RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

LONG RANGE PROGRAM PLAN

Agency for Health Care Administration

Tallahassee, Florida

September 30, 2011

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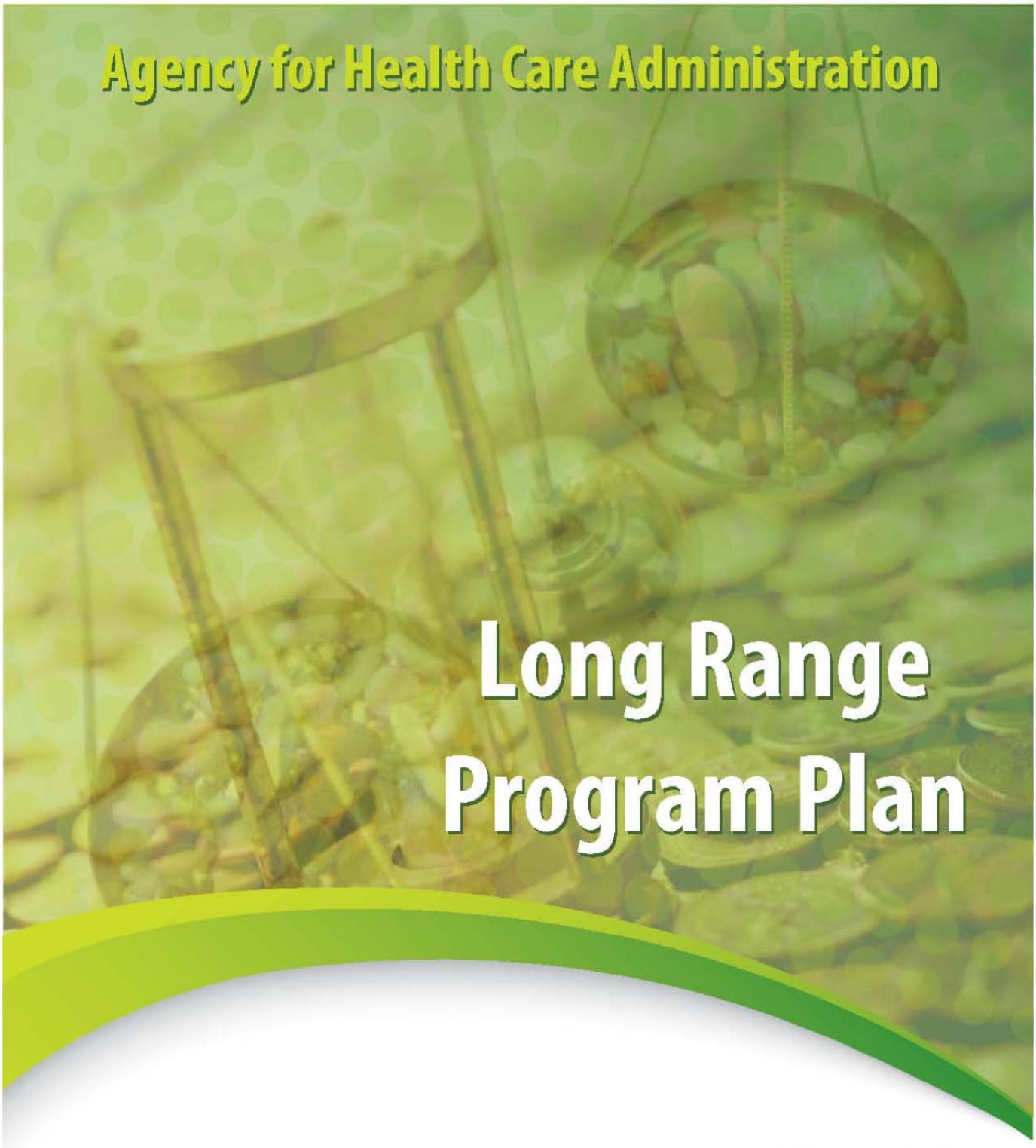
Dear Directors:

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 2012-13 through Fiscal Year 2016-17. This submission has been approved by Elizabeth Dudek, Secretary.

Tonya Kidd,
Deputy Secretary, Operations



Agency for Health Care Administration

Long Range Program Plan

FY 2012 - 2013
through
FY 2016 - 2017

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

TABLE OF CONTENTS

Letter of Transmittal ..... Page 1

Title Page ..... Page 2

Agency Mission ..... Page 4

Agency Goals ..... Page 5

Agency Objectives ..... Page 6

Agency Service Outcomes with Performance Projection Tables ..... Page 7

Linkage to Governor's Priorities ..... Page 13

Trends and Conditions

- Division of Health Quality Assurance ..... Page 14
- Division of Information Technology ..... Page 21
- Office of the Inspector General (Medicaid Program Integrity) ..... Page 23
- Division of Medicaid ..... Page 25
- List of potential policy changes affecting the Agency budget request or Governor's Recommended Budget ..... Page 33
- List of changes that would require legislative action ..... Page 35
- List of all Task Forces, Studies, etc., in progress ..... Page 36

Performance Measures and Standards (Exhibit II) ..... Page 40

Performance Measures Assessment (Exhibit III) ..... Page 45

Performance Measure Validity and Reliability (Exhibit IV) ..... Page 68

Associated Activity Contributing to Performance Measures (Exhibit V) ..... Page 92

Agency-Level Unit Cost Summary (Exhibit VI) ..... Page 101

Glossary of Terms and Acronyms ..... Page 103

Agency's Mission, Vision and Value Statements

Agency Mission

Better Health Care for all Floridians

Agency 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

Agency Values

- **Accountability** – We are responsible, efficient and transparent.
- **Fairness** – We treat people in a respectful, consistent and objective manner.
- **Responsiveness** – We address people's needs in a timely, effective, and courteous manner.
- **Teamwork** – We collaborate and share our ideas.

Agency Goals

Agency Goals *(in priority order)*	**Goal Descriptions**	**Programs Included ***
Goal 1	To operate an efficient and effective government	Health Care Regulation (Division of Health Quality Assurance) Information Technology *Health Care Services (Division of Medicaid)* *Administration and Support Services (Division of Operations)*
Goal 2	To reduce and/or eliminate waste, fraud and abuse	Executive Direction/Support Services (Inspector General – Medicaid Program Integrity)
Goal 3	To assure access to quality, and reasonably priced health services	Health Care Services (Division of Medicaid) *Health Care Regulation (Division of Health Quality Assurance)*

* The programs included above represent all Agency programs associated (directly or indirectly) with a respective goal. Programs primarily associated with a goal are listed first and those involved indirectly in achieving that goal are *italicized*.

Agency Objectives

Goal 1: To operate an efficient and effective government

Division of Health Quality Assurance

Objective 1.A: To receive 85 percent of all facility license renewal applications electronically via the Internet by FY (Fiscal Year) 2016-17.

Objective 1.B: To reduce by 50 percent the number of Division of Health Quality Assurance public records request processed by FY 2016-17

Objective 1.C: To increase the number of additional lives covered by health insurance.

Division of Information Technology

Objective 1.D: To maintain a 99.99 percent up-time availability of critical network services during normal business operations through FY 2016-17.

Objective 1.E: By FY 2016-17, 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.

Goal 2: To reduce and/or eliminate waste, fraud and abuse.

Office of the Inspector General (Medicaid Program Integrity)

Objective 2.A: To increase the amount of overpayments identified through detection activities at a rate of nine percent per year through FY 2016-17.

Objective 2.B: To increase the amount of overpayments prevented as a result of prevention activities conducted by the Bureau of Medicaid Program Integrity at a rate of five percent through FY 2016-17.

Goal 3: To assure access to quality, and reasonably priced health services.

Division of Medicaid:

Objective 3.A: To limit the growth in the per-member per-month (PMPM) expenditures to eight percent or less through FY 2016-17 under the Medicaid Reform 1115 Waiver.

Objective 3.B: By FY 2016-17, slow the growth in long-term care expenditures by $584 million through converting a portion of the institutional care budget to community-based long-term care.

Objective 3.C: To increase MediPass beneficiaries reported satisfaction with access to specialty care services to 85 percent by FY 2016-17.

Objective 3.D: To maintain or improve baseline performance on 100 percent of all outcome measures developed for the Long Range Program Plan by FY 2016-17.

Agency Service Outcomes and Performance Projections Tables

Division of Health Quality Assurance

Service Outcome Measure 1.A: The average annual number of license applications received electronically via the Internet.

Service Outcome Measure Projection Table 1.A:

Baseline Year FY 2008-09	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17
8,649	865	4,325	6,487	6,919	7,352
Percent of applications received via Internet	10%	50%	75%	80%	85%

The Agency currently receives all applications and renewals from health care facilities in paper copy. 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 progress. The 2006 Legislature passed the Health Care Licensing Procedures Act (Chapter 408, Part II, Florida Statutes) enabling the Agency to promulgate rules requiring electronic submission of documents (applications and renewals) 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 succeeded in other states as well as in other Florida agencies. The Agency is making progress with its “e-gateway” (web based) programming to implement online licensure application. The 2011 Legislature appropriated first-year funding for the three year project and the Agency anticipates implementation in late 2012.

Service Outcome Measure 1.B: The number of public records requests handled by the Agency’s Division of Health Quality Assurance.

Service Outcome Measure Projection Table 1.B:

Baseline Year FY 2010-11	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17
2,843	2,559	2,274	1,990	1,706	1,421
Percent of reduction in the annual number of public record requests processed by the Division of Health Quality Assurance	10%	20%	30%	40%	50%

This measure represents Agency efforts to streamline operations in order to enable increased productivity with existing resources which has resulted in decreased public records requests. Responses to public records requests have been reduced by more than half and can be attributed to the addition of inspection reports being placed online in a publicly available, searchable database attached to FloridaHealthFinder.gov.

Service Outcome Measure 1.C: The number of uninsured Floridians that have obtained insurance under Agency for Health Care Administration's sponsored programs.

Service Outcome Measure Projection Table 1.C:

Baseline Year FY 2008-09	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17
3,757	0	0	0	0	0

The Agency recommends deleting this LRPP outcome measure. As of December 31, 2010, total enrollment in the Cover Florida Health Care Access Program was 6,385 members. However, the Cover Florida Health Plans ended their contracts by the end of 2010 due to Affordable Care Act conflicts. Enrollees were provided with the appropriate notice and over the course of 2011 most will have transitioned out of these plans.

Division of Information Technology

Service Outcome Measure 1.D: Percent of availability of critical network services ("up-time") to authorized users during normal business operations.

Service Outcome Measure Projection Table 1.D:

Baseline Year FY 2011–12	FY 2012–13	FY 2013–14	FY 2014–15	FY 2015–16	FY 2016–17
99.99%	99.99%	99.99%	99.99%	99.99%	99.99%

Mission critical network services include 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 1.E: The percentage of Agency for Health Care Administration secured e-mail verified through e-mail encryption server reporting.

Service Outcome Measure Projection Table 1.E:

Baseline Year FY 2011–12	FY 2012–13	FY 2013–14	FY 2014–15	FY 2015–16	FY 2016–17
95%	96%	97%	98%	99%	99%

Secure against disclosure – data shall be secured against a variety of threats, 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;
- Other threats as may be identified in rapidly evolving technology environment.

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Office of the Inspector General

Service Outcome Measure 2.A: Amount, in millions, of overpayments identified by the Agency for Health Care Administration

Service Outcome Measure Projection Table 2.A:

Baseline Year FY 2006-07	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17
$35.7*	$45.1	$46.5	$47.9	$49.3	$53.7
Projected Increase %	9%	9%	9%	9%	9%

**FY 2008-09 Report: The State's Efforts to Control Medicaid Fraud and Abuse*

Service Outcome Measure 2.B: Amount, in millions, of prevented overpayments to Medicaid providers (cost avoidance).

Service Outcome Measure Projection Table 2.B:

Baseline Year FY 2008-09	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17
$18.9	$23.0	$24.1	$25.3	$26.6	$27.9
Projected Increase %	5%	5%	5%	5%	5%

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Division of Medicaid

Service Outcome Measure 3.A: Target weighted per-member, per-month (PMPM) by State Fiscal Year

Service Outcome Measure Projection Table 3.A:

Baseline Year FY 2006-07	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17
$328.24 Projected PMPM with 8% Growth*	$482.29	$520.87	$562.54	$607.54	$656.14
$269.89 Actual PMPM	$396.55	$428.27	$606.95	$607.54	$609.20

**Assumes waiver is renewed for additional years*

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

Service Outcome Measure Projection Table 3.B:

Baseline Year FY 2005-06	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17
$2,423 Current LTC Projections	$3,252	$3,395	$3,544	$3,700	$3,863
$2,294 Revised LTC Projections	$2,872	$2,969	$3,069	$3,172	$3,279
$129 LTC Savings	$380	$426	$475	$528	$584

Table excludes Medicare nursing home crossover payments.

Service Outcome Measure 3.C: 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.C:

Baseline Year FY 2005-06	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17
68%	77%	80%	83%	85%	85%

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

Service Outcome Measure Projection Table 3.D:

Baseline/Year FY 2007-08	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17
33	15	18	20	20	20
N/A Number of outcome measures maintained or improved	12	16	19	20	20
N/A Percent of outcomes maintained or improved	80%	89%	95%	100%	100%

NOTE: Not all of the Agency's "approved" measures are actual outcomes (i.e., performance measures). Other measures are output measures, or counts, that do not have relevant performance goals attached. The Agency is re-evaluating current measures with the objective of recommending measure revisions and updates to bring them more in line with current and long-term programmatic goals.

