FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

LONG RANGE PROGRAM PLAN

Agency for Health Care Administration
Tallahassee, Florida 32308

September 27, 2012

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Dear Directors:

Pursuant to chapter 216, F.S., 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 2013-2014 through Fiscal Year 2017-2018. The internet website address that provides the link to the LRPP located on the Florida Fiscal Portal is http://ahca.myflorida.com/publications/Publications.shtml. This submission has been approved by Elizabeth Dudek, Secretary of the Agency for Health Care Administration.

Tonya Kidd
Deputy Secretary for Operations

AGENCY FOR HEALTH CARE ADMINISTRATION

LONG RANGE PROGRAM PLAN

FY 2013 - 2014 THROUGH FY 2017 - 2018

Statewide Medicaid Managed Care (SMMC)
Managed Medical Assistance (MMA)
Long-term Care Services
Access to Quality Health Care Services
Quality of Care
Optimizing Resources
Reduce/Eliminate Fraud and Abuse
Better Health Care for All
Streamlining through Regulatory Reduction
Administrative Infrastructure
Prevention, Detection, and Recovery
Strategic Planning
Cost Containment
Regulatory Reform
Health Information Technology
Independent Actuarial Analyses
Statewide Health Policy Flexibility
Enhancements through Technological Advances

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

OUR MISSION

Better Health Care for All Floridians

OUR VISION

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

OUR VALUES

Accountability – We are responsible, efficient, and transparent.

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

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

Teamwork – We collaborate and share our ideas.

Agency Goals and Objectives

Goal 1: To operate an efficient and effective government.

Health Care Regulation (Division of Health Quality Assurance)

Objective 1.A: To receive 85 percent of all facility license renewal applications electronically via the Internet by Fiscal Year 2017-2018.

Objective 1.B: To reduce by 50 percent the number of Division of Health Quality Assurance public records requests manually processed by Fiscal Year 2017-2018.

Administration and Support (Division of Information Technology)

Objective 1.C: To achieve a staff retention rate of 90 percent through use of improved training opportunities, better work environment, and total compensation by Fiscal Year 2017-2018.

Objective 1.D: To identify and secure 99.99 percent of confidential or sensitive data that resides on, or passes through, the Agency for Health Care Administration's network services by Fiscal Year 2017-2018.

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

Administration and Support (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 Fiscal Year 2017-2018.

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 Fiscal Year 2017-2018.

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

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

Objective 3.A: To limit the growth in the statewide per member per month (PMPM) expenditures to eight percent or less under Statewide Medicaid Managed Care through Fiscal Year 2017-2018.

Objective 3.B: Limit the growth in total long-term care expenditures to less than 8 percent over the Base Year (FY 2012-13) by FY 2015-16.

Objective 3.C: To improve Medicaid recipients' level of satisfaction with access to specialty care services by achieving a recipient satisfaction rate of 90 percent by Fiscal Year 2017-2018.

Objective 3.D: To maintain or improve baseline performance on 100 percent of all outcome measures developed for the Long Range Program Plan by Fiscal Year 2017-2018.

Agency Service Outcomes and Performance Projection Tables

Goal 1: To operate an efficient and effective government.

Health Care Regulation (Division of Health Quality Assurance)

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

Performance Projection Table 1.A:

Baseline Year FY 2011-2012	FY 2013-2014	FY 2014-2015	FY 2015-2016	FY 2016-2017	FY 2017-2018
15,177	1,518	3,794	7,589	11,383	12,900
Percent of increase in the average number of license applications received via Internet	10%	25%	50%	75%	85%

The Agency currently receives all licensure applications in paper copy; however, passage of the Health Care Licensing Procedures Act (chapter 408, F.S., Part II) enables the Agency to require electronic submission of documents (applications and renewals) via the Internet.

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

Performance Projection Table 1.B:

Baseline Year FY 2010-2011	FY 2013-2014	FY 2014-2015	FY 2015-2016	FY 2016-2017	FY 2017-2018
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 HQA	10%	20%	30%	40%	50%

This measure represents the Agency efforts to streamline operations in order to enable increased productivity within existing resources.

Administration and Support (Division of Information Technology)

Service Outcome Measure 1.C: Information Technology's annual human resource retention rate.

Performance Projection Table 1.C:

Baseline Year FY 2012–2013	FY 2013–2014	FY 2014–2015	FY 2015–2016	FY 2016–2017	FY 2017–2018
87%	90%	90%	90%	90%	90%

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

Service Outcome Measure 1.D: The percent of secured e-mail verified through e-mail encryption server reporting.

Performance Projection Table 1 .D:

Baseline Year FY 2012–2013	FY 2013–2014	FY 2014–2015	FY 2015–2016	FY 2016–2017	FY 2017–2018
95%	99.99%	99.99%	99.99%	99.99%	99.99%

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

Administration and Support (Office of the Inspector General – Medicaid Program Integrity)

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

Performance Projection Table 2.A:

Baseline Year FY 2006-2007	FY 2013-2014	FY 2014-2015	FY 2015-2016	FY 2016-2017	FY 2017-2018
$35,700,000*	$46,464,157	$47,858,082	$49,293,824	$53,730,268	$58,565,992
Projected Increase in Percent	9%	9%	9%	9%	9%

**FY 2008-2009 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).

Performance Projection Table 2.B:

Baseline Year FY 2008-2009	FY 2013-2014	FY 2014-2015	FY 2015-2016	FY 2016-2017	FY 2017-2018
$18,900,000	$24,121,722	$25,327,808	$26,594,198	$27,923,908	$29,320,103
Projected Increase in Percent	5%	5%	5%	5%	5%

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

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

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

Performance Projection Table 3.A:

Baseline Year FY 2012-2013	FY 2013-2014	FY 2014-2015	FY 2015-2016	FY 2016-2017	FY 2017-2018
$527.28	$569.46	$615.02	$664.22	$717.36	$774.75
Percent of Projected PMPM Growth	8%	8%	8%	8%	8%

Service Outcome Measure 3.B: Long-term care cost growth.

Service Outcome Measure Projection Table 3.B:

Baseline Year FY 2012-2013	FY 2013-2014	FY 2014-2015	FY 2015-2016	FY 2016-2017	FY 2017-2018
$4,657 Medicaid Long Term Care Expenditures ($ Millions)	$4,783.98	$4,894.81	$5,010.03	$5,010.03	$5,010.03
Projected Annual Growth	2.73%	2.32%	2.35%	N/A	N/A
Projected Overall Growth from Base Year	2.73%	5.11%	7.58%	N/A	N/A

*Long Term Care Forecast only extends through FY 2015-16 Projected Long Term Care (LTC) Expenditures (in millions).

Service Outcome Measure 3.C: Percent of Medicaid beneficiaries who needed specialty care and reported on the CAHPS* survey it was "Usually or Always Easy" to obtain specialty care.

Performance Projection Table 3.C:

Baseline Year FY 2010-2011	FY 2013-2014	FY 2014-2015	FY2015-2016	FY2016-2017	FY2017-2018
81.4%	82%	84%	86%	88%	90%

*Consumer Assessment of Health Providers and Systems

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

Performance Projection Table 3.D:

Baseline Year 2012-2013	FY 2013-2014	FY 2014-2015	FY2015-2016	FY2016-2017	FY2017-2018
Number of outcome measures 20	19	19	19	19	19

Baseline Year 2012-2013	FY 2013-2014	FY 2014-2015	FY2015-2016	FY2016-2017	FY2017-2018
Number of outcome measures maintained or improved 15	16	17	18	19	19
Percent of outcomes maintained or improved 79%	84%	89%	95%	100%	100%

(Only 17 of the currently approved 35 measures are actual "performance measures" with measureable outcomes. The other measures are output measures (i.e., counts) that do not have relevant performance goals attached or are measures that no longer have an appropriate data source. The Agency will submit a budget amendment, for consideration, to revise and update the measures to bring them more in line with programmatic goals to be submitted by June 30, 2013, in accordance with section 216.1827, F.S. Upon approval, the total number of measures will decrease to 32 including 15 count measures that help define the scope of the Medicaid program. The remaining will be 17 performance/outcome measures. The final number will be reached through deletion, revision or replacement of existing measures.)

Linkage to Governor's Priorities

Number	Governor's Priorities	Agency Goals
1	Accountability Budgeting	Goal 1: To operate 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 operate 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 operate 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 operate an efficient and effective government.

Trends and Conditions Statements

Health Care Regulation (Division of Health Quality Assurance)

The Division of Health Quality Assurance (HQA) shares the Agency for Health Care Administration's (Agency's/AHCA's) mission of "Better Health Care for All Floridians" through its oversight of regulated health care providers, monitoring of managed care provider networks, and provision of health information. HQA strives to maximize the Agency's resources by operating more efficiently and effectively to achieve positive outcomes and streamline regulations. As the Agency becomes more technologically advanced, HQA continues to progress towards a more refined and transparent system that will have great benefits for not only consumers and providers of health care services, but for all stakeholders in the State of Florida.

