6,470	7,550	7,550
Average processing time (in days) for Subscriber Assistance Program cases.	53	43	53	46
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* 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.

Assessment of Performance for Approved Performance Measures - LRPP Exhibit III

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%	1.50%	.06%	4.2%

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: N/A; difference is negligible and within expected variation due to external factors beyond 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:

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 2010

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%	20.3%	0.3%	1.5%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☐ Other (Identify)
☐ Staff Capacity
☐ Level of Training
Explanation: N/A; difference is negligible and within normal variation expected due to external factors beyond 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: 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 2010

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
50%	27.6%	(22.4%)	(55%)

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:

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

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

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
86%	69.9%	(16.1%)	(12.6%)

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors ☐ Staff Capacity
☒ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect ☒ Other (Identify)
Explanation: Medicaid is not provided an outreach budget and must work with 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. 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 and DCF to ensure outreach to let women know family planning services are available to women who need them and qualify.

Office of Policy and Budget – July 2010

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%	11.6%	13.4% Under	53.6% Decrease

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 2010

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	6,470	1,080 Under	14.3% Decrease

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 2010

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%	0.5%	0.5% Over	0.5%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☐ Staff Capacity
☐ Level of Training
☒ Other (Identify)
Explanation: 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: 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 2010

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%	3.4%	3.4% Over	3.4%

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 2010

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%	N/A	N/A

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
☐ 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. 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 2010

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%	8.7%	8.7% Over	8.7%

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

Explanation: 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 2010

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%	0.29%	0.29% Over	0.29%

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 2010

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%	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
☐ Technological Problems
☐ Natural Disaster
☐ Other (Identify)
☒ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission

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 2010

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

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

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

External Factors (check all that apply):

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

Explanation: This is not a measure over which the Agency has ultimate control.

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

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

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

Office of Policy and Budget – July 2010

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% Increase

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 Cervices (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.

Office of Policy and Budget – July 2010

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 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	4,564	Over	1.4%

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

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

Explanation:

External Factors (check all that apply):

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

Explanation: The Agency has little control over the numbers of plan reviews, which are essentially dependent upon the number of reviews requested by facilities the Agency licenses and regulates.

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

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

Recommendations: None

Office of Policy and Budget – July 2010

Performance Measure Validity and Reliability - LRPP EXHIBIT IV

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: The amount of overpayments identified from prevention and detection activities

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:
Fraud and Abuse Case Tracking System (FACTS)

Validity:
§409.913, FS requires increased measures used to detect, prevent, and recover overpayments to Medicaid providers. Therefore, the measurement of overpayments identified is appropriate.

Reliability:
FACTS is a web-based, event-driven fraud and abuse case tracking system that has document scanning, workflow tracking, and querying capabilities. The system compiles all information needed to track a case over time.

Office of Policy and Budget – July 2010

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: The amount of overpayments prevented as a result of Prevention Activities conducted by MPI

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:
FACTS

Validity:
§409.913, FS requires increased measures used to detect, prevent, and recover overpayments to Medicaid providers. Therefore, the measurement of overpayments prevented is appropriate.

Reliability:
FACTS is a web-based, event-driven fraud and abuse case tracking system that has document scanning, workflow tracking, and querying capabilities. The system compiles all information needed to track a case over time.

Office of Policy and Budget – July 2010

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: To increase the number of referrals sent to Agency divisions and other state entities at a rate of seven percent per year.

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:
FACTS

Validity:
§409.913, FS requires increased measures used to detect, prevent, and recover overpayments to Medicaid providers. Increasing the coordination and cooperation among other state entities and AHCA divisions through referrals is an objective of MPI. Therefore, the measurement of case referrals to Agency divisions and other state entities is appropriate.

Reliability:
FACTS is a web-based, event-driven fraud and abuse case tracking system that has document scanning, workflow tracking, and querying capabilities. The system compiles all information needed to track a case over time.