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Linkage to Governor's Priorities

Governor's Priorities	Agency Goals
1. Accountability Budgeting	Goal 1: To create an efficient and effective government Goal 2: To reduce and/or eliminate waste, fraud, and abuse. Goal 3: To assure access to quality, and reasonably priced health services
2. Reduce Government Spending	Goal 1: To create an efficient and effective government Goal 2: To reduce and/or eliminate waste, fraud, and abuse. Goal 3: To assure access to quality, and reasonably priced health services
3. Regulatory Reform	Goal 1: To create an efficient and effective government Goal 3: To assure access to quality, and reasonably priced health services
4. Focus on Job Growth and Retention	Goal 1: To create an efficient and effective government
5. World Class Universities	None Applicable – However, achieving Agency goals may have an indirect benefit to the Governor's priority of achieving world class universities.
6. Reduce Property Taxes	None Applicable – However, achieving Agency goals may have an indirect benefit to the Governor's priority of reducing property taxes.
7. Eliminate Florida's Corporate Income Tax Over Seven Years	None Applicable – However, achieving Agency goals may have an indirect benefit to the Governor's priority of eliminating Florida's corporate income tax over seven years.

Trends and Conditions Statements

Division of Health Quality Assurance

The Division of Health Quality Assurance shares the Agency's mission of "Better Health Care for All Floridians" through its regulatory oversight of regulated health care providers. The Division strives to maximize Agency resources by operating more efficiently and effectively to achieve required outcomes and streamline health facility regulations.

Rising Health Care Costs

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)

Although health care spending in the U.S. grew at a historic low of 3.9 percent in 2010, the federal Centers for Medicare and Medicaid Services (CMS) estimates healthcare spending in the U.S. will grow faster than gross domestic product by 1.1 percent over the next 10 years (5.8 percent). Growth in private health insurance is expected to increase by 4.9 percent over the next 10 years. (National Health Spending Projections Through 2020: Economic Recovery And Reform Drive Faster Spending Growth, From the Office of the Actuary, Centers for Medicare and Medicaid Services, July, 2011)

Stretching Resources in Tough Economic Times

Given the current economic climate, the Agency continues to be proactive in focusing on mission critical functions while reducing regulatory burdens. Legislation approved in 2009 allowed the Agency to eliminate duplicative licensing for clinical laboratories that perform only waived testing and registration for utilization review agents. This eliminated redundant federal/state requirements. Although the State remains 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, these efficiencies eliminate the duplicative licensing workload issues previously associated with these facilities.

Additional efficiencies have been obtained through streamlining. The 2010 Legislature passed House Bill 7069 (Chapter 2010-114, Laws of Florida), requiring all background screening to use electronically obtained fingerprints and expand the types of disqualifying crimes for those with direct access to health care facility residents/patients. 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 independent vendor was used to fulfill the new requirements. The number of background screenings processed for licensure rose from 66,111 in FY 2009-10 to 209,012 in FY 2010-11. The Agency handled this workload growth without additional resources through increased technology efficiencies and private sector participation.

Health Care Facilities, Staffing, and Licensure Issues

The Agency licenses, investigates, reviews, evaluates, monitors, and surveys facilities and approves facilities' construction plans, while it strives 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.

Long Term Care Facilities

While Florida had the largest national percentage of its population over 65 years of age for many years, recent 2010 US Census data shows this is no longer the case. In the last decade, Florida's population increases have been fueled by working age adults. The population will continue to age due primarily to the aging of the baby boom population, but increases in the percentage of older residents have shifted from primarily in-migration of young retirees to aging in place. 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 project the 85+ population in eight of the 11 areas will more than double by 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 other states. In fact, Florida's over-85 population is already almost double the national average and the annual growth of its 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 statewide use rate for nursing homes has declined steadily since 2000. In 2000, there were 8,849 nursing home resident days per 1,000 Floridians aged 65 and over and by 2010, the use rate declined to 7,618 days per 1,000. As of April, 2011, there were 79,429 licensed and 952 approved community nursing home beds in Florida. Medicaid occupancy for 2010 was 61.33 percent and total occupancy was 87.43 percent.

There is also a federal component to the nursing home quality assurance program. The Government Performance and Results Act of 1993 was intended to hold Federal agencies accountable for achieving program results. The Act required initiation 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 has reduced in the use of restraints from 9.3 percent in 2003 to 4.1 percent in 2009. Pressure ulcer incidence is down from 9.7 percent in 2003 to 8.6 percent in 2009. While the progress for pressure ulcer reduction is not as dramatic as that for restraints, this data represents 796 fewer people with pressure ulcers as of the end of 2009.

Another Federal (CMS) effort to improve the quality of long term care has begun, called "Positive Action Critical Thinking" (PACT). PACT is a pressure ulcer reduction initiative underway in the Southeast CMS region (Region IV). States participating in this initiative coordinate with nursing home, hospital and other health care providers to improve the continuum of care particularly in the area of pressure ulcer prevention. The Agency began this initiative by focusing on South Florida (Miami-Dade County), and has since 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 Division of Health Quality Assurance is accomplishing more with the same or reduced resources, as evidenced in Table 1-1. Over the past ten years, the Division has received reduced appropriations while, over time, full time equivalent (FTE) positions have been increased and then reduced. Although the makeup of positions has changed over time with program and priority shifts, the number of FTE for FY 2011-12 is 616, two less than the Division had in FY 2002-2003 after the Medical Quality Assurance function was transferred to the Department of Health. Two of those 616 positions are associated with HB 945, passed by the 2010 Legislature, which requires additional survey activities associated automated external defibrillators in certain assisted living facilities. (See Table 1-1) Over this same time period, the Division's complement of licensed, registered, certified and regulated service providers and facilities has more than doubled from 21,409 to 44,229. (See Table 1-2) Technology improvements have enabled the Agency to document licensees that fail to renew their licenses each year. In 2009, 2,330 providers failed to renew, while 2,127 failed to renew in 2010. Net increases in the number of providers have occurred year after year despite the fact that five to ten percent of licensees are failing to renew each year.

Table 1-1: Budget Appropriations for FY 2001-02 through FY 2011-12

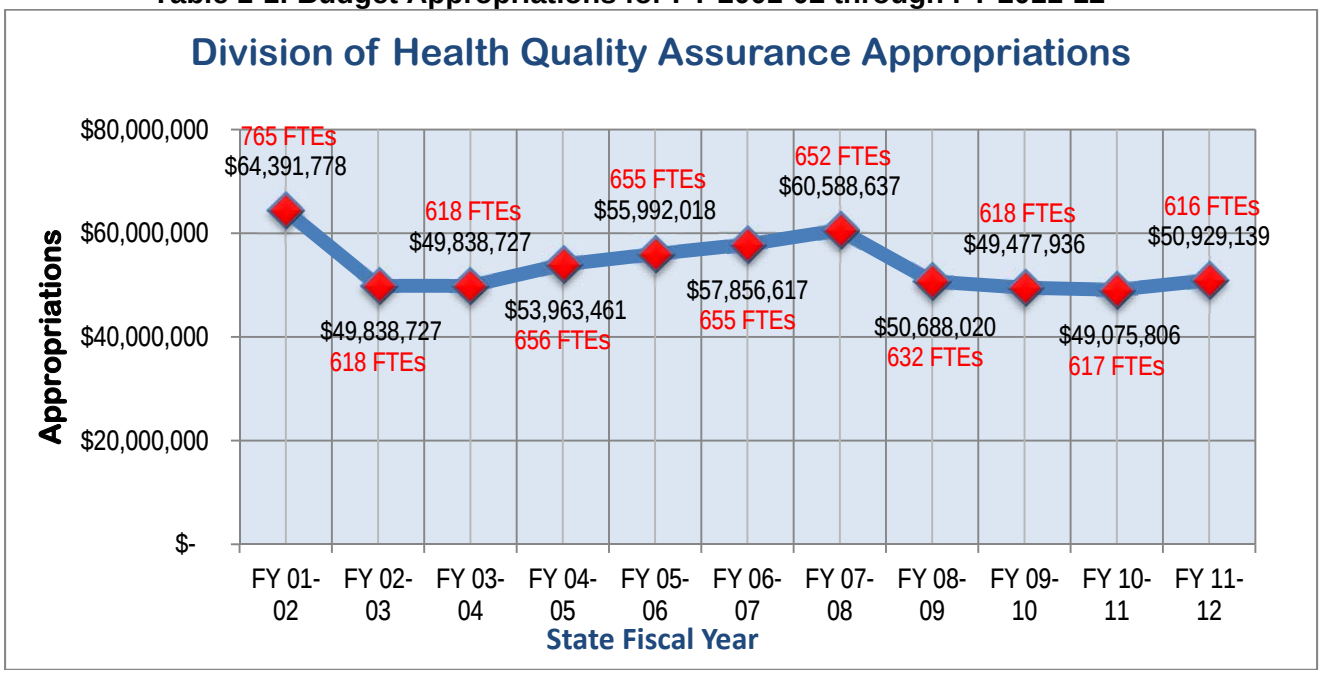
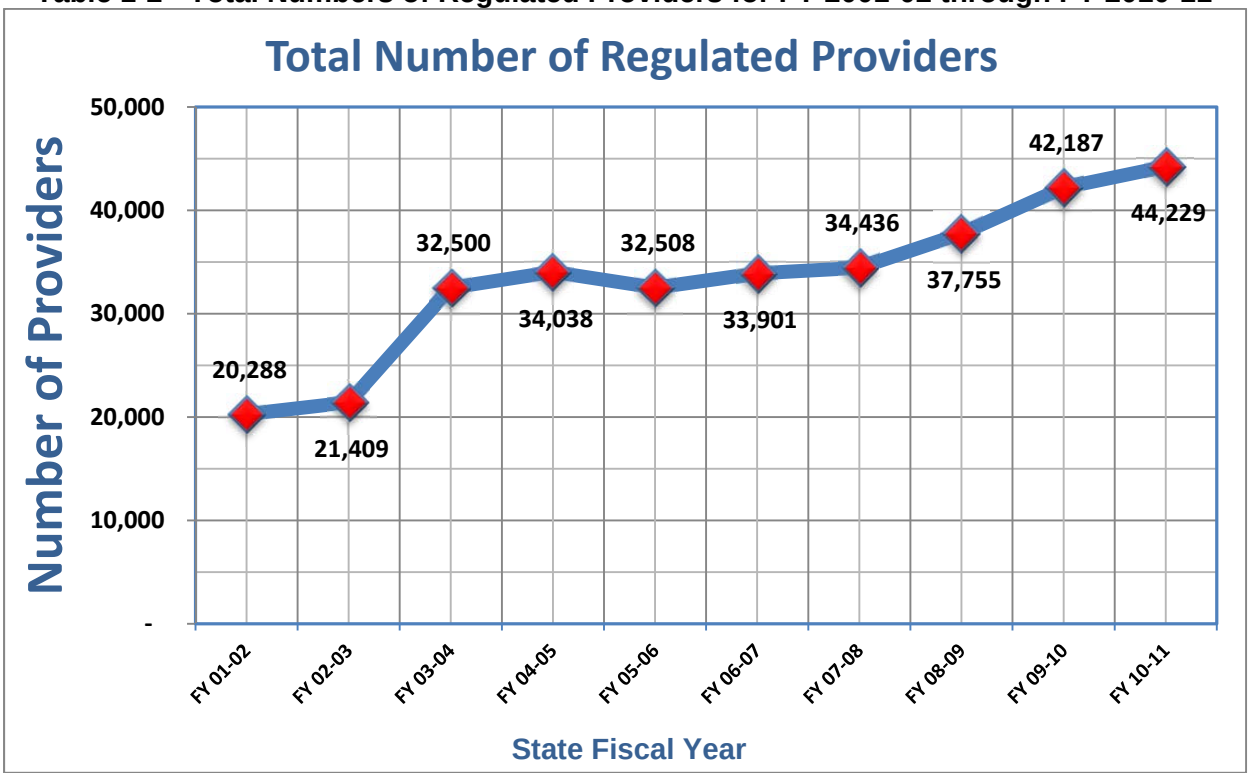


Table 1-2 - Total Numbers of Regulated Providers for FY 2001-02 through FY 2010-11



The 2009 Legislature passed Senate Bill 1986, addressing both regulatory reduction and fraud/abuse prevention, primarily due to fraud associated with the extraordinary number of home health agencies in Miami-Dade County. Consequently, the number of home health agencies in Miami-Dade was reduced from more than 900 in 2009 to 784 in August of 2011. This reduction is attributed in part to new regulatory provisions that were enacted in 2009.

The 2010 and 2011 Legislatures also passed legislation requiring licensure of pain management clinics, thus increasing the number of Agency-licensed clinics. Pain management clinics which are not wholly-owned (100 percent) by medical and osteopathic physicians must be licensed by the Agency 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 2010 and 2011 Legislative sessions, the Agency attempted to secure passage of additional regulatory reduction and fraud/abuse prevention provisions. House Bill 1143 was passed by the 2010 Legislature but vetoed by Governor Charlie Crist. In 2011, House Bill 119 passed the House on the last day of session, by was not approved by the Senate before Sine Die.

The Agency is pursuing this legislation again during the 2012 Legislative session. The potential legislation makes general changes to all statutes governing health care facilities and providers licensed or registered by the Agency.

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. 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

One of the Agency's primary goals is to use technology advances in order to better serve its constituents while maximizing current resources. Over the past several years, streamlining has occurred with the implementation of the following:

- an enhanced electronic background screening system;
- electronic fingerprinting;
- a new document management system using Laser fiche technology;
- improvements in the Versa Regulation licensure and enforcement system; and,
- integration of federal survey tracking and enforcement information.

Increasing amounts of information have been placed on the Internet through the www.FloridaHealthFinder.gov website, allowing access to survey reports and enforcement actions by the general public for use in making health care decisions. This increases transparency while reducing staff workload on responding to public records requests.

One of the automated system benefits 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 Agency has been expanding and refining the automated licensure system, while improving and expanding the Agency information available on the Internet. Internet improvements 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.