The Agency licenses, investigates, reviews, evaluates, monitors, and surveys facilities as well as approves facilities' construction plans, while it strives to decrease the number of facilities with the presence of conditions that constitute an immediate danger to the 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, nursing homes, assisted living facilities, and adult day care centers to prescribed pediatric extended care centers, skilled nursing facilities, health care clinics, and clinical laboratories.

Improving Quality of Care While Controlling Costs

Florida remains a popular choice for retirement among the elderly population. Four of the nation's top ten places with the highest percentage of population age 65 and over were in Florida. Of the 5.1 million forecasted population growth by 2030, Florida's elder population will account for 55.2 percent of the gain (Florida's Economic Future & the Impact of Aging in Place, 1st Annual Statewide Aging in Place House Summit, May 11, 2012). Florida's population potentially in need of long-term care is significantly greater than other states. 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 national average. Assisted living, independent living, and home care will double their current volumes, causing great financial strains on the state's resources (Mapping the Future: Estimating Florida's Demand for Aging Services 2008-2030, Larson Allen LLP). As health care costs continue to rise, the Agency must constantly seek solutions to maintain quality of care while providing services to a growing population reliant upon long-term care.

Assisted Living Workgroup

In July 2011, Governor Rick Scott directed the Agency to examine the regulation and oversight of assisted living facilities in Florida. In response, AHCA created the Assisted Living Workgroup (AL Workgroup). The objective of the AL Workgroup was to make recommendations to the

Governor and Legislature for improving the monitoring of safety in assisted living facilities to help ensure the well-being of residents.

The AL Workgroup's Final Report and Recommendations, submitted in November 2011, were sent to the Governor and the Florida Legislature for review. Recommendations were made regarding consumer information, Assisted Living Facility (ALF) administrator qualifications, training and staffing, surveys and inspections, licensure, resident discharge, ALF information and reporting, enforcement, resident advocacy, mental health, multiple regulators, and home and community based care. Issues which the workgroup felt could be addressed immediately were considered Phase I Recommendations.

The workgroup held three meetings around the state and heard presentations and public testimony from more than 75 individuals, including residents, family members, assisted living facility administrators and owners, provider associations, advocates, and state agency representatives. Considerable discussion ensued regarding ALF administrator qualifications and training, and as a result, the workgroup made recommendations to strengthen the current requirements. The AL Workgroup also noted that several other issues, which required more time to evaluate, be addressed and recommended they be examined by a Phase II workgroup.

The Governor requested the workgroup to reconvene in 2012 to continue its work. Phase II has begun and meetings were held in June and July of 2012. Additional meetings are scheduled for September and October of 2012.

Assisted Living Facility Project 2012

After the successful completion of Phase I, additional efforts were made to investigate and monitor compliance in assisted living facilities through the means of a large-scale investigation and enforcement project. The Miami-Dade County ALF Project 2012 was conducted during the last week of March 2012 and consisted of 100 compliance site visits to ALFs in Miami-Dade County. These efforts included staff from the Agency's Medicaid Program Integrity (MPI), HQA, and staff from the federal Centers for Medicare and Medicaid Services/Medicaid Integrity Group (MIG). The facilities involved in the project billed for Medicaid Personal Care Service Per Diem for dates of service from January 2011 through February 2012. These compliance visits yielded 175 sanctions totaling $932,500 in fines. Although the project focused on billing practices in ALFs, the investigations resulted in 76 referrals to HQA for patient care and other licensure related issues. Additional efforts are underway to improve the coordination of surveys and referrals between HQA and Medicaid which will enhance the Agency's ability to ensure facility compliance in both divisions while reducing the overlap and duplication of work. This collaboration will extend beyond assisted living facilities to encompass other licensed providers under the Agency's purview that may be enrolled in Florida's Medicaid program.

The Agency began an initiative in January 2012 to align legal actions and sanctions between HQA and Medicaid. In 2009, the Legislature passed chapter 2009-223, Laws of Florida, (Senate Bill 1986), which designated Miami-Dade County as a health care fraud area of concern and addressed both regulatory reforms and fraud and abuse prevention. The legislation provided for additional licensure requirements for home health agencies, home medical equipment providers, and health care clinics while strengthening the Agency's authority to withhold Medicaid payments under certain circumstances. As a result of its passage, Senate

Bill 1986 has enabled the Agency to be more aggressive in its enforcement actions taken against non-compliant providers across the state. The Agency submits monthly reports to the Senate Committee on Health Regulation detailing the implementation of the provisions of Senate Bill 1986 and has expanded the report to include data on all licensed facilities for provisions that apply to all licensure programs. Several issues are outlined in the report including, but not limited to, final orders, and fines assessed against providers by HQA and Medicaid. In addition the report includes the number of HQA referrals made to Medicaid Program Integrity and Medicaid Fraud Control Unit, and the number of license applications denied due to applicant or person(s) with controlling interest being disqualified because of termination for cause from the Medicaid program or a conviction or a plea of guilty or nolo contendere to, regardless of adjudication, Medicaid fraud. To augment this report, the Agency also publishes a monthly press release to identify the final orders and other legal actions that are assessed against providers by HQA and Medicaid.

Optimizing Resources in Challenging Economic Times

HQA's appropriations in Fiscal Year 2012-2013 increased as a result of a reorganization within the Agency that merged the Florida Center for Health Information and Policy Analysis (Florida Center) into HQA. The majority of the Florida Center's budget is derived from the American Recovery and Reinvestment Act of 2009 (ARRA), which is a state/federal grant for the development and maintenance of electronic health record (EHR) database technology and the administration of the Medicaid incentive payments program to eligible Medicaid providers and hospitals that adopt and use certified electronic health records technology. One of the most important responsibilities for the Florida Center is the administration of programs for the creation of a statewide health information network and the adoption of electronic health record systems. In accordance with the Agency's vision, the Florida Center strives to achieve relevant, secure, and sustainable approaches to health information technology adoption, utilization, and exchange that drive the achievement of better health care outcomes for all Floridians through improved access to information. The Agency is working with Florida stakeholders for the development of a health care clinical information exchange that is privacy-protected, aligned with national standards, engages local stakeholders, and is cost-effective for participants.

Agency efforts are still focused on accomplishing more with the same or reduced resources. Over the past five years, HQA's full time equivalent (FTE) positions (Table 1-1) have remained relatively stable. However, from Fiscal Year 2007-2008 to Fiscal Year 2011-2012, HQA's number of licensed, registered, certified, and regulated service providers and facilities continued to increase from 34,436 to 45,304 (Table 1-2). 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:

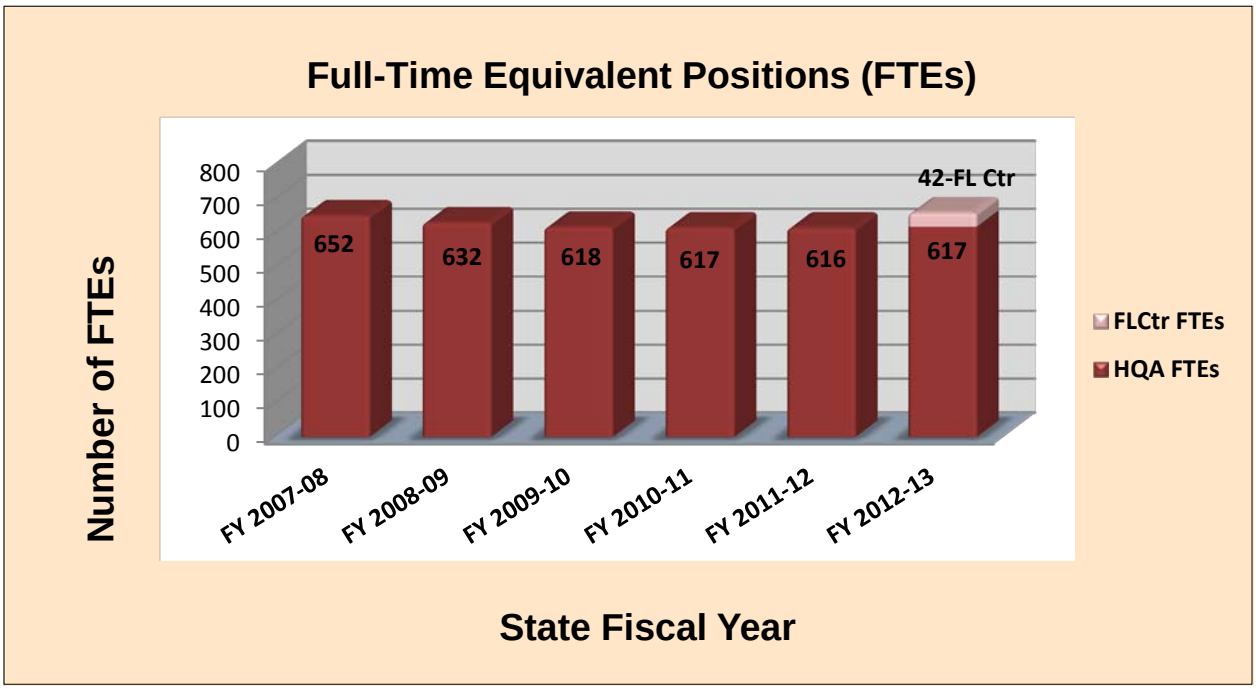
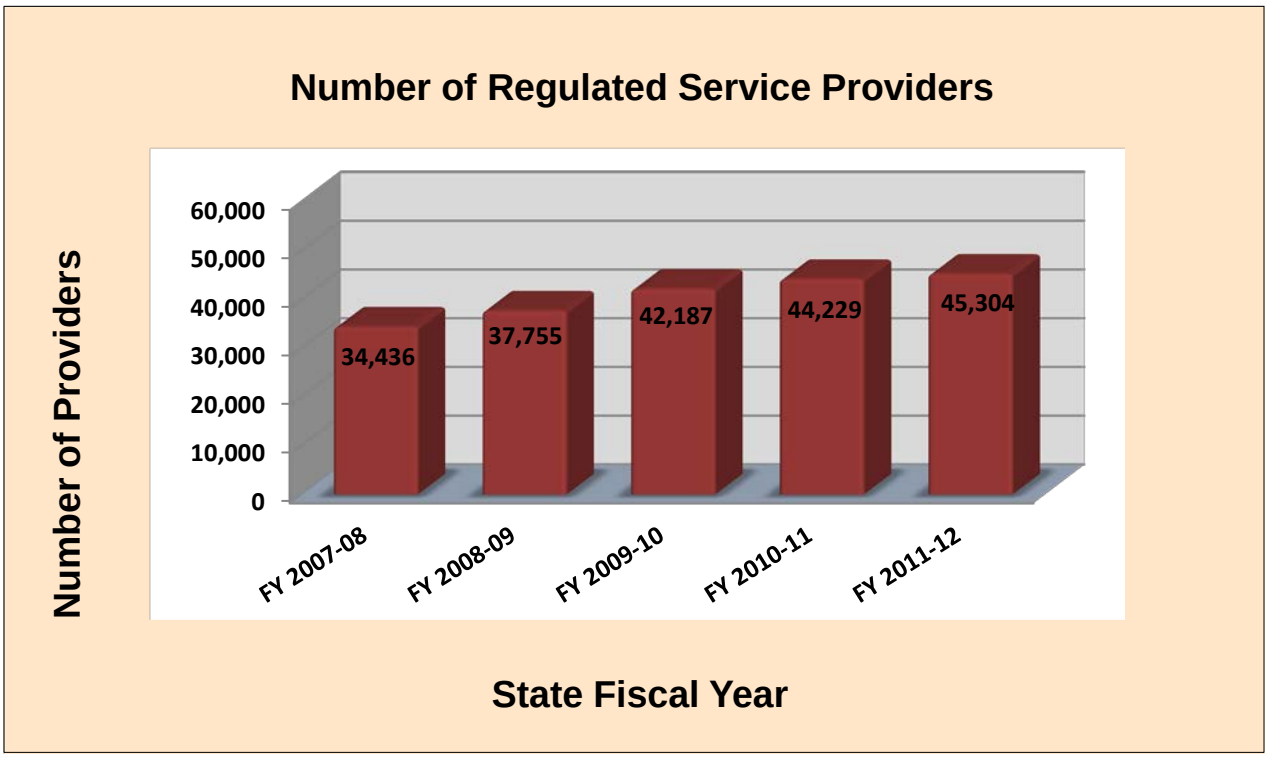


Table 1-2:



Streamlining through Regulatory Reduction

As Florida continues to face challenges in the current economic climate, the Agency strives to be proactive in focusing on mission critical functions while reducing regulatory burdens. After three years of seeking legislative regulatory reforms and reductions, the Agency was successful in the passage of a portion of the reform achieved in chapter 2012-160, Laws of Florida. The legislation made several streamlining updates, including the following:

- Allows the Agency to send a courtesy notice, at least 90 days before the expiration of a license, to inform the licensee of the upcoming expiration date. The courtesy notices will be provided either electronically or by United States mail and not via certified mail.

- Modifies Certificate of Need to allow audited financial statements of an applicant's parent corporation in exchange for the audited financial statements of an applicant when such statements do not exist. Produces an estimated savings to applicants of $700,000 annually.

- Eliminates a separate legal case for late fines by requiring an applicant pay the late fee before a late application is considered complete.

- Allows an administrator of a nurse registry to manage up to five registries within the same geographic region and identical controlling interest as long as a qualified alternate administrator is designated in writing during absences. This will save an estimated $943,690 for providers.

- Allows nursing home outpatient clinics to be staffed by a licensed practical nurse under proper supervision, establishes standards for respite services in nursing homes, and streamlines rules. Industry estimates indicate an annual savings of $335,000.

The Agency plans to request additional legislative changes during the 2013 Legislative Session that will allow for further streamlining of the licensure process and consistency in enforcement across licensure programs. The Agency will be requesting deletion of obsolete statutory language, repeal of outdated laws, and further alignment of program-specific language within chapter 408, F.S., the Agency's uniform licensing statute.

Other legislation approved in 2012, specifically chapter 2012-160, Laws of Florida, allowed the Agency to eliminate homemaker and companion services providers registration for organizations contracted with the Agency for Persons with Disabilities (APD) that provide companion services only to developmentally disabled persons. This not only eliminated the overlapping, duplicative work of two state agencies, AHCA and APD, but also reduced costs for the businesses contracted through APD. It is estimated that 503 homemaker and companion service providers registered prior to July 1, 2012 will no longer be regulated by the Agency because of a change in the law. This change in law is expected to result in a cost savings of approximately $123,486 annually to impacted private sector businesses.

Enhancing the Application Process through Streamlining

In order to better serve its constituents, the Agency utilizes information technology to enhance streamlining efforts within the Agency.

Electronic Background Screening

Electronically obtained fingerprinting for all criminal background screening requirements has been in place for nearly two years. However, in 2012 as a further enhancement to this process, the Legislature passed chapter 2012-73, Laws of Florida, which allows for retained prints. More importantly, this authorizes the creation of a secure, web-based "Care Provider Background Screening Clearinghouse" to house and manage screening results of multiple state agencies to allow for sharing of those results across these agencies. For the included agencies, and persons subject to background screenings, the elimination of duplicative processes for employees working in long term care and other health care related provider types will create a cost savings. The Clearinghouse will be available to the following agencies: AHCA, Agency for Persons with Disabilities (APD), Department of Elder Affairs (DOEA), Department of Children & Families (DCF), and Department of Health (DOH) as well as the Department of Juvenile Justice (DJJ) and Vocational Rehabilitation at the Department of Education (DOE). Integration with the state agencies will occur between January 2013 and September 2013. The Clearinghouse will include a RapBack requirement, also known as "retained prints," which enables notification to the Agency of the arrest of an employee to determine if the arrest affects access to vulnerable clients. The Agency will immediately notify the provider so appropriate action can be taken.

Online Licensing

The Agency has been moving steadily toward the ultimate goal of a comprehensive, integrated, online licensure system since 2011. The system is expected to have intra/inter-departmental connectivity with other automated systems, such as those used by Medicaid, Medicare, managed health care, background screening, accounts receivable, and practitioner regulation. The online licensing system 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. It will also incorporate a seamless interface with delinquent money owed to the Agency to facilitate collection before licenses are issued or renewed. The 2012 Legislature appropriated the second year of funding for the three-year online licensing project. The Agency will request the appropriate level of funding for year three of the project.

This system is critical in the fight against fraud and abuse and is essential in an industry that is not only growing, but an industry that includes an increasing percentage of providers that open, close, and re-open their facilities. Cost savings, as a result of implementing an online system, are inevitable as the Agency currently processes over 20,000 paper applications every year. The reduction in paper processing and administrative costs for providers, taxpayers, and the State of Florida are estimated to save over $200,000 annually. See Table 1.A that projects the average annual number of license applications received electronically via the Internet.

The three-year online licensing application project is currently in the development stage. The development includes an online-licensing application that will allow for submission of renewal, initial, and change of ownership applications via a web-portal. The system will interact with the

current licensure database, Versa Regulation (VERSA), and allow for online payment as well as the ability to attach electronic documents required for licensure. Development will also include the ability to interact with other internal and external agency databases for verification of Medicaid enrollment, monetary obligations, and appropriate business registration.