Office of Policy and Budget – July 2010

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 Agency's regulatory system (VR) 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 VR and centrally collected. Centralized collection of VR data and management review of supporting data should ensure accurate and consistent reporting.

Office of Policy and Budget – July 2010

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 Agency's regulatory system (VR). This allows a count of the actual number of surveys conducted during any given period. VR 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 VR and centrally collected. Centralized collection of VR 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 2010

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 the Agency's regulatory system (VR).

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 VR 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 2010

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 Agency's regulatory system (VR) and centrally collected. VR has the capability to capture serious deficiencies for ambulatory surgical centers. The data are pulled from VR and reviewed by Central Systems Management staff for quality control purposes. The number of facilities is also obtained from VR.

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 VR 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 2010

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 the Agency's regulatory system (VR).

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 VR 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 2010

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 Agency's regulatory system (VR) and centrally collected. VR has the capability to capture serious deficiencies for hospitals. The data are pulled from VR and reviewed by Central Systems Management staff for quality control purposes. The number of facilities is also obtained from VR.

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 VR 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 2010

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 Agency's regulatory system (VR) and centrally collected. VR has the capability to capture serious deficiencies for clinical laboratories. The data are pulled from VR and reviewed by the Central Systems Management staff for quality control purposes. The number of facilities is also obtained from VR.

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 VR 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 2010

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 the Agency's regulatory system (VR).

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 VR 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 2010

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 Agency's regulatory system (VR).

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 VR.

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 order 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 2010

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 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 that have received their accreditation survey. This measure does not include federal accreditation validation surveys.

The Joint Commission (JC) 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 JC 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 JC survey utilizing a decision matrix developed by Health Standards and Quality/Field Operations staff and make the following notation in the Agency's regulatory system (VR) 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 JC reports. The data entry is completed within 10 days of the review.

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

Office of Policy and Budget – July 2010

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 complaints of facility patient dumping received that are investigated.

Action (check one):

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

Data Sources and Methodology:
The Florida Regulatory and Enforcement System/Versa (FRAES/VR) database is used to obtain this information, which comes from a count of all complaints in the system with allegation code 48. This is the code for Medicare and Medicaid Patient Dumping. FRAES/VR 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/VR 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/VR to be investigated. Complaints received by the call center are entered into FRAES/VR 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/VR 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/VR 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/VR.

Office of Policy and Budget – July 2010

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

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

Validity:
The measure is based upon complaints entered into the FRAES/VR 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/VR to be investigated. Complaints received by the call center are entered into FRAES/VR 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/VR 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/VR 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/VR.

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Facility Regulation
Service/Budget Entity: Health Facility 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/Versa (FRAES/VR) 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/VR 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 comprised 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/VR 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/VR to be investigated. Complaints received by the call center are entered into FRAES/VR 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/VR 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/VR 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/VR.

Office of Policy and Budget – July 2010

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, 2010

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Action (check one):

☒ Requesting revision to approved performance measure (deletion)
☐ 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 2010

Associated Activities Contributing to Performance Measures - LRPP Exhibit V

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

Measure Number	Approved Performance Measures for FY 2011-2012 (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 2011-2012 (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

Measure Number	Approved Performance Measures for FY 2011-2012 (Words)		Associated Activities Title
10	Number of Title uninsured children enrolled in Medikids		Purchase MediKids Program Services ACT5110
			Purchase Children's Medical Services Network Services ACT5120
			Purchase Children's Medical Services Network Services ACT5130
11	Number of uninsured children enrolled in Children's Medical Services Network		Purchase MediKids Program Services ACT5110
			Purchase Children's Medical Services Network Services ACT5120
			Purchase Children's Medical Services Network Services ACT5130
	Executive 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 2011-2012 (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