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.

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. It will also incorporate a seamless interface with delinquent money owed to the Agency to facilitate collection before licenses are issued or renewed. The Agency has been moving steadily in this direction for the last decade and the 2011 Legislature appropriated first-year funding for the three year online licensing project. Funding will allow the Agency 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 in an industry that is not only growing, but with an increasing percentage of providers that open, close and re-open.

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. These reports provide facility information and the Agency anticipates expanding the types of documents available online to improve consumer information. These efforts include linking documents to the appropriate resources and consolidating multiple pieces of information into a single location on the Agency Web site.

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. The Agency is charged with monitoring plan networks, quality, accreditation, providing assistance to consumers through the Subscriber Assistance Program and specific monitoring and oversight of Medicaid health plans for compliance with the Medicaid contract. Oversight of Medicaid health plans includes seven Provider Service Networks (PSNs) that are not also regulated by OIR.

As of July 2011, there were 39 licensed Health Maintenance Organizations (HMOs), five Prepaid Health Clinics (PHCs), and seven Exclusive Provider Organizations (EPOs) in Florida. As of March 31, 2011, 21 HMOs offered commercial managed care, 28 provided a Medicare product and 19 offered Medicaid plans.

The following statistics are based on data available for the HMOs in 2010. Enrollment in Florida's HMOs showed a decline from 4.5 million in 2001 to 3.5 million in 2010 (December 31, 2010, Managed Care Quarterly Data Summary). The HMO with the largest market share at the end of 2010 was Humana with 493,768 enrollees, followed by WellCare (including the two Medicaid plans HealthEase* and Staywell) with 475,634 enrollees and Aetna with 364,282 enrollees. *HealthEase generally reports separate enrollment figures to the Agency and OIR, although it is a wholly owned subsidiary of the same parent organization. The Office of Insurance Regulation reported that Florida HMOs had increased profits from $575 million in 2009 to $675 million for 2010.

A total of 19 HMOs and seven Provider Service Networks (PSNs) contract with Medicaid to provide services in 48 Florida counties. Enrollment in Medicaid HMO and PSNs has grown with the increases in Medicaid recipients related to the economy and as plans expand into additional counties. Overall Medicaid managed care enrollment is up from 1.1 million in July 2010 to 1.36 million in July 2011. The Agency's oversight includes but is not limited to the assessment of care quality as measured by the Health Plan Employer Data and Information Set (HEDIS) quality of care measures and by the requirements for national accreditation.

During FY 2011-12 and beyond, the Agency will be designing and implementing new regulations related to expansion of the Medicaid Managed Care Program to include statewide enrollment of Medicaid recipients in Long Term Care Managed Care and Medical Assistance Managed Care. Development of standards in the Invitations to Negotiate (ITNs) will be critical to the State's ability to monitor and regulate performance. Use of encounter data will be more robust and will allow closer scrutiny of managed care outcomes. It will allow for more refinement and enforcement of network adequacy and access standards as most Medicaid recipients gain access to health care through these arrangements.

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.

Strategic Planning, Vision, Oversight

The Agency is committed to using technology as an effective tool in furthering its overall goals and objectives. The Division of Information Technology functions as a partner in Agency strategic planning and vision creation.

The established Agency framework facilitates an efficient and effective 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 and align with the Agency's priorities. This ensures IT projects are designed to fulfill current or immediate needs and serve the Agency's mission in the future. This approach also standardizes the proper vetting of options along with performance measures with costs and benefits prior to implementation.

Continuity of Operations Plan

As health care needs evolve, the Agency continues to actively prepare for conditions that threaten to disrupt normal operations. Natural disasters and pandemics, though rare, are a real threat. To mitigate the risk of major disruptions in service, the Agency is in the process of providing mobile computing devices and technologies (laptops, tablets, Virtual Private Network

(VPN), etc.) 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.

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 and state level;
- the increasing importance of securing data from threats and disclosure; and the
- IT public sector labor market.

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 health care industry sector 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 disparate systems;
- Health Information Exchange capabilities; and
- Automation of regulatory processes.

The second strong influence on the Agency is comprised of two trends: 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 of 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. 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 recognizes the importance of data security and developing programs and strategies to secure data. The Agency's Computer Security Incident Response Team (CSIRT) is at the forefront of coordination with the Agency for Enterprise Information Technology in its operations. Despite success, the risk of security breaches from unintentional human mistake or lack of compliance by users must be better mitigated. Objective 1.E 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 Agency security standards on access, encryption, backup, etc.

The final influence 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 trends that jeopardize the Agency's ability to retain or hire qualified staff. When combined with the need to aggressively apply technology to lower costs, as well as the increasing responsibility and rising complexity of securing data, the impact of understaffed or under qualified IT staff is the most significant influence on the Agency's IT planning and

execution. The general IT landscape grows more complex each year and the range of skills needed today is much greater, making recruiting and retaining qualified staff more difficult than ever before.

In summary, 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. The Agency's commitment to technology and its potential demonstrates that appropriate attention and investment yields great benefits.

Statutorily Required AHCA Primary Data Center Consolidation Relocation and E-mail Consolidation

A legislatively mandated state data center consolidation effort is underway where a state designated primary data center, the Northwood Shared Resource Center (NSRC) is expected to house the current AHCA primary data center by July, 2012. Further, an expedited State initiative for state-wide e-mail consolidation is also underway during FY 2011-12. Considerations regarding these initiatives must be focused on risk analysis/mitigation, federal statutory compliance and any increased Agency budget costs that result.

Significant transition planning will need to be completed before moving the Agency data center. The Florida AEIT is assisting AHCA in planning coordination but much of the responsibility remains with the Agency. A Legislative Budget Request (LBR) issue was submitted as part of the Agency's FY 2012-13 LBR.

Outcomes

The Division's goal and objectives indirectly, but critically, affect all Florida health care consumers. The Division is responsible for supporting ongoing Agency operations and plays a significant supportive role. Without reliable technology infrastructure and applications, no modern state Agency is able to fulfill its mission. Particularly in the health care sector, technology holds the promise of helping the Agency to deliver better services faster, and at a lower cost. Accomplishing these IT objectives will be vital in helping the Agency fulfill its mission and achieve its goals.

Office of the Inspector General - Medicaid Program Integrity

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 Bureau of Medicaid Program Integrity (MPI).

The Florida Medicaid program is a $21 billion program with an estimated total of 114,000 providers providing Medicaid services to approximately 3.1 million beneficiaries during FY 2011-12. Section 409.913, Florida Statutes and Title 42, Code of Federal Regulations (CFR) mandates that the Agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible and to recover overpayments and impose sanctions as appropriate.

In the Medicaid program, the key indicator of fraud and abuse is overpayments. The Bureau of Medicaid Program Integrity (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, MPI continues to ensure the Medicaid program is managed in accordance with state and federal mandates.

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). 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.

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.

All Agency divisions 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 involved organizations help 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 resources may not be adequate to meet all of the anticipated challenges the Agency will encounter during the next five years covered by this Long Range Program Plan (LRPP). Additional resources could increase overpayments recouped and enhance return on investment.

In the normal course of business and to accomplish Agency 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 Agency divisions, 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 website. 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.

Prevention, Detection and Recovery

MPI strives to increase prevention, detection, and recovery efforts in order to identify improper billing and fraudulent schemes in the Medicaid program. During FY 2009-10, MPI prevention efforts resulted in cost savings of $19.8 million. Actual overpayments recovered total $58.5 million for the same fiscal year.

Prevention - Prevention efforts enhance the efficiency of the Medicaid Program in that detection, auditing and recovery of overpayments become unnecessary (cost avoidance). Stopping overpayments before they happen avoids recovery costs and allows those funds to be used as intended.

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.

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.

Division of Medicaid

Authority for the Florida Medicaid Program is established in Chapter 409, Florida Statutes (F.S.), (Social and Economic Assistance) and Chapter 59G (Medicaid) of the Florida Administrative Code. The statutes that mandate the management and administration of state and federal Medicaid programs, child health insurance programs, and the development of plans and policies for Florida's health care industry include Chapters 20, 216, 393, 395, 400, 408, 409, 440, 626 and 641, F.S. Medicaid must meet federal standards or obtain a federal waiver to receive federal financial program participation. Although federal participation rates vary each year, in FY 2010-11, 64.82 percent of the expenditures for most Medicaid services are reimbursed with federal funds. 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 population profile (age) and economic conditions that impact employment and income. In April, 2010, the U.S. Census Bureau estimated Florida's population to be 18.8 million, making it the fourth most populous state in the nation. Projections indicate that Florida will become the third most populous state by 2025; its growth rate has been among the fastest in the nation for decades.

At the time of the 2010 U.S. Census, Florida had the highest percentage (17.2 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 2010-11, it is estimated that Medicaid will have served 2.9 million beneficiaries and paid claims to approximately 80,000 active providers. With a budget of $21 billion in FY 2011-12, Medicaid is the largest single program in the State budget, accounting for more than 30 percent of the State's total. It is also the largest source of federal funding for the State. Medicaid

caseloads in FY 2010-11 were more than 62 percent higher than a decade ago. The caseload increased by 8.1 percent in FY 2010-11 over the prior fiscal year and is projected to increase in FY 2011-12 by more than 8.7 percent compared to FY 2010-11. The caseload increases in recent years reflect external factors not within the Medicaid program's control, especially the economic downturn and the resulting statewide unemployment rate.

In the last ten years, Florida Medicaid program costs more than doubled from almost $10.2 billion in FY 2001-02 to $21 billion budgeted in FY 2011-12, 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 2011-12 are: Hospital Inpatient Services ($4.2 billion), Prepaid Health Plans ($3.2 billion), Nursing Home Care ($2.7 billion), Prescription Services ($2.0 billion), Supplemental Medical Insurance ($1.3 billion), Physician Services ($1.2 billion), Hospital Outpatient Services ($1.1 billion), Low Income Pool ($1.0 billion), and Home/Community Based Services ($1.0 billion).

During FY 2009-10, the Florida Medicaid Management Information System (FMMIS) received full federal certification from the Centers for Medicare and Medicaid Services (CMS), allowing Florida to receive the maximum federal funding of 75 percent to operate the system.

Medicaid - Transition to Managed Care

The 2011 Legislature passed House Bill 7107 (CS/HB 7107) directing the Agency to implement the Medicaid managed care program as a statewide, integrated managed care program for all covered medical assistance services and long-term care services. This program is hereafter referred to as the Statewide Medicaid Managed Care program (SMMCP).

The 2011 Legislature also passed House Bill 7109 (CS/HB 7109) containing conforming sunset provisions, outlined several programs ancillary to the SMMCP, established interim programs designed to sunset with full SMMCP implementation, and required the Agency to develop a reorganization plan in concert with the program's transition to the SMMCP. Both bills were signed into law by Governor Scott on June 2, 2011.

These bills are codified as follows: CS/HB 7107 as Chapter 2011-134, Laws of Florida and CS/HB 7109 as Chapter 2011-135, Laws of Florida. For the remainder of this document, these bills are simply referred to as HB 7107 and HB 7109.

HB 7109 requires the Agency to develop a reorganization plan, due to the Governor, Speaker of the House of Representatives, and the President of the Senate by August 1, 2011, for "realignment of administrative resources of the Medicaid program to respond to changes in functional responsibilities and priorities necessary for implementation of HB 7107." The plan is required to "assess the Agency's current capabilities, identify shifts in staffing and other resources necessary to strengthen procurement and contract monitoring functions, and establish an implementation timeline." The reorganization plan was submitted on August 1, 2011.

Current Structure - Division of Medicaid

Core functions of the Division can be summarized as the development and maintenance of coverage and reimbursement policy; monitoring of contracts, program compliance, and quality; rate setting and budgeting; recipient and provider assistance; and systems driven data and claims processing.

Current Capabilities and Functional Responsibilities

Since its inception, the Florida Medicaid program has evolved into a complex model with an array of programs, waivers, and delivery systems through which recipients receive care. These delivery systems for covered medical services include fee-for-service, primary care case management (offered in Florida through the MediPass program), managed care under a capitated health maintenance organization (HMO) or a provider service network (PSN) reimbursed on either a fee-for-service (FFS) or capitated basis. Recipients who also require long-term care services may receive additional services through a home and community based services (HCBS) waiver, if eligibility criteria are met. If a recipient meets level of care criteria for nursing home coverage, the recipient can receive nursing home and other long-term care services (including home and community based services).

Managed care organizations and PSNs have played an ever-increasing role in Medicaid service delivery since the first Medicaid HMO was established in Florida in 1984. The Agency has extensive experience with the managed care delivery system and currently has almost 1.4 million recipients enrolled in Medicaid managed care plans. Enrollees in managed care now account for approximately 47 percent of all enrollees**.** Figures 3-1 and 3-2 show the statewide distribution of enrollment by delivery system as of June 1, 2011. While it might appear that 47 percent managed care enrollment represents a minority of the Medicaid population, the total Florida Medicaid population includes individuals who are excluded from managed care enrollment under the current program.