Once the online licensing portal is implemented, the submission of incomplete license applications will be significantly reduced. Approximately 65 percent of the license applications currently received has incorrect or missing information. The online licensing system is being developed to prepopulate certain fields contained on renewal applications with information already housed in VERSA by recognizing limited data input provided by the applicant, such as license number and type, federal employment identification number (FEIN), and pulling in the corresponding information already on record in VERSA. Responsibility for correct data entry will remain with the applicant. However, with the system's ability to recognize empty fields or incorrect data, the applicant will be notified of these errors, and be instructed to address them prior to submission. Online applications will also remove the need for redundant data entry, the provider will input the data directly into the system, where it will be "pended" until it is reviewed and either approved or denied.

The internal agency version of the Skilled Nursing Home renewal application is scheduled to be available by late 2012; the external public version is scheduled for release in early 2013. Both internal and external versions that include initial and change of ownership applications will be released by the end of 2013. All licensure types are scheduled to be available for online applications by the middle of 2014. Although initial submission of online applications will be voluntary, we anticipate significant adoption as there will be additional feature to encourage use.

Public Information and Transparency

Health care facilities and providers are routinely inspected in accordance with current law 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. As part of on-going efforts to promote transparency in health care, the Agency continues to improve the availability of provider information on the Internet through the AHCA Docs and Florida Health Finder websites for the general public to use in making health care decisions.

Fiscal Year 2011-2012 resulted in a substantial rise in public record requests, particularly in the areas of health care clinics and long term care facilities. The increase in requests for health care clinic information corresponds to increased visibility and inquiries related to clinics seeking personal injury protection (PIP) insurance reimbursement and legislative changes for PIP reform. Increases in long term care facility requests were related to complaint investigation reports that require redaction of confidential information thus this information cannot be posted online. The Agency continues to expand the amount of information made available to the public on Florida Health Finder and AHCA Docs. With a continued shift towards transparency, the percent of public record requests processed manually by HQA is expected to decrease by more than half within the next five years.

In addition to publishing inspection reports, AHCA Docs now includes legal orders issued against providers. These include final orders and emergency orders for agency actions, such

as license denials and revocations, moratoriums on admissions, emergency suspensions, and fines assessed against providers with links to the active facilities' profile pages on Florida Health Finder. Likewise, Florida Health Finder now lists enforcement actions against providers including emergency orders and fines assessed against providers with live links back to the legal orders. This increases transparency while reducing staff workload on responding to public records requests.

The Agency anticipates further expansion of documents available online to improve consumer access to information. These efforts will include application forms with the implementation of online licensing and consolidating multiple pieces of information into a single location on the Agency's website.

The Shift towards Managed Health Care

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/Beneficiary Assistance Program, and specific monitoring and oversight of Medicaid health plans for compliance with the Medicaid contract. The Agency's oversight includes, but is not limited to, the assessment of care quality as measured by the Healthcare Effectiveness Data and Information Set (HEDIS) quality of care measures and by the requirements for national accreditation. Oversight of Medicaid health plans includes Provider Service Networks (PSNs) that are not regulated by OIR.

A total of 19 Health Maintenance Organizations (HMO) and seven PSNs are contracted with Medicaid to provide services in 48 counties throughout Florida. Enrollment in Medicaid HMOs and PSNs has grown with the increase in Medicaid recipients related to the economy and as plans expand into additional counties. Overall, Medicaid managed care enrollment is up from 1.4 million in July 2011 to 1.8 million in July 2012. See Table 1-3 for the type of product provided by Managed Care Organizations (MCO).

Table 1-3:

Type of Managed Care Organization	Products and Services Provided*		
	Commercial Managed Care	Medicare Products	Medicaid Plans
Health Maintenance Organization (HMO)	24	28	19
Exclusive Provider Organization (EPO)	5	2	0
Prepaid Health Clinic (PHC)	5	0	0
Provider Services Network (PSN)	0	0	7

More than one product or service may be provided by a single HMO or EPO.

During Fiscal Year 2012-2013 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 Managed Medical Assistance Care. Development of new contract 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.

Automation of manual processes and review can provide efficiencies similar to the benefits of the Online Licensing Project in managed care oversight. The Bureau of Managed Health Care is working collaboratively with Medicaid to expand the current Choice Counseling software to include a Provider Network Verification (PNV) module that will enable contracted Medicaid managed care plans to submit weekly files of their provider networks for verification of network adequacy. The module is expected to be released in the spring of 2013. The PNV will automate many manual checks currently performed when networks are reviewed including the verification of provider eligibility with Medicaid enrollment or registration, federal exclusion status, criminal background screening, and proper licensure by the Agency or DOH. This system will help create important infrastructure for data connectivity across multiple health provider systems**.**

In addition, HQA and Medicaid are currently working towards better system integration and connectivity regarding the Medicaid Information Technology Architecture (MITA). Current projects involve automating data submission by managed care plan network providers contracted with Florida's Medicaid managed care plans and facilitating greater electronic data exchange between provider licensure information and managed care plan network provider information.

Administration and Support (Division of Information Technology)

The Agency'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. IT's overall goal is to maximize the Agency's efficiency through technology. Currently, IT's functional areas are represented by three named bureaus, each with clear and distinct responsibilities but deeply invested in working as a unit to ensure that the Agency's strategic goals are met. Those bureaus are: Customer Service and Support, Application Development and Support, and IT Strategic Planning and Security. Previously, there was a fourth bureau entitled "Enterprise Infrastructure." However, due to the statewide Data Center Consolidation initiative, where the Agency moved its data center to the Northwood Shared Resource Center, that bureau was downsized and consolidated.

The administration of enterprise security of data and information technology is governed by section 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.

As Florida's population continues to age, finding new and more cost efficient ways to support vital health care services is critical to the continued success of the Agency and its charge to keep Floridians healthy. Technology initiatives and operational needs continue to grow. With the national and state spotlight continually focused on health care initiatives, the Agency's

success depends on its response to new programs and initiatives. For this reason, the Agency has chosen to prioritize innovation, return on investment, efficiency, and customer service. To meet these goals, the Agency will focus on its mission with a heightened regard for information technology, its capacity to strengthen and streamline the Agency's internal operations, and services to customers. Attributes that will help to maintain the focus on important initiatives within IT continue to include: qualified staff, technical adaptability, customer service standards, frontline employee communication, and collaboration of skills and efforts.

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.

Agency Responsibilities and Obligations

The Agency recognizes that its routine and mission critical operations must be consistently and reliably available to internal and external customers and service providers. A key factor in the Agency's ability to meet its responsibilities in this regard is the quality and retention of its staff. The Agency must do everything in its power to recruit and retain qualified, experienced staff. The Agency's rate of compensation is critical in keeping valued staff employed by the Agency; it is a significant component of employee job satisfaction. In years past when the state economy flourished, Agency employees were often lost to the private sector. Currently, the recessionary trends have not had a detrimental effect on the Health Industry and Information Technology sectors:

"Even during the recession, many industries—from manufacturing and environmental firms to health care and information technology—have had trouble hiring skilled workers." (Excerpt From: "Enterprising States; Recovery and Renewal for the 21st century;" A Project of the U.S. Chamber of Commerce and the National Chamber Foundation; June 20, 2011)

In the past two years, IT has been challenged with replacing valuable resources and institutional knowledge lost to both the private sector and other state agencies. Due to disparity in budgets, many state agencies are in the position to offer higher salary levels than this Agency, and therefore, are in a position to draw current IT staff away from the Agency. A recent review of comparable position titles across state agencies showed the Agency's IT staff to be compensated at about ten percent below the state average in each category. Private sector compensations have ranged from 25 to 50 percent higher based on exit interviews and information received from state vendors.

Strategic Planning, Vision, Oversight

The appointment of an agency chief information officer (CIO) is governed by section 282.3055, F.S. This statute instructs the CIO to coordinate and facilitate the management and planning of the Agency's information technology services.

The Agency's Management Team strongly supports the use of technology as an effective tool in furthering the Agency's overall goals and objectives. IT functions as a partner in Agency strategic planning and vision creation.

In order to achieve Objectives 1.C and 1.D, to better serve the Agency, and align information technology with its core mission, it is the vision of the CIO to make improvements in two major areas within IT. The first includes, as noted above, finding ways to compensate, attract, and retain competent information technology staff. The second is to better leverage staff to improve overall technical performance.