Measure Number	Approved Performance Measures for FY 2011-2012 (Words)		Associated Activities Title
19	Percent of eligible children who received all required components of EPSDT screen		Prescribed Medicines ACT4220
			Physician Services ACT4230
			Early Periodic Screening Diagnosis & Treatment ACT4260
			Therapeutic Services for Children ACT4310
20	Number of children ages 1-20 enrolled in Medicaid		Purchase MediKids Program Services ACT5110
			Purchase Children's Medical Services Network Services ACT5120
			Purchase Children's Medical Services Network Services ACT5130
21	Number of children receiving EPSDT services		Physician Services ACT4230
			Early Periodic Screening Diagnosis & Treatment ACT4260
			School Based Services ACT4310
			Clinic Services ACT4330
22	Number of hospital inpatient services provided to children		Hospital Inpatient ACT4210
			Therapeutic Services for Children ACT4310
23	Number of physician services provided to children		Physician Services ACT4230
			Therapeutic Services for Children ACT4310

Measure Number	Approved Performance Measures for FY 2011-2012 (Words)		Associated Activities Title
24	Number of prescribed drugs provided to children		Prescribed Medicines 4220
			School Based Services ACT4320
25	Number of hospital inpatient services provided to elders		Hospital Inpatient -Elderly and Disabled/fee for service ACT4010
			Prescribed Medicines- Elderly and Disabled/fee for service ACT4020
			Physician Services-Elderly and Disabled/fee for service ACT4030
			Hospital Insurance Benefit-Elderly and Disabled /Fee for service ACT4140
26	Number of physician services provided to elders		Physician Services-Elderly and Disabled/fee for service ACT4030
			Supplemental Medical Insurance-Elderly and Disabled/fee
			for service ACT4050
			Prescribed Medicines- Elderly and Disabled/fee for service ACT4020
27	Number of prescribed drugs provided to elders		Prescribed Medicines- Elderly and Disabled/fee for service ACT4020
28	Number of uninsured children enrolled in the Medicaid Expansion		Purchase MediKids Program Services ACT5110
			Purchase Children's Medical Services Network Services ACT5120
			Purchase Children's Medical Services Network Services ACT5130

Measure Number	Approved Performance Measures for FY 2011-2012 (Words)		Associated Activities Title
	Medicaid Long Term Care - 68501500		
29	Percent of hospitalizations for conditions preventable with good ambulatory care		Nursing Home Care ACT5020 Home and Community Based Services ACT5030 Capitates Nursing Home Diversion Waiver ACT5060
30	Number of case months (home and community-based services)		Home and Community Based Services ACT5030 Capitates Nursing Home Diversion Waiver ACT5060
31	Number of case months services purchased (Nursing Home)		Nursing Home Care ACT5020 Other ACT5070
	Medicaid Prepaid Health Plan - 68501600		
32	Percent of hospitalizations for conditions preventable by good ambulatory care		Prepaid Health Plans Elderly and Disabled ACT1620 Prepaid Health Plans - Family ACT1650
33	Percent of women and child hospitalizations for conditions preventable with good ambulatory care		Prepaid Health Plans - Family ACT1650

Measure Number	Approved Performance Measures for FY 2011-2012 (Words)		Associated Activities Title
34	Number of case months services purchased (elderly and disabled)		Prepaid Health Plans Elderly and Disabled ACT1620
35	Number of case months services purchased (families)		Prepaid Health Plans - Family ACT1650
	Health Care Regulation - 68700700		
36	Percent of nursing home facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
37	Percent of investigations of alleged unlicensed facilities and programs that have been previously issued a cease and desist order, that are confirmed as repeated unlicensed activity		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020

Measure Number	Approved Performance Measures for FY 2011-2012 (Words)		Associated Activities Title
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