Figure 3-1: June 1, 2011 Florida Medicaid Enrollment by Delivery System

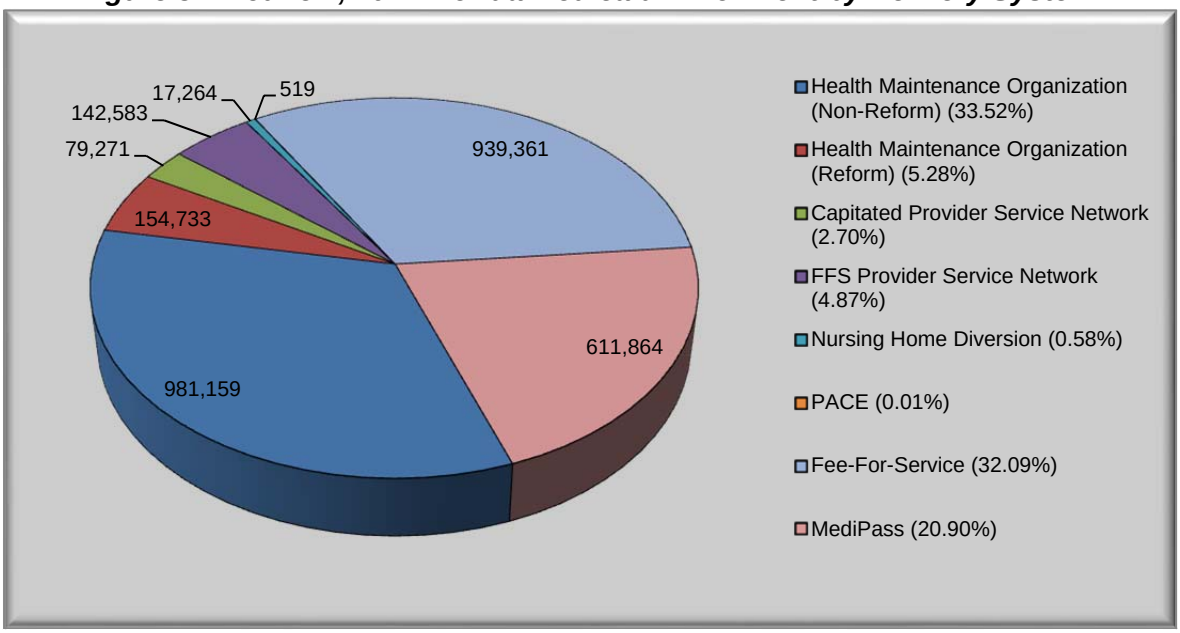
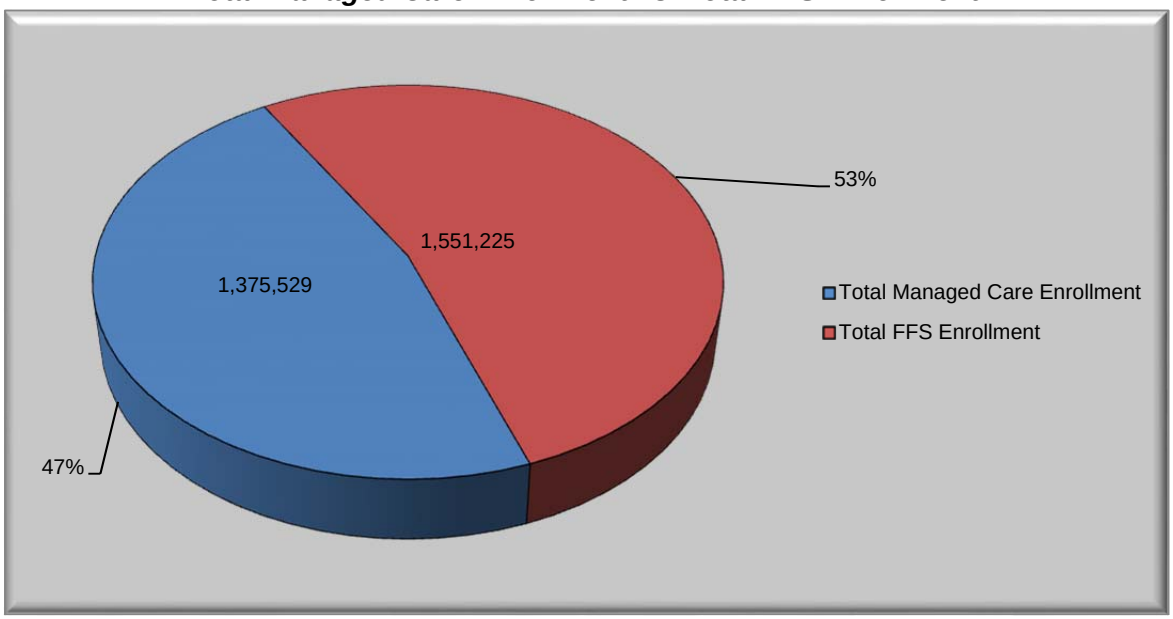


Figure 3-2: June 1, 2011 Florida Medicaid Enrollment – Total Managed Care Enrollment vs. Total FFS Enrollment



Future Roles and Functional Responsibilities

As Medicaid transitions to the SMMCP, many of the current FFS functions will transition with the program into managed care roles and responsibilities to support the increased need for procurement and contract compliance/monitoring functions. Additional staff positions will be needed for oversight activities to ensure accountability of plan operations.

A baseline staffing analysis of current roles and responsibilities, coupled with an analysis of the resource needs associated with implementation efforts and maintenance of current and bridge programs during implementation, shows that little shift will occur during Years one (FY 2011-12), two (FY 2012-13), and three (FY 2013-14) of program implementation.

However, upon full program implementation in year four (FY 2014-15), there will be a significant shift toward contracting, contract compliance/monitoring and policy-related functions. Current Agency responsibilities, such as prior authorization, utilization management, and program and provider monitoring under FFS will primarily become the responsibility of the managed care plans. Even with the significant shift, Medicaid and the Agency will continue other core functions such as policy, administration, systems maintenance, data collection and analysis, and provider and recipient assistance. Despite the shift to a staffing more focused primarily on managed care, certain Medicaid enrollees will still have the option to receive services through the Florida Medicaid FFS program. Coverage and reimbursement policy-related functions will remain, for both the FFS population and managed care population (capitated rate setting), regardless of the transition to a primarily managed care environment. As a result, functions currently dedicated to FFS activities will remain, but with fewer staff dedicated to those roles.

Staffing analysis results for FY 2011-12 through FY 2013-14 (years one, two, and three) indicate minimal shift in staffing roles and responsibilities as during this period the state will maintain almost all current programs, implement bridge programs required to occur prior to implementation of the SMMCP and undertake implementation of the SMMCP. However, it does

indicate the potential need for additional resources during implementation while maintenance of current programs is still required.

While some resources will be released from current duties based on sunset provisions that occur during Years one through three, additional needs associated with implementation of bridge programs, transition and pre-implementation activities will be significantly greater than the resources made available. During the transition period, the Agency will continually evaluate resources and staffing capabilities to enhance monitoring of managed care plans and expand focus on outcomes and quality to ensure accountability and value for the state.

The transition of Medicaid to a predominantly managed care program provides the Agency an opportunity to competitively bid health plan contracts, develop contract standards for quality and access and focus efforts on monitoring activities. Process changes that accompany the shift to managed care will enhance current monitoring capabilities, improve plan accountability and allow an increased focus on quality outcomes. These process changes include implementing the new procurement processes, adding greater financial accountability requirements including incentives, as well as an increased emphasis on network adequacy and program integrity to improve the overall quality of care.

As a result, during years one through three, the Agency will enhance and create new processes to focus on contract monitoring and accountability. This analysis will include an evaluation of current functional activities, needed skill sets and the need to reclassify or request new positions. For example, as part of contract compliance/monitoring, the Agency anticipates additional focus on analysis of data for quality and audit purposes. To ensure the appropriate skill set, the Agency will develop legislative budget requests for resources.

Full program implementation will occur in year four and the majority of sunset provisions contained in HB 7109 will be effective October 1, 2014. These provisions will release staff currently responsible for programs scheduled to sunset and reassign them to enhanced procurement and contract compliance/monitoring duties under the SMMCP. However, beyond a known shift to primarily managed care related roles, total staffing needs for outer years are difficult to predict at this point. There are many external factors that can impact Medicaid enrollment, including economic and political changes, and potential implementation of the Affordable Care Act (ACA).

Moving Forward with Transition

Together, HB 7107 and HB 7109 contain a comprehensive expansion of managed care on a statewide basis for most Medicaid recipients.

HB 7107 directs the Agency to implement the Medicaid managed care program as a statewide, integrated managed care program for all covered medical assistance services and long-term care services. It is established that the Agency is to administer this program.

The SMMCP has two key program components: the Managed Medical Assistance program and the Long-term Care Managed Care program. For each component, the legislation establishes parameters for the following:

- Regional Procurement
- Implementation Timeline
- Procurement Methods
- Minimum and Maximum Number of Plans

- Plan Types and Qualifications
- Eligible and Excluded Populations
- Plan and Provider Reimbursement
- Covered and Excluded Services
- Network Requirements and Plan Accountability
- Data Analysis
- Quality Monitoring

The Agency is directed to begin program implementation by July 1, 2012, with full program implementation by October 1, 2014. During the implementation period, the Agency will maintain current programs, implement "bridge" programs, and implement the SMMCP.

Based on the baseline assessment, the Agency evaluated current workload and functions related to the current managed care and FFS programs. It is notable that the work distribution is very similar for the following activities:

- Administration
- Policy
- Recipient Assistance
- Provider Assistance
- File/System Maintenance

Consistent with a survey of other states' Medicaid managed care programs, the major shift in transitioning to managed care is anticipated to be related to the following:

- Increase in contracting
- Decrease in program monitoring of FFS providers
- Increase in data analysis
- Increase in outreach, education and training materials

As a result of the full implementation of the SMMCP program in 2014, enrollment in the Florida Medicaid program is likely to shift from its current level of 47 percent enrolled in managed care to nearly 85 percent enrolled in managed care. During the implementation period, now through full program implementation in October 2014, the Agency will generally seek to implement the Long-term Care Managed Care program and the Managed Medical Assistance program in the following three phases: pre-implementation, transition, and post implementation.

Since this initiative spans multiple years, the Agency is making the following initial recommendations:

1. Increase Agency staffing and contract resources during the pre-implementation and transition periods to evaluate current and new functions and processes to implement and monitor contracted plans. Specific resources will be needed for data analysis, auditing, and enhanced quality focus.

2. Develop an internal evaluation process to update the staffing analysis, as Medicaid moves through pre-implementation and transition to the SMMCP.

    a. Years one, two, and three: Focus on reallocation of roles and responsibilities to manage "bridge" needs as well as maintaining current programs and preparing for implementation of the SMMCP, as program components are transitioned. Analysis will include the need to reclassify and/or request new positions to ensure the Agency

has the right skill sets. Anticipated resources and skill needs include contract compliance, data analysis and fraud and abuse prevention and detection.
   b. Year four: Focus on transition of staff from programs scheduled to sunset to procurement and contract monitoring functions.

3. Make annual recommendations to the Governor, Speaker of the House of Representatives and President of the Senate utilizing current legislative proposal and budget request processes. Specifically, the Agency anticipates annually evaluating and seeking appropriate authority based on the following:

   a. Staffing requests necessary to procure, implement and monitor interim activities, maintain necessary activities, and implement necessary changes for transition to the SMMCP.
   b. Need for contract resources for implementation.
   c. External changes that impact Medicaid enrollment and transition activities.
   d. Policy and budget changes necessary for program transition.

Planning for Diagnosis Code Conversion (ICD-9 to ICD-10)

The Agency has begun implementing the federally required changes in Medicaid policy and billing procedures (International Classification of Diseases (ICD)-9 to ICD-10). ICD-10 is a coding of diseases and signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases, as classified by the World Health Organization (WHO). Compliance with this standard set of diagnosis and inpatient hospital procedure codes will necessitate that the state revise not only the codes used, but the Medicaid policies that govern the application of the codes. These changes include major revisions of most provider coverage and limitation handbooks, reimbursement handbooks, Medicaid reporting to internal and external entities, Medicaid operating procedures, the rules that govern the administration of Medicaid policy, the Medicaid claims processing system, as well as changes to Medicaid fraud and abuse detection.

The ICD-10 federally required changes are applied to the entire US health care industry and represent a significant modification to diagnosis coding that all health care providers and payers must adopt. Medicaid policy and claims billing rules encompass a complex set of operations and standards. The Health Insurance Portability and Accountability Act (HIPAA) mandated that all providers and payers begin using the International Classification of Disease-10th revision (ICD-10) by October 1, 2013. This change represents for Florida Medicaid, as well as all health care entities, substantial modifications to business rules, coverage and limitations policy, and systems changes. The changes with the ICD-10 revision impact health care policy, business rules, and claims adjudication processes, and will have a direct effect on submitted health care claims and the resulting Medicaid claims payments.

This effort will encompass four major components:

1) Change Medicaid policy that governs the use of diagnosis and inpatient hospital procedure codes. The Agency must continue to procure the services of a consultant with sufficient expertise to guide policy specialists in determining the most appropriate application of the new coding system. Policy changes will necessitate the revision of Medicaid policy and reimbursement handbooks, as well as internal and external reporting mechanisms. Medicaid efforts in fraud and abuse detection will also require updating due to these changes. These expenditures will be eligible for 90% federal match.

2) Determine the most appropriate reimbursement rates for the new procedure code system in a budget neutral manner. The Agency must continue to procure services of a consultant with sufficient expertise to determine sound reimbursement rates for fee-for-service Medicaid providers. These expenditures are eligible for 90% federal match

3) Augment Fiscal Agent staffing provider call center and provider training for the ICD-10 transition. The Agency must also remain proactive in its relations with the more than 100,000 enrolled Medicaid providers regarding Medicaid policy changes and billing procedures and must enhance its current provider outreach and training program. The Agency must require the Medicaid Fiscal Agent to augment its staff and provider training materials to ensure that providers are fully apprised of the changes arising from the implementation of the ICD-10 code set. These expenditures will be eligible for 50% federal match.

4) Augment Fiscal Agent staffing for system changes for the ICD-10 transition. Additional system programmers are needed for the increase in work associated with the ICD-10 transition. These expenditures will be eligible for 90% federal match.