AHCA's long term policy intentions are further demonstrated by the efforts of the Agency's Management Team to consolidate all information technology purchases and other significant decision-making (with the exception of the Medicaid program fiscal agent FMISS/DSS) within IT. IT will seek assistance from the private sector to better equip management and the Agency's Project Governance Team through thorough business case analysis to include the Return on Investment (ROI). The Agency's Project Governance Agency Management Team Committee and the APG provide direction and oversight to the Agency by reviewing all proposed projects and prioritizing them according to need. It is the expressed purpose of these bodies (AHCA Project Governance Agency Management Team Committee and the APG) to align all information technology initiatives with the ongoing mission of the Agency.

Internal and External Influences

There are several factors that strongly influence the Agency's ability to fulfill 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, including:

- 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 first and most powerful factor influencing the Agency's planning is the integration of information technology in health care. Every sector of the health care industry has experienced significant growth and increases in the cost of doing business and providing services. Information technology will become instrumental in facilitating integration of disparate systems and automation of regulatory processes.

The second factor influencing the Agency is comprised of two variables: 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.

To achieve the ongoing objective of identifying and securing confidential or sensitive data, Objective 1.D was established. Objective 1.D will measure the overall effort to strengthen the

Agency's data security capabilities. By Fiscal Year 2016-2017, 99.99 percent of any data stored on or passing through IT-managed resources will be secured according to the Agency's security standards on access, encryption, and backup.

The third factor influencing the Agency's ability to achieve its goals is the impact of the private sector labor market. Objective 1.C measures the Agency's ability to attract, develop, retain, and reward a high performance workforce. The public sector traditionally has difficulty in competing with the private sector for skilled information technology workers. However, benefits, such as retirement, insurance, training, flexible schedules, and other factors, can partially compensate for the lower salaries. Competition from the private sector and other state agencies is one of the most significant factors affecting the ability to retain the necessary IT workforce.

Considering all of the combined factors influencing the Agency's ability to retain a high performance workforce, IT has developed an objective to achieve a 90 percent employee retention rate by Fiscal Year 2017-2018. The Agency recognizes the importance of employee retention in achieving its mission and plans to address this issue by realigning its existing resources to ensure adequate funding is available to offset workforce retention challenges.

Statutorily Required AHCA Primary Data Center Consolidation

The Agency is in the process of consolidating its data center, as legislatively mandated, into the Northwood Shared Resource Center (NSRC). Significant transition planning was completed to ensure the success of this delicate data center move to NSRC. The Agency decided to take the "phased approach" to limit the impact to users and due to the limited number of qualified staff available to assist with the physical transition. The phased approach is defined by a series of both physical and virtual moves to allow for a settling period between each. The Agency rejected the "forklift approach" because it required more down time and adds different elements of risk. The final step will be to migrate email mailboxes, which the Agency expects to complete by the end of October 2012.

IT will work closely with NSRC to ensure that the same or a better level of services will be available to the Agency. Service Level Agreements (SLAs) will be executed to ensure these services are effectively and efficiently carried out by NSRC.

Administration and Support (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. This purpose is carried out, in part, by the Bureau of Medicaid Program Integrity (MPI), for the Medicaid program. In this program, the key indicator of fraud and abuse is overpayments. The Florida Medicaid program is a $21.2 billion program with an estimated total of 80,000 enrolled providers that provided Medicaid services to approximately 3.1 million beneficiaries during Fiscal Year 2011-2012.

In addition, MPI continues to ensure that the Medicaid program is managed in accordance with Section 409.913, F.S., and Title 42, Code of Federal Regulations (CFR), which mandates that the Agency operate a program to oversee the activities of Florida Medicaid recipients, providers

and their representatives to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, to recover overpayments, and impose sanctions, as appropriate.

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 collaboration between state and federal organizations will assist in identifying more fraud prevention and monetary recovery opportunities in addition to identifying areas where state Medicaid policy needs to be strengthened.

Through this audit 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 improper 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 Attorney General's Medicaid Fraud Control Unit (MFCU), the DOH, APD, CMS, 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, and the Medicaid and Public Assistance Fraud Strike Force (created during the 2010 Legislative Session), to stop criminals, reduce fraud, and protect the integrity of the Florida Medicaid program. Additional resources could increase overpayments recouped and enhance return on investment.

To accomplish the Agency's 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. MPI will work collaboratively to achieve its goals 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 new system 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 Fiscal Year 2010-2011, MPI prevention efforts resulted in cost savings of $22.1 million. Actual overpayments recovered through the efforts of MPI totaled $53 million for the same fiscal year.

- **Prevention -** Prevention efforts enhance the efficiency of the Medicaid Program in that detection, auditing, and recovery of overpayments are complemented through enhanced 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 identifying 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; imposition of fines and costs as appropriate; and referrals to MFCU and other regulatory and enforcement agencies.

Health Care Services (Division of Medicaid)

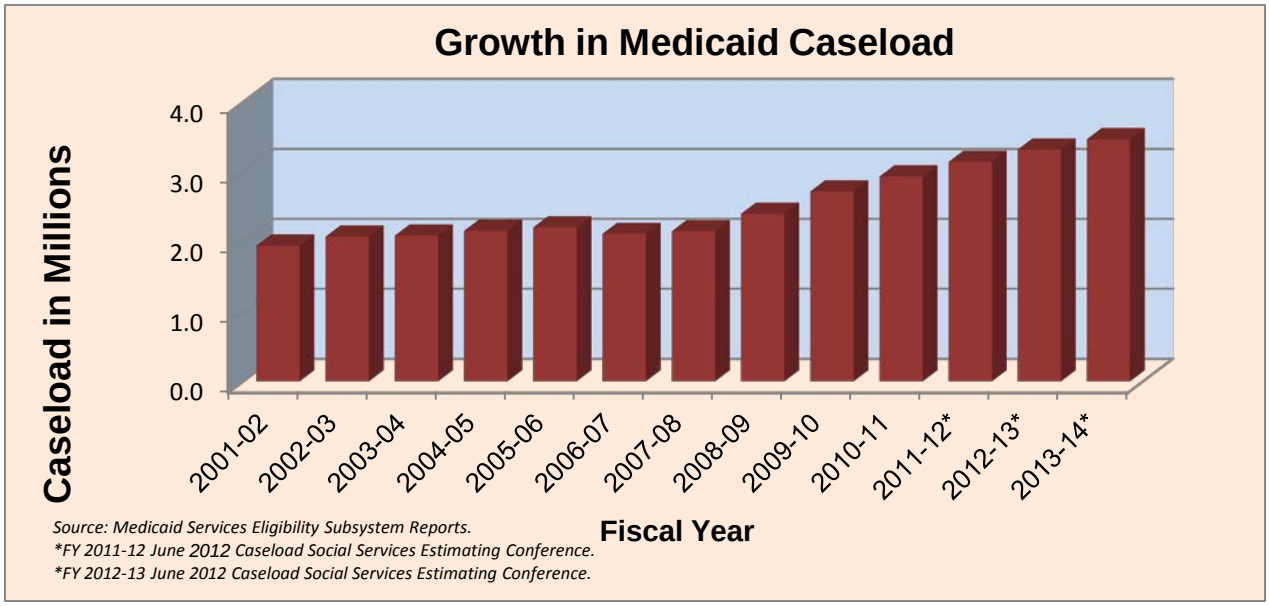
Authority for the Florida Medicaid Program is established in chapter 409, F.S., (Social and Economic Assistance) and chapter 59G, F.A.C., (Medicaid). Other relevant statutes that mandate the management and administration of state and federal Medicaid programs, child health insurance programs, and the 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 of such, to receive federal financial participation (FFP) in the program. Although rates of federal participation vary each year and by activity, in Fiscal Year 2011-2012, 55.94 percent of the expenditures for most Medicaid services were reimbursed with federal funds. Administrative costs continue to be reimbursed at 50 percent and information technology projects and specific services such as family planning are reimbursed at higher levels.

The need for Medicaid funded health care services is affected by population growth, the demographic profile of the population, and economic conditions that impact employment and income. In April 2010, the U.S. Census Bureau estimated Florida's population to be approximately 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 (17.3 percent) of elderly residents in the nation. As the baby–boom generation (those born between 1946 and 1964, per US Census Bureau) 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 Fiscal Year 2011-2012, it is estimated that Medicaid will have served 3.1 million beneficiaries and paid claims to approximately 80,000 enrolled providers. With a budget of $21.2 billion in Fiscal Year 2012-2013, Medicaid is the largest single program in the state, accounting for more than 30 percent of the state's total budget. It is also the largest source of federal funding for the state. Medicaid caseloads in Fiscal Year 2011-2012 were more than 52 percent higher than a decade ago (Table 3-1). The caseload increased by 7.1 percent in Fiscal Year 2011-2012 over the prior fiscal year and is projected to increase in FY 2012-2013 by more than 5.5 percent compared to Fiscal Year 2011-2012. The caseload increases in recent years reflect external factors not within the Medicaid program's control, especially the rapid downturn in the economy in Fiscal Year 2007-2008 through Fiscal Year 2010-2011 and the resulting statewide unemployment rate of 10.6 percent as of June, 2011.