Measure Number	Approved Performance Measures for FY 2011-2012 (Words)		Associated Activities Title
42	Percent of home health facilities with deficiencies that pose a serious threat to the health, safety or welfare of the public		Health Facility Regulation (Compliance, Complaints) - Field Offices
			Survey Staff ACT7030
			Health Facility Regulation (Compliance, Licensure, Complaints) -
			Tallahassee ACT7020
43	Percent of clinical laboratories with deficiencies that pose a serious threat for not complying with life safety, licensure or emergency access standards		Health Facility Regulation (Compliance, Complaints) - Field Offices
			Survey Staff ACT7030
			Health Facility Regulation (Compliance, Licensure, Complaints) -
			Tallahassee ACT7020
44	Percent of ambulatory surgical centers with deficiencies that pose a serious threat to the health, safety or welfare of the public		Health Facility Regulation (Compliance, Complaints) - Field Offices
			Survey Staff ACT7030
			Health Facility Regulation (Compliance, Licensure, Complaints) -
			Tallahassee ACT7020
45	Percent of hospitals with deficiencies that pose a serious threat to the health, safety or welfare of the public		Health Facility Regulation (Compliance, Complaints) - Field Offices
			Survey Staff ACT7030
			Health Facility Regulation (Compliance, Licensure, Complaints) -
			Tallahassee ACT7020

Measure Number	Approved Performance Measures for FY 2011-2012 (Words)		Associated Activities Title
46	Percent of hospitals that fail to report serious incidents (agency identified)		Health Facility Regulation (Compliance, Complaints) - Field Offices
			Survey Staff ACT7030
			Health Facility Regulation (Compliance, Licensure, Complaints) -
			Tallahassee ACT7020
48	Percent of complaints of HMO patient dumping received that are investigated		Managed Health Care ACT7090
49	Percent of complaints of facility patient dumping received that are investigated		Health Facility Regulation (Compliance, Complaints) - Field Offices
			Survey Staff ACT7030
			Health Facility Regulation (Compliance, Licensure, Complaints) -
			Tallahassee ACT7020
50	Number of inquiries to the call center regarding practitioner licensure and disciplinary information		Health Facility Regulation (Compliance, Licensure, Complaints) -
			Tallahassee ACT7020

Measure Number	Approved Performance Measures for FY 2011-12 (Words)		Associated Activities Title
51	Total number of full facility quality-of-care surveys conducted		Health Facility Regulation (Compliance, Complaints) - Field Offices
			Survey Staff ACT7030
			Health Facility Regulation (Compliance, Licensure, Complaints) -
			Tallahassee ACT7020
52	Average processing time (in days) for Statewide Provider and Subscriber Assistance Panel cases		Subscriber Assistance Panel ACT7130
53	Number of construction reviews performed (plans and construction)		Plans & Construction ACT7080

Agency – Level Unit Cost Summary - LRPP Exhibit VI

AGENCY FOR HEALTH CARE ADMINISTRATION

SECTION I: BUDGET	OPERATING	FIXED CAPITAL
TOTAL ALL FUNDS GENERAL APPROPRIATIONS ACT	18,239,862,302	0
ADJUSTMENTS TO GENERAL APPROPRIATIONS ACT (Supplementals, Vetoes, Budget	1,163,627,975	0
FINAL BUDGET FOR AGENCY	19,403,490,277	0