The ICD-9 to ICD-10 project is estimated to cost nearly $21 million to implement, but the Federal match ranges from 50% to 90% reimbursement. The Agency requested $8,523,257 year 2 funding in its FY 2012-13 LBR which will allow for the activities started in Year 1 to be completed, changes installed and testing performed in the Florida Medicaid Management Information System.

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List of Potential Policy Changes Affecting the Agency's Legislative 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
Health Quality Assurance			
1	Moving toward online licensure for health care providers	$2,322,800 – LBR issue – Agency Priority #6 The 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. This would allow 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). The project also integrates with all Agency fees, assessments, overpayments, and fines to facilitate full collection before licenses are issued.	If the LBR issue is not approved, the Agency would be unable to implement the online project solution. Further, integration with all Agency fees, assessments, overpayments, and fines to facilitate full collection before licenses are issued would be jeopardized.
2	Background Screening Expansion - Changes in law passed during the 2010 legislative session require persons seeking employment with a health care provider to have a Level 2 screening. The statutes also allow for the retaining of prints upon request if the FDLE has sufficient resources to support the program.	$472,309 – LBR issue – Agency Priority #5 Expand background screening capability with grant funds from Centers for Medicare and Medicaid Services (CMS). The Agency was awarded a grant with the Centers for Medicare and Medicaid (CMS) Services to implement additional background screening enhancements and expand provider types that would require employment screening.	If the LBR issue is not approved the Agency will be unable to accommodate the change in law and the entire grant must be refunded.

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
Division of Information Technology			
3	Primary Data Center	$1,467,401 – LBR issue – Agency Priority #4 This is a statewide issue to consolidate data center resources within the Northwood Shared Resource Center (NSRC) to comply with Ch.282.201, Florida Statutes. The Agency currently has a legislative request to move the Statutory move date from July 1, 2012 to December 31, 2012.	If the LBR issue is not approved, the Agency would incur additional transitional costs for moving the Agency Primary Data Center, which would have to be absorbed using existing resources.
Office of the Inspector General			
4	None		
Division of Medicaid			
5	Statewide Medicaid Managed Care Program	$7,782,294 – LBR issue – Agency Priority #1 This issue represents funding for program implementation of the Statewide Medicaid Managed Care Program pursuant to HB 7107 and HB 7109, passed by the 2010 Florida Legislature.	If this LBR issue is not approved, the Agency would have difficulty meeting the statutory requirements of implementing the Statewide Medicaid Managed Care Program.
6	ICD-9 to ICD-10 Conversion This federal HIPPA mandate represents a significant modification to diagnosis coding that all health care providers and payers must adopt. This affects Medicaid policy and claims billing rules, which encompass a complex set of operations and standards.	$8,523,257 – LBR issue – Agency Priority #2 This change represents for Florida Medicaid, as well as all health care entities, substantial modifications to business rules, coverage and limitations policy, and systems changes. The changes with the ICD-10 revision impact health care policy, business rules, and claims adjudication processes, and will have a direct effect on submitted health care claims and the resulting Medicaid claims payments.	If the LBR issue is not approved, risk of non-compliance with the federal HIPAA mandate that all providers and payers begin using the International Classification of Disease-10th revision (ICD-10) by October 1, 2013 would be increased.

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

Number	Proposed Changes	Describe Expected Results of Proposed Change	Describe Legislative Actions Required to Implement the Proposed Change
1.	Regulatory Reform	To reduce the regulatory burden on healthcare providers by streamlining processes and eliminating unnecessary reporting.	Statutory Change
2.	Medicaid Provider Accountability	To give the Agency the authority to impose additional or more restrictive requirements on Medicaid providers to maintain the integrity of the Medicaid Program	Statutory Change

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

Number	Implementing Bill or Statute	Task Forces and Studies in Progress	Required / Expected Completion Date
Administration and Support, and Executive Direction			
1	402.56, Florida Statutes	Florida's Children and Youth Cabinet	Ongoing responsibilities
2	420.622(9), Florida Statutes	Council on Homelessness	Ongoing responsibilities
3	s. 499.01211 F.S.	Drug Wholesale Distributor Advisory Council	Ongoing responsibilities
4	Florida Arthritis Program Web Site	Florida Arthritis Partnership (FLAP)	Ongoing responsibilities
5	(Chapter 1004.435, Florida Statutes).	Cancer Control and Research Advisory Council	Ongoing responsibilities
6	In May 2008, S.B. 2534 was signed into law	Florida Health Choices Corporation	Ongoing responsibilities
7	Chapter 627 F.S.	Florida Health Reinsurance Program	Ongoing responsibilities
8	409.810-409.821.F.S.	Florida Healthy Kids Corporation Board of Directors	Ongoing responsibilities
9	Part C of the Individuals with Disabilities Education Act (IDEA) as amended by Public Law 105-17.	The Florida Interagency Coordinating Council for Infants and Toddlers (FICCIT)	Ongoing responsibilities

Number	Implementing Bill or Statute	Task Forces and Studies in Progress	Required / Expected Completion Date
10	s. 216.0166 F.S	Florida Older Adults Workgroup	Ongoing responsibilities
11	s. 20.43, F.S	Florida Trauma System Plan Advisory Council	Ongoing responsibilities
12	Executive Order 08-36	The Governor's Task Force on Autism	Final Report submitted to the Executive Office of the Governor in March 2009 |
13	s. 381.0403 (9) F.S.	The Graduate Medical Education Committee (GMEC)	Ongoing responsibilities
14	Passage of Senate Bill 988/House Bill 793 during the 2008 Florida legislative session	Florida Health and Transition Services (HATS) Task Force	Ongoing responsibilities
15	s. 409.1451(7) F.S.,	Independent Living Advisory Council	Ongoing responsibilities
16	s. 381.87 F.S.	Florida Osteoporosis Prevention and Education Program	Ongoing responsibilities
17	s. 395.3025, 405.01, and 405.03 F.S.	Pregnancy-Associated Mortality Review (PAMR) Team	Ongoing responsibilities
18	Excerpt from 20 U.S.C. Chapter 33 IDEA 2004, P.L. 108-446	The State Advisory Committee for the Education of Exceptional Students (SAC)	Ongoing responsibilities
19	s. 427.013, F.S.	Commission for the Transportation Disadvantaged	Ongoing responsibilities
20	s. 14.20195, F.S.	Florida Suicide Prevention Coordinating Council	Ongoing responsibilities

Number	Implementing Bill or Statute	Task Forces and Studies in Progress	Required / Expected Completion Date
Health Quality Assurance			
21	s. 408.909 (9) F.S.	Annual report on Health Flex to be submitted jointly with the Office of Insurance Regulation	January 1, 2012
22	s. 408.7057(2)(g)2., F.S.	Annual Report on the Cases of the Statewide Managed Care Dispute Resolution Program	February 1, 2012
23	s. 400.191(2), F.S.	Nursing Home Guide Quarterly Report	February 15, May 15, August 15 and November 15, 2012
24	s. 408.9091(10), F.S.	Cover Florida Health Care Access Program Annual Evaluation to be submitted jointly with the Office of Insurance Regulation	March 1, 2012
25	S 429.19 F.S.	Assisted living facilities annual report of fines of $5,000 or more for violation of state standards	July 30, 2012
26	s. 395.10972 F.S.	Risk Managers Advisory Group – This is a standing advisory group that has not met in several years.	None
27	s. 408.0361(6), F.S.	Organ transplant programs advisory group	Nothing after 2005
28	s. 483.26, F.S.	Technical Advisory Panel (laboratory)	Ongoing meetings. Recent meeting details may be found at : AHCA: Laboratory Unit
29	s. 627.4236, F.S.	Bone Marrow Transplant Advisory Panel	Ongoing responsibilities
30	s. 483.26, F.S.	Clinical Laboratory Technical Advisory Panel	Ongoing responsibilities
31	s. 409.912, F.S.	Drug Utilization Review Board	Ongoing responsibilities
32	s. 288.0656, F.S.	Rural Economic Development Initiative	Ongoing responsibilities
33	s. 408.05(8), F.S.	Health Information Exchange Coordinating Committee	Ongoing responsibilities
34	s. 391.221 F.S.	Statewide Children's Medical Services Network Advisory Council.	Ongoing responsibilities
35	Governor Scott's Directive	Assisted Living Workgroup	August 31, 2012
36	s.402.281, F.S.	Governor's Panel on Excellence in Long-Term Care (Gold Seal Program)	Ongoing responsibilities
37	s.765.543, F.S..	Organ & Tissue Procurement and Transplantation Advisory Board	Ongoing responsibilities

Number	Implementing Bill or Statute	Task Forces and Studies in Progress	Required / Expected Completion Date
Office of the Inspector General			
38	409.913, FS	Statewide Provider and Subscriber Assistance Panel	Ongoing responsibilities
39	20.055(5)(h), FS	Joint report AHCA and MFCU documenting effectiveness of efforts to control fraud.	Annually / January 1
40	20.055(7), FS	Schedules engagement for the upcoming fiscal year.	Annually / September 30
41	Senate Bill 1986 (2009 Legislative Session)	Summary of all activities within the Inspector General's office for the previous fiscal year.	Annually / September 30
42	409.913, FS	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
Division of Information Technology			
	None		
Division of Medicaid			
43	409.91211 F.S.	Enhanced Benefits Panel	Ongoing responsibilities
44	409.818 F.S.	Florida KidCare Grievance Committee	Ongoing responsibilities
45	409.911 F.S.	Low Income Pool Council	Ongoing responsibilities
46	409.91211 F.S.	Medicaid Reform Technical Advisory Panel	Ongoing responsibilities
47	765.53 F.S.	Organ Transplant Advisory Council	Ongoing responsibilities
48	409.91195 F.S.	Pharmaceutical and Therapeutics Committee	Ongoing responsibilities
49	409.912 F.S.	Practitioner Prescribing Patterns Review Panel	Ongoing responsibilities
49	16.615 F.S.	Council on the Social Status of Black Men (membership only)	Ongoing responsibilities
50	393.002 F.S.	Florida Developmental Disabilities Council	Ongoing responsibilities
51	393.002 F.S.	Florida Developmental Disabilities Council's Health Care/ Prevention Task Force	Ongoing responsibilities
52	409.818 (3)(e) F.S.	KidCare Coordinating Council (membership only)	Ongoing responsibilities

Performance Measures and Standards
LRPP Exhibit II

LRPP Exhibit II - Performance & Standards

Department: AGENCY FOR HEALTH CARE ADMINISTRATION	Department No: 68000000			
Approved Performance Measures (Words)	**Approved Prior Year Standards FY 2010-11 (Numbers)**	**Prior Year Actual FY 2010-11 (Numbers)**	**Approved Standards for FY 2011-12 (Numbers)**	**Requested FY 2012-13 Standard (Numbers)**
Program: Administration and Support	**Code: 68200000**			
Service/Budget Entity: Executive Direction	**Code: 68200000**			
Administrative costs as a percent of total agency costs	0.11%	0.11%	0.11%	0.11%
Administrative positions as a percent of total agency positions	11.45%	11.07%	11.45%	10.94%
Program: Health Care Services	**Code: 68500000**			
Service/Budget Entity: Children's Special Health Care	**Code: 68500100**			
Percent of hospitalizations for conditions preventable by good ambulatory care	7.7%	N/A	7.7%	Delete
Percent of eligible children renewing Title XXI health care coverage*	N/A	73.7%	N/A	75.0%
Percent of children enrolled with up-to-date immunizations	85%	N/A[1]	85%	Delete
Percent of Children Ages 2-6 with a Reported Well-Child Visit in the Previous 12 Months	N/A	80.6%	N/A	90.0%
Percent of families rating their health plan a 9 or 10	N/A	62.0%	N/A	60.0%
Total number of children enrolled in Kidcare	228,159	252,447	228,159	Per Est. Conf.[2]
Number of uninsured children enrolled in Florida Healthy Kids	195,867	199,198	195,867	Per Est. Conf.
Total number of children enrolled in Florida Healthy Kids	195,867	199,198	195,867	Per Est. Conf.
Number of children enrolled in Medikids	21,000	29,435	21,000	Per Est. Conf.
Number of children enrolled in Children's Medical Services Network	10,053	23,005	10,053	Per Est. Conf.

Measures highlighted in **BLUE indicate revisions to existing measures. In each instance, the measure shown is similar in intent to existing measures but has been revised to include updated reporting requirements or to establish a measure in line with national standards.*

Approved Performance Measures (Words)	Approved Prior Year Standards FY 2010-11 (Numbers)	Prior Year Actual FY 2010-11 (Numbers)	Approved Standards for FY 2011-12 (Numbers)	Requested FY 2012-13 Standard (Numbers)
Program: Health Care Services		**Code: 68500000**		
Service/Budget Entity: Executive Direction and Support Services		**Code: 68500200**		
Program administrative costs as a percent of total program costs	1.44%	1.50%	1.44%	2.00%
Average number of days between receipt of clean Medicaid claim and payment	15	14.9	15	15
Number of Medicaid claims received	145,101,035	201,682,002	145,101,035	Per Est. Conf.
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

[1]Data Source KidCare Annual Report - Data not collected/reported in 2010/11
[2]Per Estimating Conference - Targets are set at estimating conferences and represent expected volumes (counts) rather than measurable performance outcomes.