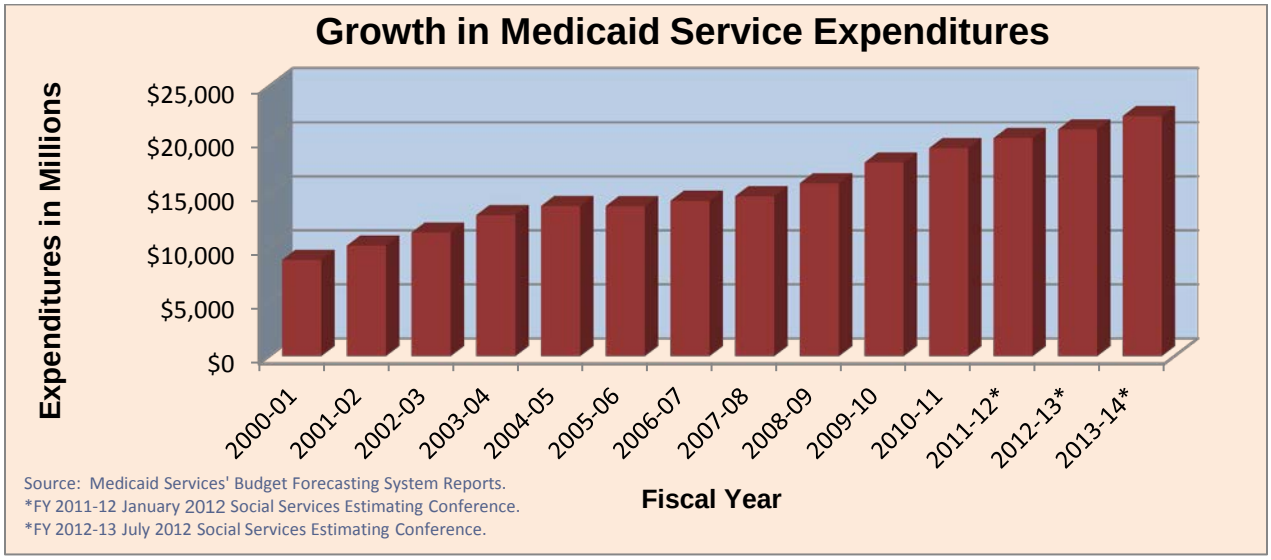
Table 3-1



In the last ten years, expenditures in the Medicaid program grew from almost $11.4 billion in Fiscal Year 2002-2003 to $21.2 billion budgeted in Fiscal Year 2012-2013, close to doubling in that time period (Table 3-2). 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 Fiscal Year 2012-2013 are: Hospital Inpatient Services ($3.7 billion), Prepaid Health Plans ($3.6 billion), Nursing Home Care ($2.8 billion), Prescription Services ($2.0 billion), Supplemental Medical Insurance ($1.3 billion), Physician

Services ($1.1 billion), Hospital Outpatient Services ($1.1 billion), Low Income Pool ($1.0 billion), and Home/Community Based Services ($1.1 billion).

Table 3-2



During Fiscal Year 2009-2010, the Florida Medicaid Management Information System (MMIS) received full federal certification from the CMS. The certification allows Florida to receive and to continue to receive the maximum federal funding of 75 percent for the operation of the system.

Medicaid enrollment has seen a steady growth over the last decade in line with an increasing state population. Recently, due to poor economic conditions beginning with the national recession in 2009, the state's Medicaid rolls have grown at a faster rate than in previous years. As a social safety net program, Medicaid enrollment and expenditures are closely tied and inversely related to economic performance. In other words, when the economy worsens, Medicaid rolls increase. Increased enrollment is not the only factor that influences Medicaid expenditures. Health care cost inflation has outstripped cost increases in other economic sectors for years. The 2011 Legislature passed an act relating to Medicaid Managed Care, chapter 2011-134, Laws of Florida, 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 referred to as the Statewide Medicaid Managed Care program (SMMC). SMMC will provide greater predictability in costs while ensuring Medicaid recipients continue to have access to quality health care services.

Structure, Functions, and Current Activities

Core functions of the Division of Medicaid 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. Medicaid staff is responsible for planning and development for SMMC, as well as maintaining current operations which are organized in seven bureaus: Program Analysis, Medicaid Services, Health Systems Development, Pharmacy Services, Program Finance, Contract Management, and Field Operations.

Some of the key activities over the last fiscal year include the development of policies, procedures, fee schedules, and programs to promote access to quality acute and long-term medical, behavioral, therapeutic, and transportation services for Medicaid beneficiaries. Medicaid Services, for example, increased oversight of several Medicaid programs (therapy services, prescribed pediatric extended care services) by implementing utilization management, including prior authorization processes. This should help the Agency better control cost and quality in those programs. The Agency also partnered with the APD to implement the iBudget waiver, which replaces the four home and community based waiver programs that serve individuals with development disabilities. The iBudget waiver provides waiver enrollees with greater control, choice, and flexibility over the waiver services they choose to purchase with their budget. Several home and community based waiver programs were renewed including the Nursing Home Diversion waiver, Traumatic Brain Injury/Spinal Cord Injury and the Adult Cystic Fibrosis waiver. These programs provide community based alternatives to costly institutional care. Several other programs and efforts were undertaken to improve payment system controls, as well as improving the quality and access to services.

The Bureau of Medicaid Health Systems Development (HSD) is responsible for the development and oversight of Medicaid's managed care programs. HSD developed an amendment to the previous (ending June 30, 2012) Medicaid Health Plan contract to cover telemedicine, medical loss ratio requirements and other federal and state statutory changes, and developed the Medicaid Health Plan contract for the next three fiscal years.

HSD assisted nine Medicaid health plan applicants in the health plan application process resulting in two new Medicaid health plans, which expands the access and choice options available to Medicaid recipients in Florida. HSD continues to manage the operations of the MediPass and Disease Management programs and submitted an amendment request to the current 1115 Reform Waiver to federal CMS. The amendment was submitted to implement the medical assistance program under SMMC. HSD also renewed the 1115 Reform Waiver and amended the 1915(b) Managed Care Waiver through June 2014.

The Bureau of Pharmacy Services is responsible for administration, management, and oversight of the Medicaid Pharmacy Services program. This includes policy development and implementation and rulemaking necessary to implement statutes to optimize drug therapy for Medicaid recipients by ensuring access to pharmaceuticals that are clinically efficient, cost effective, and produce desired outcomes. Fiscal and operational analysis of policy and legislative proposals to determine the impact to the program and statutory reports to the Legislature are produced by this bureau.

The Bureau of Medicaid Contract Management (MCM) oversees the contract with the Medicaid fiscal agent and coordinates federal and state initiatives that involve technology shifts and changes to data collection and reporting. Over the past year, MCM completed the Agency's MITA State Self-Assessment Project to align the Agency to the MITA 3.0 Version/Rule and set the roadmap for future business and systems interoperability planning and development, and maintain federal enhanced funding for development projects and ongoing enhanced federal funding. MCM in conjunction with the Florida Center also initiated the Electronic Health Record (EHR) Provider Incentive Payment Program in September 2011 to provide payments to hospitals and eligible professionals enrolled in the Florida Medicaid Program to enhance and purchase EHR capability, with funding provided through ARRA.

Medicaid Program Analysis (MPA) was reorganized into two separate bureaus including the Bureau of Medicaid Program Finance (MPF) and the Bureau of Medicaid Program Analysis (see "Reorganization…" below.) MPA's responsibilities include encounter data collection and analysis and the multiple administrative and analysis functions for which those data are used. MPF is responsible for budget and fiscal planning, administration of the Low Income Pool and Disproportionate Share program, and setting rates for institutional providers who are reimbursed on a cost basis.

The staff of the Medicaid Field Offices provide local operational management and facilitation of the Medicaid provider networks, conduct provider training, handle provider and beneficiary relations, oversee community resource development, process exceptional claims, authorize certain beneficiary services, monitor programs, and conduct program audits. They are a key component to the daily operations of Medicaid.

Reorganization for Statewide Medicaid Managed Care

Many of the activities within Medicaid focus on preparation for the launch of SMMC. In order to meet the changing demands that SMMC will bring, Medicaid underwent a reorganization to better align resources and staffing with the needs for a statewide managed care system. The reorganization included:

1. Creation of the Assistant Deputy Secretary Position for Medicaid Health Systems Development and reorganization of Areas of Responsibility.

   In order to realign resources and staffing to better align with the expanded managed care functions under the SMMC program, the Division of Medicaid has reorganized to include three Assistant Deputy Secretaries rather than two.