FISCAL YEAR 2009-10

SECTION II: ACTIVITIES * MEASURES	Number of Units	(1) Unit Cost	(2) Expenditures	(3) FCO
Executive Direction, Administrative Support and Information Technology (2)				0
Prepaid Health Plans - Elderly And Disabled *	1,964,616	792.99	1,557,923,053	
Prepaid Health Plans - Families *	10,820,244	117.92	1,275,896,271	
Elderly And Disabled/Fee For Service/Medicare - Hospital Inpatient * Number of care months Medicaid program services	442,127	4,115.17	1,819,426,875	
Elderly And Disabled/Fee For Service/Medicare - Prescribed Medicines * Number of care months Medicaid program services	442,127	1,842.75	814,729,402	
Elderly And Disabled/Fee For Service/Medicare - Physician Services * Number of care months Medicaid program services	442,127	1,093.40	483,422,083	
Elderly And Disabled/Fee For Service/Medicare - Hospital Outpatient * Number of care months Medicaid program services	442,127	743.63	328,777,618	
Elderly And Disabled/Fee For Service/Medicare - Supplemental Medical Insurance * Number of care months Medicaid program	303,567	2,887.12	876,435,294	
Elderly And Disabled/Fee For Service/Medicare - Early Periodic Screening Diagnosis And Treatment * Number of care months Medicaid program services purchased	83,664	151.49	12,674,075	
Elderly And Disabled/Fee For Service/Medicare - Patient Transportation * Number of care months Medicaid program services	442,127	158.26	69,969,443	
Elderly And Disabled/Fee For Service/Medicare - Case Management * Number of care months Medicaid program services	442,127	199.31	88,141,611	
Elderly And Disabled/Fee For Service/Medicare - Home Health Services * Number of care months Medicaid program services	442,127	83.86	37,077,469	
Elderly And Disabled/Fee For Service/Medicare - Therapeutic Services For Children * Number of care months Medicaid program	83,664	214.76	17,967,421	
Elderly And Disabled/Fee For Service/Medicare - Hospital Insurance Benefit * Number of care months Medicaid program	264,602	425.26	112,525,718	
Elderly And Disabled/Fee For Service/Medicare - Hospice * Number of care months Medicaid program services purchased	442,127	533.43	235,843,295	
Elderly And Disabled/Fee For Service/Medicare - Private Duty Nursing * Number of care months Medicaid program services	83,664	2,462.31	206,007,027	
Elderly And Disabled/Fee For Service/Medicare - Other * Number of care months Medicaid program services purchased	442,127	1,336.61	590,953,317	
Women And Children/Fee For Service/Medicare - Hospital Inpatient * Number of care months Medicaid program services	901,829	1,415.46	1,276,498,430	
Women And Children/Fee For Service/Medicare - Prescribed Medicines * Number of care months Medicaid program services	901,829	262.23	236,483,059	
Women And Children/Fee For Service / Medicare - Physician Services * Number of care months Medicaid program services	901,829	576.16	519,594,146	
Women And Children/Fee For Service / Medicare - Hospital Outpatient * Number of care months Medicaid program services	901,829	589.52	531,646,686	
Women And Children/Fee For Service / Medicare - Supplemental Medical Insurance * Number of care months Medicaid program	941	170,198.79	160,157,062	
Women And Children/Fee For Service / Medicare - Early Periodic Screening Diagnosis And Treatment * Number of care months Medicaid program services purchased	720,496	210.84	151,907,144	
Women And Children/Fee For Service / Medicare - Patient Transportation * Number of care months Medicaid program	901,829	63.10	56,902,917	
Women And Children/Fee For Service / Medicare - Case Management * Number of care months Medicaid program services	901,829	11.92	10,752,005	
Women And Children/Fee For Service / Medicare - Home Health Services * Number of care months Medicaid program services	901,829	106.19	95,766,191	
Women And Children/Fee For Service / Medicare - Therapeutic Services For Children * Number of care months Medicaid	720,496	74.52	53,694,240	
Women And Children/Fee For Service / Medicare - Clinic Services * Number of care months and Medicaid program services	901,829	114.36	103,135,930	
Women And Children/Fee For Service / Medicare - Other * Number of care months Medicaid program services purchased	901,829	413.90	373,270,720	
Medically Needy - Hospital Inpatient * Number of care months Medicaid program services purchased	28,166	8,756.74	246,642,337	
Medically Needy - Prescribed Medicines * Number of care months Medicaid program services purchased	28,166	3,673.51	103,468,005	
Medically Needy - Physician Services * Number of care months Medicaid program services purchased	28,166	1,980.25	55,775,643	