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 (adults)	20%	17.8%	20%	20.0%
Percent of women receiving adequate prenatal care	86%	82.8%	86%	85.0%
Neonatal mortality rate per 1000	5	5.1	5	5
Percentage of women with an Interpregnancy Interval (IPI) greater than or equal to 28 months.	50%	57.2%	50%	50%
Percent of eligible children who received an EPSDT screening	64%	66%	64%	65.0%
Number of children ages 1-20 enrolled in Medicaid	1,249,276	2,108,295	1,249,276	Per Est. Conf.
Number of children receiving EPSDT services	407,052	529,729	407,052	Per Est. Conf.
Number of hospital inpatient services provided to children	92,960	191,325	92,960	Per Est. Conf.
Number of physician services provided to children	6,457,900	9,911,036	6,457,900	Per Est. Conf.
Number of prescribed drugs provided to children	4,444,636	6,553,967	4,444,636	Per Est. Conf.
Number of hospital inpatient services provided to elders	100,808	111,007	100,808	Per Est. Conf.
Number of physician services provided to elders	1,436,160	2,119,224	1,436,160	Per Est. Conf.
Number of uninsured children enrolled in the Medicaid Expansion	1,227	N/A	1,227	N/A

Approved Performance Measures (Words)	Approved Prior Year Standards FY 2010-11 (Numbers)	Prior Year Actual FY 2010-11 (Numbers)	Approved Standards for FY 2011-12 (Numbers)	Requested FY 2012-13 Standard (Numbers)
Program: Health Care Services		**Code: 68500000**		
Service/Budget Entity: Medicaid Services to Individuals		**Code: 68501400**		
Percent of hospitalizations for conditions preventable by good ambulatory care (adults)	20.0%	19.3%	20.0%	20.0%
Percent of hospitalizations for conditions preventable with good ambulatory care (children)	20.0%	30.1%	20.0%	30.0%
Number of case months services purchased (elderly and disabled)	1,877,040	202,344	1,877,040	Per Est. Conf.
Number of case months services purchased (families)	9,850,224	5,602,752	9,850,224	Per Est. Conf.
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	20.0%	13.4%	20.0%	20.0%
Number of case months (home and community-based services)	550,436	597,471	550,436	Per Est. Conf.
Number of case months services purchased (Nursing Home)	619,387	527,292	619,387	Per Est. Conf.
Program: Program: Health Care Regulation		**Code: 68700700**		
Service/Budget Entity: Health Care Regulation		**Code: 68700700**		
Percent of nursing home facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0%	2.4%	0%	0%
Percent of investigations of alleged unlicensed facilities and programs that have been previously issued a cease and desist order that are confirmed as repeated unlicensed activity	4%	0%	4%	4%
Percent of Priority I consumer complaints about licensed facilities and programs that are investigated within two business days.	100%	100%	100%	100%
Percent of accredited hospitals and ambulatory surgical centers cited for not complying with life safety, licensure, or emergency access standards	25%	9.7%	25%	25%

Measures highlighted in **BLUE indicate revisions to existing measures. In each instance, the measure shown is similar in intent to existing measures but has been revised to include updated reporting requirements or to establish a measure in line with national standards.*

Approved Performance Measures (Words)	Approved Prior Year Standards FY 2010-11 (Numbers)	Prior Year Actual FY 2010-11 (Numbers)	Approved Standards for FY 2011-12 (Numbers)	Requested FY 2012-13 Standard (Numbers)
Percent of validation surveys that are consistent with findings noted during the accreditation survey	98%	100%	98%	98%
Percent of assisted living facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0%	1.0%	0%	0%
Percent of home health facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0%	0%	0%	0%
Percent of clinical laboratories with deficiencies that pose a serious threat to the health, safety, or welfare of the public.	0%	0%	0%	0%
Percent of ambulatory surgical centers with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0%	5.0%	0%	0%
Percent of hospitals with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0%	5.9%	0%	0%
Percent of hospitals that fail to report serious incidents (agency identified)	6%	0%	6%	Recommend Deletion
Percent of complaints of HMO patient dumping received that are investigated*** *proposed revision: Percent of complaints of HMO access to care that are investigated.***	100%	0	100%	100%
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	4	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	7,344	7,550	7,550
Average processing time (in days) for Subscriber Assistance Program cases.	53	19	53	21
Number of construction reviews performed (plans and construction)	4,500	4,684	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 handled 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: Children's Special Health Care/68500100
Measure: Percent of children enrolled with up-to-date immunizations

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
85%	N/A	N/A	N/A

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect ☒ Other (Identify)
Explanation: Information previously reported has been based on a composite measure developed from the Annual KidCare Evaluation Report. Immunization information is not collected every year and was not collected for 2009-10.

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: KidCare and Medicaid should work with the Florida Department of Health to incorporate immunization data into the SHOTS database.

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
1.44%	1.5%	.06%	4%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect ☒ Other (Identify)
Explanation: The difference is negligible and within expected variation due to external factors beyond the Agency's control. It is also below the standard of 2% that the Agency has previously requested.

External Factors (check all that apply):
☐ Resources Unavailable ☐ Technological Problems
☒ Legal/Legislative Change ☐ Natural Disaster
☐ Target Population Change ☐ Other (Identify)
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
Explanation: Administrative costs could rise in the near future as a result of the implementation of Statewide Medicaid Managed Care and necessary administrative activities required due to transition.

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

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
85%	82.8%	2.2%	2.6%

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

External Factors (check all that apply):
☐ Resources Unavailable ☐ Technological Problems
☐ Legal/Legislative Change ☐ Natural Disaster
☐ Target Population Change ☒ Other (Identify)
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
Explanation: While the actual result is below the target, it represents an improvement over the previous year. The Agency is focusing on programs like the Family Planning Waiver and other educational activities to inform women of the importance of pre-natal care in birth outcomes.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: Agency should continue waiver and outreach/education programs.

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure: Neonatal mortality rate per 1000

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
5.0	5.1	0.1	2.0%

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

External Factors (check all that apply):
☐ Resources Unavailable ☐ Technological Problems
☐ Legal/Legislative Change ☐ Natural Disaster
☐ Target Population Change ☒ Other (Identify)
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
Explanation: The neo-natal mortality rates are highly variable and not always directly attributable to program policies. Poor birth outcomes can be linked to inadequacy of prenatal care, and unhealthy behaviors such as smoking during pregnancy, but can also be a result of hereditary and/or environmental factors beyond the Agency's control.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: Agency should continue waiver and outreach/education programs and coordinate with sister agencies to ensure mothers maintain healthy lifestyles, good nutrition, and seek appropriate prenatal care.

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
20%	30.1%	10.1%	50.5%

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

External Factors (check all that apply):
☐ Resources Unavailable ☒ Technological Problems
☐ Legal/Legislative Change ☐ Natural Disaster
☐ Target Population Change ☒ Other (Identify)
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
Explanation: The data source and difficulty identifying Medicaid managed care plan enrollees in the hospital discharge database creates an artificially small denominator. This in turn inflates the percentage reported.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☒ Technology
☐ Personnel ☐ Other (Identify)
Recommendations: The Agency will begin using the managed care plan encounter submissions to calculate future rates. In addition, the standard should be revised to reflect historical trends and the result of programmatic changes should the new methods demonstrate the need for change.

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%	2.4%	2.4% Over	2.4%

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

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☒ This Program/Service Cannot Fix the Problem
☐ Current Laws Are Working Against the Agency Mission
☐ Technological Problems
☐ Natural Disaster
☐ Other (Identify)
Explanation: Although this is a legitimate measure of facility performance, it is not a reasonable measure of Agency performance.

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

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

Office of Policy and Budget – July 2011

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 this measure to be deleted.

Office of Policy and Budget – July 2011

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

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

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

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

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

Office of Policy and Budget – July 2011

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
25%	9.7%	15.3% Under	62.1% Decrease

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect ☒ Other (Identify)
Explanation: While the number of accredited hospitals and ambulatory surgical centers remains fairly constant, the number of times these facilities were inspected is not a fixed number. Deficiencies cited during these inspections may run the gamut from minor to severe. The Agency can find and require correction of deficiencies, but cannot prevent those deficiencies from occurring.

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

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

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

Office of Policy and Budget – July 2011

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 this measure to be deleted.

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0%	0.9%	0.9% Over	0.9%

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

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

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

Explanation: 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 this measure to be deleted.

Office of Policy and Budget – July 2011

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

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

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

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

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

Office of Policy and Budget – July 2011

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

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

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect ☒ Other (Identify)
Explanation: 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 ☐ Technological Problems
☐ Legal/Legislative Change ☐ Natural Disaster
☐ Target Population Change ☐ Other (Identify)
☒ This Program/Service Cannot Fix the Problem
☐ Current Laws Are Working Against the Agency Mission
Explanation: The Agency has no control over whether there will be serious deficiencies. We can only site and require correction of these deficiencies.

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

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

Office of Policy and Budget – July 2011

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%	5.0%	5.0% Over	5.0%

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

Explanation: 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 this measure to be deleted.

Office of Policy and Budget – July 2011

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%	5.9%	5.9% Over	5.9%

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

Explanation: 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 this measure to be deleted.

Office of Policy and Budget – July 2011

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
6.00	0.00	Under	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: There are no internal factors that impact the Agency's ability to meet this standard.

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

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

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

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

Office of Policy and Budget – July 2011

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Bureau of Managed Health Care
Program: Managed Health Care
Service/Budget Entity: Health Care Regulation/68700700
Measure: Percent of complaints of HMO patient dumping received that are investigated

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

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

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

Explanation:

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

Explanation: There have been no HMO patient dumping complaints received for several years. Any complaints received would be investigated.

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

Recommendations: The Agency proposes the following revision to this measure. Percent of complaints regarding HMO access to care that are investigated.

Office of Policy and Budget – July 2011

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
7,550	7,344	208 Under	2.7% Decrease

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

Explanation: The Agency has no control over the numbers of facilities that either desire licensure or that no longer 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 ☐ Technological Problems
☐ Legal/Legislative Change ☐ Natural Disaster
☐ Target Population Change ☒ Other (Identify)
☐ This Program/Service Cannot Fix the Problem
☐ Current Laws Are Working Against the Agency Mission

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

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

Recommendations: The Agency is requesting this measure to be deleted because it measures workload but not performance.

Office of Policy and Budget – July 2011

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Bureau of Managed Health Care
Program: Subscriber Assistance Program
Service/Budget Entity: Health Care Regulation/68700700
Measure: Average processing time (in days) for Subscriber Assistance Program cases

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
53	19	34	64

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

Explanation:

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

Explanation: While the current standard is acceptable, workload changes have enabled the Agency to cut processing time in half.

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

Recommendations: The Agency requests the approved standard to be updated to 21 days.

Office of Policy and Budget – July 2011

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
4,500	4,684	Over	3.93%

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

Explanation: The number of plan reviews fluctuates with the number of reviews requested.

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

Explanation: 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 ☐ Technology
☐ Personnel ☒ Other (Identify)

Recommendations: The Agency is requesting this measure to be deleted because it measures workload but not performance.

Office of Policy and Budget – July 2011

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 complaints of facility patient dumping received that are investigated

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

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

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

Explanation:

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

Explanation: The Agency investigates every facility patient dumping complaint received.

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

Recommendations:

Office of Policy and Budget – July 2011

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 complaints of facility patient dumping received that are investigated

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
N/A	11	N/A	N/A

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

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

Explanation: The Agency cannot control the number of complaints reviewed.

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

Recommendations: The Agency is requesting this measure to be deleted because it measures workload but not performance. The actual performance is measured through current performance measure "percentage of complaints investigated" which will always be 100%.

Office of Policy and Budget – July 2011

Performance Measure Validity and Reliability

LRPP Exhibit IV

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: **Agency for Healthcare Administration**
Program: **Health Care Services**
Service/Budget Entity: **Children's Special Health Care (KidCare)/68500100**
Measure: **Percentage of all Title XXI KidCare enrollees eligible for renewal who renew KidCare coverage**

Action (check one):

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

Proposed Change to Measure: Change the proposed measure, change the standard to 75%; modify the data source.

Data Sources and Methodology:

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

Proposed Standard/Target: 75%

Validity:
The validity of this measure is high. The enrollment data come directly from administrative data.

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

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

Ideally all children who are eligible for renewal will re-enroll or obtain health care coverage from some other source. Without knowing the resultant insurance status for children who do not re-enroll, the only source of information is for children who actually stay in the KidCare program. Historically, between 70% and 75% of those eligible have re-enrolled. The target represents the upper end of that historical trend to reflect the underlying goal of ensuring health care coverage.

Office of Policy and Budget – July, 2011

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: **Agency for Healthcare Administration**
Program: **Health Care Services**
Service/Budget Entity: **Children's Special Health Care (KidCare)/68500100**
Measure: **Percentage of children ages 2-6 receiving a well-child checkup in the previous 12 months**

Action (check one):

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

Proposed Change to Measure:

Data Sources and Methodology:
To assess compliance with children receiving well-child check-ups according to the guidelines of the American Academy of Pediatrics, the Institute for Child Health Policy (ICHP) conducts a telephone interview survey, as part of the annual KidCare Evaluation, with caregivers whose children have been receiving healthy care coverage through one of the KidCare program components for at least 12 months. The survey population includes children receiving the following coverage: Medicaid enrolled with an HMO, Medicaid enrolled with a MediPass provider, and the Title XXI programs, MediKids, Healthy Kids and Children's Medical Services Network. The caregiver responds whether their child has had a routine visit within the last 12 months preceding the interview.

Validity:
Data are self-reported by respondent and can subject to errors in recollection. However, this measure has shown remarkable consistency for more than five years and should be a valid measure of health care access for comparison purposes between program years. The interview and data gathering process is well-established and there should not be any response bias introduced through the process itself.

Reliability:
There is no reason to believe there is systemic variation in how respondents answer the question from year to year and the results should be reliable for within program comparisons and trend analysis.

Discussion:

The American Academy of Pediatrics (AAP) and others have established guidelines for the appropriate number of well-child/preventive care visits. Beginning at two years of age, children are expected to have annual well-child visits.

Office of Policy and Budget – July, 2011

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Action (check one):

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

Proposed Change to Measure: Change the measure to the percentage of parents who rate their health plan/provider at least a 9 out of 10 on the annual satisfaction surveys. This is to bring the measure in line with national standards.