   - **Assistant Deputy Secretary for Finance**

     The position continues to serve as the Chief Financial Officer for Medicaid and includes supervision of the Medicaid Finance Bureau, the Medicaid Program Analysis Bureau, and the Medicaid Contract Management Bureau. In addition, the Quality Management Bureau, which previously reported to the Assistant Deputy Secretary for Medicaid Finance, is effectively dissolved. As subsequently described, the units in this bureau are being transferred to other sections of the Medicaid Program.

   - **Assistant Deputy Secretary for Operations**

     The position is responsible for Medicaid service waivers and Medicaid service policy, quality initiatives, and includes supervision of the Medicaid Services Bureau, the Medicaid Pharmacy Services Bureau, and the Performance, Evaluations, and Research Unit.

- **Assistant Deputy Secretary for Medicaid Health Systems**

  This newly created position heads up a Medicaid health systems section that includes the Bureau of Health Systems Development, the Bureau of Medicaid Field Operations, and the Choice Counseling Unit (moved from its prior locations under the Medicaid Contract Management Bureau).

As legislatively directed, once expansion of managed care is implemented, the number of Medicaid recipients who receive services through managed care plans will increase drastically to more than two million. The Agency is directed to competitively procure for managed care plans statewide. The number of plans is expected to increase from the current number of 21 to possibly over 100. Implementation of these efforts will be resource intensive and will require focused leadership and coordination between multiple bureaus and divisions in the Agency.

2. Creation of two separate bureaus from the existing Medicaid Program Analysis bureau to better align resources for managed care rate setting and data analysis, including processing and use of encounter data.

   - **Medicaid Program Analysis**

     As part of the separation into two distinct bureaus, the unit and staff associated with the Medicaid Encounter Data Systems (MEDS) and managed care rate risk adjustment were moved from their prior location in the Bureau of Quality Management to the Bureau of Program Analysis. In addition to responsibilities relating to managed care rate setting and encounter data analysis, the Medicaid Program Analysis Bureau is responsible for functions relating to analysis and modeling of data. More emphasis can be placed on audit functions and findings, especially with the addition of managed care audit functions.

   - **Medicaid Program Finance**

     The organization of the Bureau of Medicaid Program Finance consolidates the fiscal support, institutional rate setting, and Low Income Pool (LIP)/Disproportionate Share (DSH) activities, providing for enhanced focus on tracking and monitoring of expenditures, especially intergovernmental transfers (IGTs) as a growing funding source for hospital funding into one bureau. Additional staff resources could also enhance the interrelations with the Agency's Division of Operations.

3. Creation of an in-house actuary position.

   The addition of an actuary position provides the Agency the ability to perform independent actuarial analyses in the Medicaid managed care rate setting process. In addition, we will use an actuary's experience and expertise in matters of rate analysis for various eligibility categories in managed medical assistance care and managed long term care, as well as Incurred But Not Reported Losses (IBNR) analysis, Medical Loss Ratio analysis, benchmarking, and achieved savings analysis. This position will develop cost estimates for Medicaid programs and will be an Agency resource in all other rate setting processes. The Actuary position is located within the Medicaid Director's office.

Activities over the Next Five Years

Chapter 2011-134, Laws of Florida, directs the Agency to implement the SMMC program as a statewide, integrated managed care program for all covered medical assistance services and long-term care services. As Medicaid transitions to SMMC, many of the current Fee-for-Service (FFS) functions will diminish as managed care roles and responsibilities increase to support the need for procurement and contract compliance/monitoring functions.

Significant activities over the next five years by the Division of Medicaid will be directed toward program development and implementation of the SMMC program. This includes executing contracts with winning long-term care (LTC) plans and ensuring approximately 85,000 frail elders and adults with disabilities who receive services are appropriately notified, educated, and counseled about managed care plan choices. The Division of Medicaid will also begin the implementation of the Managed Medical Assistance (MMA) component of the SMMC program. These activities will include finishing the procurement of MMA plans to award bids and implement contracts covering approximately two million Medicaid recipients.

Reviewing, inspecting, and monitoring managed care plans to ensure readiness and ongoing capacity to serve enrollees will be a significant activity for both the LTC and MMA components of the SMMC program. Modifications to the MMIS and the transition of the Prepaid Mental Health Plans, Prepaid Dental Plans, and MediPass into the SMMC program will also be significant. Additionally, increased managed care plan accountability will drive ongoing activities related to contract compliance, network access standards, encounter data, continuous quality improvement, financial accountability, and program integrity.

The Division of Medicaid will also continue to provide necessary information to the federal CMS as required by Special Terms and Conditions imposed by CMS in obtaining waiver authorities necessary for the implementation of the SMMC program.

Despite the shift to staffing primarily focused 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, regardless of the transition to a primarily managed care environment. As a result, functions currently dedicated to FFS such as rate setting activities, tracking and monitoring of IGTs, continuing to streamline the rulemaking process in order to assist in a quicker turnaround for promulgating policy handbooks, and maintaining a FFS provider network for excluded populations will remain.

The Division of Medicaid will be managing a MMIS transition (with procurement and either a takeover of existing MMIS architecture, or new MMIS) starting 2013 and going through 2018. Other significant activities will include implementing new quality and fraud fighting initiatives statewide (such as the telephony pilot and the comprehensive care management pilot projects). The Division of Medicaid will also be working with Florida Healthy Kids Corporation as they transition to a new third party administrator, effective August 2013, to ensure a smooth transition for file transmissions, Title XXI eligibility determinations, enhancements and simplifications and, improved quality performance standards for all of the Title XXI programs.

The Agency has been directed by the Florida Legislature to develop and implement a Medicaid Diagnosis-Related Group (DRG) payment system for hospital inpatient services by July 1, 2013. A DRG is a system to classify hospital case types into groups expected to have similar hospital resource use. The DRG payment rates include most routine operating costs attributable to patient care, including routine nursing services, room and board, and diagnostic and ancillary services. The Agency must develop a plan to convert Medicaid inpatient hospital rates to a prospective payment system that categorizes each case into diagnosis-related groups (DRG) and assigns a payment weight based on the average resources used to treat Medicaid patients in that DRG. Medicaid currently uses a per diem payment system for hospital inpatient reimbursement based on provider costs. In order to convert the inpatient hospitalization payment methodology to a DRG system, a rate of payment must be developed to deliver care to a patient with a particular disease by grouping related diagnoses. Development of the DRG system will include an analysis of the options available for a DRG system including the impact on current policy, procedures and systems, and the Medicaid reimbursement plan.

MCM is responsible for the oversight of the conversion to International Classification of Disease, 10th (ICD-10) addition as mandated by the federal CMS. 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). The ICD-10 federally required changes are applied to the entire U.S. Health care industry and represents a significant modification to diagnosis coding that all heath care providers and payers must adopt. The Health Insurance Portability and Accountability Act (HIPAA) mandated that all providers and payers begin using ICD-10 coding by October 1, 2014. The Agency will request year 3 funding in its Legislative Budget Request. Activities for the third year of the project will include changing the Medicaid policy that governs the use of diagnosis and hospital inpatient procedure codes, determine the most appropriate reimbursement rates for the new procedure code system, and outreach and training for the enrolled Medicaid providers.

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	Online Licensure and Reconciliation System	The online licensing and reconciliation project will include full implementation of online licensing for 29 provider types regulated by the Agency, including online payment, integration with document management, web portal for providers to submit applications, check status, and update licensure information between license renewals. The application will allow a 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 all Agency fees, assessments, overpayments, and fine to facilitate full collection before licenses are issued.	If the LBR issue is not approved, the Agency would not be able 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	Expand background screening capability with grant funds from federal CMS. The Agency was awarded a grant with the	If the LBR issue is not approved, the Agency will not be able to accommodate the change in law and the entire grant must

		CMS to implement additional background screening enhancements and expand provider types that would require employment screening.	be refunded.
Division of Information Technology			
3	None		
Office of the Inspector General			
4	None		
Division of Medicaid			
5	Statewide Medicaid Managed Care Program	The Agency requests funding to implement the Statewide Medicaid Managed Care program pursuant to HB 7107 and HB 7109.	If this funding is not approved, the Agency would have difficulty meeting the statutory requirements of implementing the statewide program.
6	ICD-10 Conversion	This change represents a substantial modification 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 this LBR issue is not approved, the Agency will be at risk of not complying with the federal HIPAA mandate that requires all providers and payers to begin using the ICD-10 version by October 1, 2014.