Medically Needy - Hospital Outpatient * Number of care months Medicaid program services purchased	28,166	2,354.41	66,314,306	
Medically Needy - Supplemental Medical Insurance * Number of care months Medicaid program services purchased	3,696	1,466.03	5,418,456	
Medically Needy - Early Periodic Screening Diagnosis And Treatment * Number of care months Medicaid program services	4,759	138.89	660,969	
Medically Needy - Patient Transportation * Number of care months Medicaid program services purchased	28,166	89.81	2,529,543	
Medically Needy - Case Management * Number of care months Medicaid program services purchased	28,166	56.12	1,580,585	
Medically Needy - Home Health Services * Number of care months Medicaid program services purchased	28,166	34.75	978,686	
Medically Needy - Therapeutic Services For Children * Number of care months Medicaid program services purchased	4,759	7.53	35,849	
Medically Needy - Other * Number of care months Medicaid program services purchased	28,166	40,977.27	1,154,165,825	
Refugees - Hospital Inpatient * Number of care months Medicaid program services purchased	4,636	1,281.69	5,941,903	
Refugees - Prescribed Medicines * Number of care months Medicaid program services purchased	4,636	58,458.72	271,014,635	
Refugees - Physician Services * Number of care months Medicaid program services purchased	4,636	1,360.98	6,309,492	
Refugees - Hospital Outpatient * Number of care months Medicaid program services purchased	4,636	289.95	1,344,208	
Refugees - Early Periodic Screening Diagnosis And Treatment * Number of care months Medicaid program services	569	257.56	146,550	
Refugees - Patient Transportation * Number of care months Medicaid program services purchased	4,636	6.47	30,000	
Refugees - Case Management * Number of care months Medicaid program services purchased	4,636	0.20	923	
Refugees - Home Health Services * Number of care months Medicaid program services purchased	4,636	30.43	141,089	
Refugees - Therapeutic Services For Children * Number of care months Medicaid program services purchased	569	1.24	704	
Refugees - Other * Number of care months Medicaid program services purchased	4,636	268.92	1,246,693	
Nursing Home Care * Number of care months Medicaid program services purchased	75,662	36,468.71	2,759,295,227	
Home And Community Based Services * Number of care months Medicaid program services purchased	87,754	11,613.82	1,019,158,765	
Intermediate Care Facilities For The Developmentally Disabled - Sunland Centers * Number of care months Medicaid program	729	181,406.31	132,245,197	
Mental Health Disproportionate Share Program * Number of care months Medicaid program services purchased	720	93,226.42	67,123,021	
Long Term Care - Other * Number of care months Medicaid program services purchased	27,420	22,810.49	625,463,723	
Purchase Medikids Program Services * Number of care months	26,210	2,085.74	54,667,161	
Purchase Children's Medical Services Network Services * Number of care months	23,347	5,966.81	139,307,167	
Purchase Florida Healthy Kids Corporation Services * Number of care months	203,579	1,326.84	270,115,847	
Certificate Of Need/Financial Analysis * Number of certificate of need (CON) requests/financial reviews conducted	2,669	666.75	1,779,543	
Health Facility Regulation (compliance, Licensure, Complaints) - Tallahassee * Number of licensures/certifications	24,278	555.21	13,479,397	
Facility Field Operations (compliance, Complaints) - Field Office Survey Staff * Number of surveys and complaint	42,410	1,056.67	44,813,511	
Health Standards And Quality * Number of transactions	2,559,853	1.57	4,015,461	
Plans And Construction * Number of reviews performed	4,564	1,390.65	6,346,923	
Managed Health Care * Number of HMO and workers' compensation arrangement surveys	177	16,169.63	2,862,024	
Organ And Tissue Donor * Number of donor designations	5,443,500	0.01	52,244	
Background Screening * Number of requests for screenings	66,393	13.50	896,112	
Subscriber Assistance Panel * Number of cases	506	1,897.93	960,355	
Health Facilities And Practitioner Regulation - Medicaid Choice Counseling *	334,088	5.74	1,918,077	
TOTAL			19,166,024,758	

SECTION III: RECONCILIATION TO BUDGET			
PASS THROUGHS			
TRANSFER - STATE AGENCIES			
AID TO LOCAL GOVERNMENTS			
PAYMENT OF PENSIONS, BENEFITS AND CLAIMS			
OTHER		203,238,468	
REVERSIONS		34,227,206	
TOTAL BUDGET FOR AGENCY (Total Activities + Pass Throughs + Reversions) - Should equal		19,403,490,432	

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

(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)