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

For this measure, the standard reflects the percentage of caregivers who rate their plan 9 or higher on a 10-point scale. This is a nationally recognized measure and standard developed and reported by the Agency for Health Care Research and Quality, a federal HHS department responsible for state and national health policy research.

Proposed Standard/Target: 60%

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

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

Discussion:

ICHP includes this measurement in each annual evaluation. The national Medicaid benchmark for this measure is 60% and represents the highest levels of satisfaction within a health plan or program.

Office of Policy and Budget – July, 2011

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: **Agency for Health Care Administration**
Program: **Health Care Services**
Service/Budget Entity: **Medicaid Prepaid Health Plans/ 68501400**
Measure **Percent of hospitalizations of beneficiaries for conditions preventable by good ambulatory care (adults)**

Action (check one):

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

Proposed Change to Measure: The existing categories of "women and children", and "children" do not encompass all populations receiving care in managed care plans and are partially redundant. The proposed measure creates two new groups, adults and children, so that all population groups are measured and the measures themselves fall along more relevant programmatic lines.

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

This population would include all eligibles 21 years of age and older in capitated managed care plans. Enrollees are divided into under and over 21 age groups because the Medicaid benefit package varies for adults and children.

Proposed Standard/Target: 20%, based on baseline calculations utilizing the updated AHRQ methodology.

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

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

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

Office of Policy and Budget – July, 2011

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: **Agency for Health Care Administration**
Program: **Health Care Services**
Service/Budget Entity: **Medicaid Prepaid Health Plans/ 68501400**
Measure **Percent of hospitalizations of beneficiaries for conditions preventable by good ambulatory care (children)**

Action (check one):

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

Proposed Change to Measure: The existing categories of women and children, and children do not encompass all populations receiving care in managed care plans and are partially redundant. The proposed measure creates two new groups, adults and children, so that all population groups are measured and the measures themselves fall along more relevant programmatic lines.

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

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

Proposed Standard/Target: 30%, based on baseline calculations utilizing the updated AHRQ methodology.

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

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

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

Office of Policy and Budget – July, 2011

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, VERSA Regulation (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 2011

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 2011

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Action (check one):

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

Data Sources and Methodology:
The Florida Regulatory and Enforcement System/Versa (FRAES/VR) and the Centers for Medicare and Medicaid Services ASPEN Central Office (CMS/ACO) database are 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 surveys investigated by field operations survey staff that are in the CMS/ACO database. 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 and to be entered into the CMS/ACO database.

Reliability: The measure is as reliable as the input of data into the FRAES/VR and CMS/ACO databases. 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 and CMS/ACO.

Office of Policy and Budget – July 2011

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 and complaint data are maintained in the Agency's regulatory system (VR) and centrally collected. The number of accredited facilities is also obtained from VR. Survey deficiency data are maintained in the federal Automated Survey Processing Environment (ASPEN) 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:
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 2011

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). Validation survey data are maintained in the federal Automated Survey Processing Environment (ASPEN)

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) 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.

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 2011

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 2011

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 2011

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 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 2011

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 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 2011

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 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 2011

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

Data Sources and Methodology:
Data Sources: Annual state licensure surveys for non-accredited hospitals; complaint investigations where risk management related tags were cited; and Code 15 investigations for hospitals.

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 for risk management activities.

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 2011

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Bureau of Managed Health Care
Program: Managed Health Care
Service/Budget Entity: Health Care Regulation/68700700
Measure: Percent of complaints regarding HMO access to care 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:

CIRTS data base; 100% of complaints regarding access to care will be investigated.

Validity:

Reliability:

Office of Policy and Budget – July 2011

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Action (check one):

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

Data Sources and Methodology:
The Florida Regulatory and Enforcement System/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. These are Medicare and Medicaid Patient Dumping, respectively. 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.

Office of Policy and Budget – July 2011

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. These are Medicare and Medicaid Patient Dumping, respectively. 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 2011

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Bureau of Managed Health Care
Program: Subscriber Assistance Program
Service/Budget Entity: Health Care Regulation/68700700
Measure: Average processing time (in days) for Subscriber Assistance Program cases

Action (check one):

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

Data Sources and Methodology: Tracking database saved as excel spreadsheet.

Validity: The revised measure is based on an average from the past three fiscal years.

Reliability: The revised measure is more accurate and would yield a more compatible result.

Office of Policy and Budget – July 2011

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

Reliability:
Project time sheets are reviewed and approved by the supervisors. One person enters the data from these sheets into the data system. There are various electronic flags in the system that will signal false data entry, i.e., incorrect date, incorrect log number, projects already closed, etc. 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 2011

Associated Activity Contributing to Performance Measures
LRPP Exhibit V

Measure Number	Approved Performance Measures for FY 2011-12 (Words)		Associated Activities Title
	Administration and Support - 68200000		
1	Administrative costs as a percent of total agency costs		Executive Direction ACT0010
2	Administrative positions as a percent of total agency positions		Executive Direction ACT0010
	Children's Special Health Care - 68500100		
3	Percent of hospitalizations for conditions preventable by good ambulatory care		Purchase MediKids Program Services ACT5110 Purchase Children's Medical Services Network Services ACT5120 Purchase Children's Medical Services Network Services ACT5130
4	Percent of eligible uninsured children receiving health benefits coverage		Purchase MediKids Program Services ACT5110 Purchase Children's Medical Services Network Services ACT5120 Purchase Children's Medical Services Network Services ACT5130
5	Percent of children enrolled with up-to-date immunizations		Purchase MediKids Program Services ACT5110 Purchase Children's Medical Services Network Services ACT5120 Purchase Children's Medical Services Network Services ACT5130
6	Percent of compliance with the standards established in the Guidelines for Health Supervision of Children and Youth as developed by the American Academy of Pediatrics for children eligible under the program		Purchase MediKids Program Services ACT5110 Purchase Children's Medical Services Network Services ACT5120 Purchase Children's Medical Services Network Services ACT5130
7	Percent of families satisfied with the care provided under the program		Purchase MediKids Program Services ACT5110 Purchase Children's Medical Services Network Services ACT5120 Purchase Children's Medical Services Network Services ACT5130

Measure Number	Approved Performance Measures for FY 2011-12 (Words)		Associated Activities Title
8	Total number of uninsured children enrolled in Kidcare		Purchase MediKids Program Services ACT5110 Purchase Children's Medical Services Network Services ACT5120 Purchase Children's Medical Services Network Services ACT5130
9	Number of Uninsured children enrolled in Florida Healthy Kids		Purchase MediKids Program Services ACT5110 Purchase Children's Medical Services Network Services ACT5120 Purchase Children's Medical Services Network Services ACT5130
10	Number of Title uninsured children enrolled in Medikids		Purchase MediKids Program Services ACT5110 Purchase Children's Medical Services Network Services ACT5120 Purchase Children's Medical Services Network Services ACT5130
11	Number of uninsured children enrolled in Children's Medical Services Network		Purchase MediKids Program Services ACT5110 Purchase Children's Medical Services Network Services ACT5120 Purchase Children's Medical Services Network Services ACT5130
	Executive Direction/Support Services - 68500200		
12	Program administrative costs as a percent of total program costs		Executive Direction ACT0010
13	Average number of days between receipt of clean Medicaid claim and payment		Fiscal Agent Contract ACT5260
14	Number of Medicaid claims received		Fiscal Agent Contract ACT5260
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 2011-12 (Words)		Associated Activities Title
15	Percent of hospitalizations that are preventable by good ambulatory care		Hospital Inpatient - Elderly and Disabled/fee for service ACT4010
			Hospital Inpatient ACT4210
			Hospital Inpatient ACT 4510
			Hospital Inpatient ACT 4710
16	Percent of women receiving adequate prenatal care		Prescribed Medicines ACT4220
			Physician Services ACT4230
			Early Periodic Screening Diagnosis & Treatment ACT4260
			Patient Transportation ACT4270
17	Neonatal mortality rate per 1000		Hospital Inpatient ACT4210
			Physician Services ACT4220
			Early Periodic Screening Diagnosis & Treatment ACT4260
18	Average number of months between pregnancies for those receiving family planning services		Physician Services ACT4230
			Case Management ACT4280
19	Percent of eligible children who received all required components of EPSDT screen		Prescribed Medicines ACT4220
			Physician Services ACT4230
			Early Periodic Screening Diagnosis & Treatment ACT4260
			Therapeutic Services for Children ACT4310

Measure Number	Approved Performance Measures for FY 2011-12 (Words)		Associated Activities Title
20	Number of children ages 1-20 enrolled in Medicaid		Purchase Children's Medical Services Network Services ACT5120
			Purchase Children's Medical Services Network Services ACT5130
21	Number of children receiving EPSDT services		Physician Services ACT4230
			Early Periodic Screening Diagnosis & Treatment ACT4260
			School Based Services ACT4310
			Clinic Services ACT4330
22	Number of hospital inpatient services provided to children		Hospital Inpatient ACT4210
			Therapeutic Services for Children ACT4310
23	Number of physician services provided to children		Physician Services ACT4230
			Therapeutic Services for Children ACT4310
24	Number of prescribed drugs provided to children		Prescribed Medicines ACT4220
			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

Measure Number	Approved Performance Measures for FY 2011-12 (Words)		Associated Activities Title
26	Number of physician services provided to elders		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
32	Percent of hospitalizations for conditions preventable by good ambulatory care		Prepaid Health Plans Elderly and Disabled ACT1620
			Prepaid Health Plans - Family ACT1650
33	Percent of women and child hospitalizations for conditions preventable with good ambulatory care		Prepaid Health Plans - Family ACT1650
34	Number of case months services purchased (elderly and disabled)		Prepaid Health Plans Elderly and Disabled ACT1620
35	Number of case months services purchased (families)		Prepaid Health Plans - Family ACT1650
	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

Measure Number	Approved Performance Measures for FY 2011-12 (Words)		Associated Activities Title
			Other ACT5070
36	Percent of nursing home facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030
			Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
37	Percent of investigations of alleged unlicensed facilities and programs that have been previously issued a cease and desist order, that are confirmed as repeated unlicensed activity		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030
			Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
38	Percent of Priority I consumer complaints about licensed facilities and programs that are investigated within 48 hours		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030
			Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
39	Percent of accredited hospitals and ambulatory surgical centers cited for not complying with life safety, licensure or emergency access standards		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030
			Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
40	Percent of validation surveys that are consistent with findings noted during the accreditation survey		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030
			Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020

Measure Number	Approved Performance Measures for FY 2011-12 (Words)		Associated Activities Title
41	Percent of assisted living facilities with deficiencies that pose a serious threat to the health, safety or welfare of the public		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030
			Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
42	Percent of home health facilities with deficiencies that pose a serious threat to the health, safety or welfare of the public		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030
			Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
43	Percent of clinical laboratories with deficiencies that pose a serious threat for not complying with life safety, licensure or emergency access standards		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030
			Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
44	Percent of ambulatory surgical centers with deficiencies that pose a serious threat to the health, safety or welfare of the public		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030
			Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
45	Percent of hospitals with deficiencies that pose a serious threat to the health, safety or welfare of the public		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030
			Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
46	Percent of hospitals that fail to report serious incidents (agency identified)		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030
			Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
48	Percent of complaints of HMO patient dumping received that are investigated		Managed Health Care ACT7090

Measure Number	Approved Performance Measures for FY 2011-12 (Words)		Associated Activities Title
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
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

FISCAL YEAR 2010-11

SECTION I: BUDGET	OPERATING	FIXED CAPITAL OUTLAY
TOTAL ALL FUNDS GENERAL APPROPRIATIONS ACT	20,801,954,676	0
ADJUSTMENTS TO GENERAL APPROPRIATIONS ACT (Supplementals, Vetoes, Budget Amendments, etc.)	835,431,392	0
FINAL BUDGET FOR AGENCY	21,637,386,068	0

SECTION II: ACTIVITIES * MEASURES	Number of Units	(1) Unit Cost	(2) Expenditures (Allocated)	(3) FCO
Executive Direction, Administrative Support and Information Technology (2)				0
Prepaid Health Plans - Elderly And Disabled *	2,153,592	765.36	1,648,272,337	
Prepaid Health Plans - Families *	11,767,452	114.26	1,344,772,523	
Elderly And Disabled/Fee For Service/Medipass - Hospital Inpatient * Number of case months Medicaid program services purchased	454,007	4,512.60	2,048,754,153	
Elderly And Disabled/Fee For Service/Medipass - Prescribed Medicines * Number of case months Medicaid program services purchased	454,007	2,036.05	924,381,049	
Elderly And Disabled/Fee For Service/Medipass - Physician Services * Number of case months Medicaid program services purchased	454,007	1,068.82	485,251,895	
Elderly And Disabled/Fee For Service/Medipass - Hospital Outpatient * Number of case months Medicaid program services purchased	454,007	954.88	433,520,768	
Elderly And Disabled/Fee For Service/Medipass - Supplemental Medical Insurance * Number of case months Medicaid program services purchased	321,901	3,048.83	981,429,508	
Elderly And Disabled/Fee For Service/Medipass - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	85,598	162.25	13,888,661	
Elderly And Disabled/Fee For Service/Medipass - Patient Transportation * Number of case months Medicaid program services purchased	454,007	148.34	67,347,515	
Elderly And Disabled/Fee For Service/Medipass - Case Management * Number of case months Medicaid program services purchased	454,007	200.59	91,067,350	
Elderly And Disabled/Fee For Service/Medipass - Home Health Services * Number of case months Medicaid program services purchased	454,007	115.93	52,634,552	
Elderly And Disabled/Fee For Service/Medipass - Therapeutic Services For Children * Number of case months Medicaid program services purchased	85,598	218.15	18,673,503	
Elderly And Disabled/Fee For Service/Medipass - Hospital Insurance Benefit * Number of case months Medicaid program services purchased	269,038	464.10	124,861,622	
Elderly And Disabled/Fee For Service/Medipass - Hospice * Number of case months Medicaid program services purchased	454,007	481.61	218,655,110	
Elderly And Disabled/Fee For Service/Medipass - Private Duty Nursing * Number of case months Medicaid program services purchased	85,598	2,490.88	213,214,509	
Elderly And Disabled/Fee For Service/Medipass - Other * Number of case months Medicaid program services purchased	454,007	1,398.39	634,878,286	
Women And Children/Fee For Service/Medipass - Hospital Inpatient * Number of case months Medicaid program services purchased	974,323	1,475.27	1,437,399,005	
Women And Children/Fee For Service/Medipass - Prescribed Medicines * Number of case months Medicaid program services purchased	974,323	279.34	272,164,506	
Women And Children/Fee For Service / Medipass - Physician Services * Number of case months Medicaid program services purchased	974,323	616.13	600,313,635	
Women And Children/Fee For Service / Medipass - Hospital Outpatient * Number of case months Medicaid program services purchased	974,323	577.40	562,569,317	
Women And Children/Fee For Service / Medipass - Supplemental Medical Insurance * Number of case months Medicaid program services purchased	1,037	172,942.85	179,341,734	
Women And Children/Fee For Service / Medipass - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	779,578	213.53	166,464,756	
Women And Children/Fee For Service / Medipass - Patient Transportation * Number of case months Medicaid program services purchased	974,323	66.14	64,444,668	
Women And Children/Fee For Service / Medipass - Case Management * Number of case months Medicaid program services purchased	974,323	11.38	11,083,752	
Women And Children/Fee For Service / Medipass - Home Health Services * Number of case months Medicaid program services purchased	974,323	114.00	111,077,585	
Women And Children/Fee For Service / Medipass - Therapeutic Services For Children * Number of case months Medicaid program services purchased	779,578	71.56	55,804,419	
Women And Children/Fee For Service / Medipass - Clinic Services * Number of case months and Medicaid program services purchased	974,323	118.66	115,617,290	
Women And Children/Fee For Service / Medipass - Other * Number of case months Medicaid program services purchased	974,323	425.54	414,615,149	
Medically Needy - Hospital Inpatient * Number of case months Medicaid program services purchased	35,988	7,683.42	276,510,756	
Medically Needy - Prescribed Medicines * Number of case months Medicaid program services purchased	35,988	3,308.87	119,079,644	
Medically Needy - Physician Services * Number of case months Medicaid program services purchased	35,988	1,790.61	64,440,447	
Medically Needy - Hospital Outpatient * Number of case months Medicaid program services purchased	35,988	2,429.73	87,440,956	
Medically Needy - Supplemental Medical Insurance * Number of case months Medicaid program services purchased	4,466	1,358.60	6,067,514	
Medically Needy - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	5,999	120.74	724,311	
Medically Needy - Patient Transportation * Number of case months Medicaid program services purchased	35,988	67.65	2,434,755	
Medically Needy - Case Management * Number of case months Medicaid program services purchased	35,988	45.27	1,629,353	
Medically Needy - Home Health Services * Number of case months Medicaid program services purchased	35,988	38.61	1,389,326	
Medically Needy - Therapeutic Services For Children * Number of case months Medicaid program services purchased	5,999	6.21	37,258	
Medically Needy - Other * Number of case months Medicaid program services purchased	35,988	31,258.34	1,124,925,091	
Refugees - Hospital Inpatient * Number of case months Medicaid program services purchased	4,400	501.99	2,208,755	
Refugees - Prescribed Medicines * Number of case months Medicaid program services purchased	4,400	84,814.87	373,185,441	
Refugees - Physician Services * Number of case months Medicaid program services purchased	4,400	588.98	2,591,504	
Refugees - Hospital Outpatient * Number of case months Medicaid program services purchased	4,400	362.76	1,596,221	
Refugees - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	540	319.93	172,763	
Refugees - Patient Transportation * Number of case months Medicaid program services purchased	4,400	7.49	32,964	
Refugees - Case Management * Number of case months Medicaid program services purchased	4,400	19.19	84,456	
Refugees - Home Health Services * Number of case months Medicaid program services purchased	4,400	20.38	89,676	
Refugees - Therapeutic Services For Children * Number of case months Medicaid program services purchased	540	7.81	4,220	
Refugees - Other * Number of case months Medicaid program services purchased	4,400	330.80	1,455,509	
Nursing Home Care * Number of case months Medicaid program services purchased	75,276	38,116.10	2,869,227,611	
Home And Community Based Services * Number of case months Medicaid program services purchased	87,598	12,193.07	1,068,088,204	
Intermediate Care Facilities For The Developmentally Disabled - Sunland Centers * Number of case months Medicaid program services purchased	714	163,294.30	116,592,130	
Mental Health Disproportionate Share Program * Number of case months Medicaid program services purchased	720	94,023.37	67,696,826	
Long Term Care - Other * Number of case months Medicaid program services purchased	29,906	23,321.26	697,445,627	
Purchase Medikids Program Services * Number of case months	29,779	1,816.00	54,078,621	
Purchase Children's Medical Services Network Services * Number of case months	23,005	6,762.87	155,579,748	
Purchase Florida Healthy Kids Corporation Services * Number of case months	199,198	1,325.47	264,031,316	
Certificate Of Need/Financial Analysis * Number of certificate of need (CON) requests/financial reviews conducted	3,761	443.47	1,667,879	
Health Facility Regulation (compliance, Licensure, Complaints) - Tallahassee * Number of licensure/certification applications	23,665	559.67	13,244,641	
Facility Field Operations (compliance, Complaints) - Field Offices Survey Staff * Number of surveys and complaint investigations	43,506	987.88	42,978,890	
Health Standards And Quality * Number of transactions	2,784,324	1.38	3,829,280	
Plans And Construction * Number of reviews performed	4,684	1,306.14	6,117,963	
Managed Health Care * Number of Health Maintenance Organization (HMO) and workers' compensation arrangement surveys	165	17,064.58	2,815,656	
Background Screening * Number of requests for screenings	209,012	4.60	961,394	
Subscriber Assistance Panel * Number of cases	491	1,891.67	928,808	
TOTAL			20,723,869,670	

SECTION III: RECONCILIATION TO BUDGET				
PASS THROUGHS				
TRANSFER - STATE AGENCIES				
AID TO LOCAL GOVERNMENTS				
PAYMENT OF PENSIONS, BENEFITS AND CLAIMS				
OTHER			213,766,310	
REVERSIONS			699,750,275	
TOTAL BUDGET FOR AGENCY (Total Activities + Pass Throughs + Reversions) - Should equal Section I above. (4)			21,637,386,255	

SCHEDULE XI/EXHIBIT VI: AGENCY-LEVEL UNIT COST SUMMARY

(1) Some activity unit costs may be overstated due to the allocation of double budgeted items.

(2) Expenditures associated with Executive Direction, Administrative Support and Information Technology have been allocated based on FTE. Other allocation methodologies could result in significantly different unit costs per activity.

(3) Information for FCO depicts amounts for current year appropriations only. Additional information and systems are needed to develop meaningful FCO unit costs.

(4) Final Budget for Agency and Total Budget for Agency may not equal due to rounding.

Glossary of Terms and Acronyms

ACA - Affordable Care Act - http://www.healthcare.gov/law/introduction/index.html

AHCA – Agency for Health Care Administration - http://www.ahca.myflorida.com/

Ambulatory Surgery Centers - An ambulatory surgery center (ASC) is a licensed facility that is not part of a hospital and that may also be Medicaid/Medicare certified. The primary purpose of this type of facility is to provide elective surgical care. The patient is admitted to and discharged from the facility within the same working day. Overnight stays are not permitted.

Assisted Living Facilities - A living arrangement in which people with special needs, especially older people with disabilities, reside in a facility that provides help with everyday tasks such as bathing, dressing, and taking medication

Authorized Accrediting Organizations for Hospitals - Authorized Accrediting Organizations for Hospitals - Hospitals must maintain current state licensure, but may choose to be Medicare certified and may choose to be accredited by a CMS authorized accreditation organization. Accredited hospitals meeting Chapter 59A-3.253(3), Florida Administrative Code may be "deemed" to be in compliance with the licensure and certification requirements. Deemed hospitals are not scheduled for routine on-site licensure surveys. All hospitals are subject to periodic Life-Safety Code inspections.

CMS - Centers for Medicare and Medicaid Services– http://www.cms.gov

COW - Certificate of Waiver - Laboratories that only do "waived" testing are issued a Certificate of Wavier by the CLIA program.

CSMU - Central Systems Management Unit - This unit consist of three sections; Central Intake processes all licensure units incoming mail; Background Screening of employees of licensed health care providers; and Training and Reporting for Health Quality Assurance licensed provider data base.

CHIPRA Grant - Children's Health Insurance Program Reauthorization Act Grant – A grant to test collection and reporting of recommended and selected supplemental measures of children's health quality, using existing data sources and improved data sharing. Other objectives include health information exchange and health information technology efforts supporting the achievement of child health quality objectives, enhancing the development of provider-based systems of care that incorporate practice redesign and strong referral and coordination networks, and supporting collaborative quality improvement projects to improve birth outcomes.

CSIRT - Computer Security Incident Response Team – Name given to expert groups that handle computer security incidents

Cover Florida Health Care Access Program - http://coverfloridaenrollment.com/about-cover-florida-insurance - The Cover Florida Health Care Access Program was created out of the 2008 Legislative session in Florida. The program provides affordable health insurance options to nearly 4 million Florida residents who would otherwise be uninsured.

Disproportionate Share Hospital (DSH) payment program - Medicaid disproportionate share hospital (DSH) payments provide financial assistance to hospitals that serve a large number of low-income patients, such as people with Medicaid and the uninsured.

Drug Utilization Review (DUR) Board - The Drug Utilization Board (DUR Board) reviews and approves drug use criteria and standards for both prospective and retrospective drug use reviews. It applies these criteria and standards in the application of DUR activities, reviews and reports the results of the drug use reviews, and recommends and evaluates the educational intervention programs.

ESS - Emergency Status System - Database to allow health care providers to enter emergency-related information through the Internet. During an emergency event, this information is utilized by Local Emergency Operations Centers as well as the Statewide Emergency Operations Center to identify needed resources or assistance, and to direct action necessary to assure they are made available in the most effective way possible

EPOs - Exclusive Provider Organizations - A network of individual medical care providers, or groups of medical care providers, who have entered into written agreements with an insurer to provide health insurance to subscribers.

EMTALA - Emergency Medical Treatment and Active Labor Act - Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) in 1986 to ensure public access to emergency services regardless of ability to pay. See http://www.cms.gov/EMTALA for more information.

Federal CLIA Certification - Requires that all laboratories that test human specimens be certified by the federal government. The AHCA Laboratory Unit handles applications and changes for both the state laboratory licensure and federal Clinical Laboratory Improvement Amendment certification programs.

FFS – Fee-for-Service

FMMIS/DSS - Florida Medicaid Management Information System / Decision Support System – Florida's data management system, and data warehouse, for collecting, processing and storing Medicaid recipient encounter claims.

FRAES - Florida Regulatory Administration and Enforcement System is a computerized system that assigns a unique identifier to each licensed and/or certified facility. Each facility has its own FRAES file number that remains constant through changes of ownership.

FY – Fiscal Year – denotes the State of Florida's fiscal year which begins on July 1st and ends on June 30th.

Health Care Licensing Procedures Act - 408 Part II, F.S. and 59A-35.060 Florida Administrative Rules

HMO - Health Maintenance Organizations

HEDIS - Healthcare Effectiveness Data and Information Set - HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. http://www.ncqa.org/tabid/59/Default.aspx

ICF-DD - Institutional Care Facility for the Developmentally Disabled

LIP - Low Income Pool - http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/lip.shtml

Medicaid - A program funded by the U.S. federal and state governments that pay the medical expenses of people who are unable to pay some or all of their own medical expenses. Medicaid was established in Florida in 1970 and the primary beneficiaries are poor women and children and disabled persons.

Medicaid FFS Program – Providers who are not in managed care or "capitated" payment plans are reimbursed on a fee-for-service (FFS) basis as services are provided. The FFS program treats Medicaid recipients who are not enrolled in managed care.

MFCU - Medicaid Fraud Control Unit

Medicaid State Plan - Florida's Medicaid State Plan is a large, comprehensive written statement describing the scope and nature of the Medicaid program. The Plan outlines current Medicaid eligibility standards, policies and reimbursement methodologies to ensure the state program receives matching federal funds under Title XIX of the Social Security Act.

MediPass – Most Medicaid recipients must enroll in a managed health care plan. MediPass is one of your Medicaid managed health care choices. It is a primary care case management system. In other words, a Medicaid beneficiary has a primary care provider that manages their continuum of medical care.

1115 Demonstration Waivers - Section 1115 of the Social Security Act provides the Secretary of Health and Human Services broad authority to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow states to test substantially new ideas of policy merit. These projects are intended to demonstrate and evaluate a policy or approach has not been demonstrated on a widespread basis. Some states expand eligibility to individuals not otherwise eligible under the Medicaid program, provide services that are not typically covered, or use innovative service delivery systems.

PACT - Positive Action Critical Thinking is a pressure ulcer reduction initiative underway in the Southeast CMS region (Region IV)

PHCs - Prepaid Health Clinics

PPRP - Prescribing Pattern Review Panel

PSNs - Provider Service Networks

SAP - Subscriber Assistance Program - Networks established or organized and operated by a health care provider or group of affiliated health care providers.

State Long Term Care Ombudsman Program - DOEA Long Term Care Ombudsman Program

SMMCP - Statewide Medicaid Managed Care Program