List of Changes that Would Require Legislative Action

Number	Proposed Changes	Describe Expected Results of Proposed Changes	Describe Legislative Actions Required to Implement the Proposed Changes
1.	Regulatory Reform	To reduce the regulatory burden on healthcare providers by streamlining processes and eliminating unnecessary reporting.	Statutory Change

List of All Task Forces, Studies in Progress

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
Administration and Support, and Executive Direction			
1.	section 402.56, F.S.	Florida's Children and Youth Cabinet	Ongoing responsibilities
2.	section 420.622 (9), F.S.	Council on Homelessness	Ongoing responsibilities
3.	section 499.01211, F.S.	Drug Wholesale Distributor Advisory Council	Ongoing responsibilities
4.	Florida Arthritis Prevention and Education Program Web Site	Florida Arthritis Partnership (FLAP)	Ongoing responsibilities
5.	section 1004.435, F.S.	Cancer Control and Research Advisory Council	Annually / February 15
6.	http://myfloridachoices.org/	Florida Health Choices Corporation	Ongoing responsibilities

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
7.	section 627.6475, F.S.	Florida Health Reinsurance Program	Ongoing responsibilities
8.	section 624.91, F.S.	Florida Healthy Kids Corporations Board of Directors	Ongoing responsibilities
9.	Part C of the Individuals with Disabilities Education Act as Amended by Public Law 105-17	The Florida Interagency Coordinating Council for Infants and Toddlers (FICCIT)	Ongoing responsibilities
10.	section 409.1451, F.S.	Florida Older Adults Workgroup	Ongoing responsibilities
11.	section 20.43, F.S.	Florida Trauma System Plan Advisory Council	Ongoing responsibilities
12.	section 381.0403 (9), F.S.	The Graduate Medical Education Committee (GMEC)	Ongoing responsibilities
13.	chapter 2008-211, Laws of Florida	Florida Health and Transition Services (HATS) Task Force	Ongoing responsibilities

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
14.	section 409.1451 (7), F.S.	Independent Living Advisory Council	Ongoing responsibilities
15.	sections 395.3025, 405.01, and 405.03, F.S.	Pregnancy-Associated Mortality Review (PAMR) Team	Ongoing responsibilities
16.	Excerpt from 20 U.S.C. chapter 33 IDEA 2004, P.L. 108-446	State Advisory Committee for the Education of Exceptional Students	Ongoing responsibilities
17.	section 427.013, F.S.	Commission for the Transportation Disadvantaged	Ongoing responsibilities
18.	section 14.20195, F.S.	Florida Suicide Prevention Coordinating Council	Ongoing responsibilities
19.	section 624.351, F.S.	Medicaid and Public Assistance Fraud Strike Force	Annually / October 1
20.	chapter 2012-120, Laws of Florida	Statewide Task Force on Prescription Drug Abuse and Newborns	Interim Report / January 15, 2013 Final Report / January 15, 2015

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
21.	section 381.90, F.S.	Health Information Systems Council	Ongoing responsibility
22.	section 893.055, F.S.	Prescription Drug Monitoring Program	Ongoing responsibility
Health Quality Assurance			
23.	section 408.909(9), F.S.	Annual report on Health Flex to be submitted jointly with the Office of Insurance Regulation	January 1, 2013
24.	section 408.7057(2)(g)2., F.S.	Annual Report on the Cases of the Statewide Managed Care Dispute Resolution Program	February 1, 2013
25.	section 400.191, F.S.(2)	Nursing Home Guide Quarterly Report	Ongoing responsibilities
26.	section 395.10972, F.S.	Risk Managers Advisory Group – This is a standing advisory group that has not met in several years.	Ongoing responsibilities
27.	section 483.26, F.S.	Clinical Laboratory Technical Advisory Panel	Ongoing responsibilities
28.	section 627.4236, F.S.	Bone Marrow Transplant Advisory Panel	Ongoing responsibilities
29.	section 409.912, F.S.	Drug Utilization Review Board	Ongoing responsibilities

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
30.	section 288.0656, F.S.	Rural Economic Development Initiative	Ongoing responsibilities
31.	section 408.05, F.S.(8)	Health Information Exchange Coordinating Committee	Ongoing responsibilities
32.	section 391.221, F.S.	Statewide Children's Medical Services Network Advisory Council.	Ongoing responsibilities
33.	Executive Memorandum – July 2012	Assisted Living Workgroup	October 2012
34.	section 402.281, F.S.	Governor's Panel on Excellence in Long Term Care (Gold Seal Program)	Ongoing responsibilities
35.	section 765.543, F.S.	Organ and Tissue Procurement and Transplantation Advisory Board	Ongoing responsibilities
36.	section 408.7056 and section 408.7057, F.S.	Statewide Provider and Subscriber Assistance Panel	Ongoing responsibilities
37.	section 409.913, F.S.	Joint report Agency for Health Care Administration (AHCA) and Medicaid Fraud Control Unit (MFCU) documenting effectiveness of efforts to control fraud	Annually / January 1

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
38.	section 20.055(5)(i), F.S.	Schedules engagement for the upcoming fiscal year	Annually / September 30
39.	section 20.055(7), F.S.	Summary of all activities within the Inspector General's office for the previous fiscal year	Annually / September 30
40.	section 409.9841, F.S.	Long-term Care Managed Care Technical Advisory Workgroup	June 30, 2013
41.	section 641.60, F.S.	Managed Care Ombudsman Committees	Ongoing responsibilities
42.	section 429.19, F.S.	Assisted Living Facilities Annual Report on Fines	Annually / July 30
43.	section 408.05(8), F.S.	State Consumer Health Information and Policy Advisory Council	Ongoing responsibility
44.	section 627.6699, F.S.	Florida Health Insurance Advisory Board (FHIAB)	Ongoing responsibilities
Division of Information Technology			
45.	None		

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
Division of Medicaid			
46.	section 409.913, F.S.	Annual Medicaid Fraud and Abuse Report	Ongoing responsibilities
47.	section 409.91211, F.S.	Enhanced Benefits Panel	Ongoing responsibilities
48.	section 409.818, F.S.	Florida KidCare Grievance Committee	Ongoing responsibilities
49.	section 409.91213, F.S.	Low Income Pool	Quarterly progress reports and annual reports for 1115 waivers
50.	section 409.911, F.S.	Low Income Pool (LIP) Council	Ongoing responsibilities
51.	section 409.91211, F.S.	Medicaid Reform Technical Advisory Panel	Ongoing responsibilities
52.	section 765.53, F.S.	Organ Transplant Advisory Council	Ongoing responsibilities
53.	section 409.91195, F.S.	Pharmaceutical and Therapeutics Committee	Ongoing responsibilities

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
54.	section 409.912, F.S.	Practitioner Prescribing Patterns Review Panel	Ongoing responsibilities
55.	section 16.615, F.S.	Council on the Social Status of Black Men and Boys	Ongoing responsibilities
56.	section 393.002, F.S.	Florida Developmental Disabilities Council's Health Care/Prevention Task Force	Ongoing responsibilities
57.	section 409.818(3)(e), F.S.	Kid Care Coordinating Council (Membership Only)	Ongoing responsibilities
58.	chapter 2012-118, Laws of Florida	Contract with an independent, third party consulting firm to complete a feasibility study for developing an Internet-based system for eligibility determination for Medicaid and the Children's Health Insurance Program (CHIP)	December 1, 2012
59.	http://www.fcso.com/stakeholders/095847.asp#P2_566	Florida Carrier Advisory Committee	Ongoing responsibilities
60.	section 409.8177(2), F.S.	Florida KidCare Enrollment Report on enrollment for each component of Florida KidCare Program.	Ongoing responsibilities
61.	section 409.908(2)(b)5, F.S.	Nursing Care Cost Report: Annual Report on direct and indirect care costs.	Ongoing responsibilities

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
62.	section 409.912 (39)(c), F.S.	Medicaid Prescribed-Drug Spending Control Quarterly Report must include at least the progress made in implementing this subsection and its effect on Medicaid prescribed-drug expenditures.	Ongoing responsibilities
63.	section 409.91213, F.S.	Medicaid Reform Quarterly Report: Agency analysis and the status of various operational areas.	Ongoing responsibilities
64.	section 409.91213, F.S.	Medicaid Reform Annual Report: Report documenting accomplishments, project status, quantitative and case-study findings, utilization data, and policy, and administrative difficulties in the operation of the Medicaid waiver demonstration program.	Ongoing responsibilities
65.	section 409.912 (44), F.S.	Health Systems Development annual report of audit results to ensure cost effectiveness relating to Medicaid Managed Care	Ongoing responsibilities
66.	section 409.8177(1), F.S.	Florida KidCare Evaluation Annual Report: AHCA, in consultation with DOH, DCF & Florida Healthy Kids contract for evaluation and report on KidCare program	Ongoing responsibilities

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
67.	section 409.912(15)(e), F.S.	CARES Program Operation Annual Report: AHCA & DOEA submit annual report on operation of CARES.	Ongoing responsibilities
68.	section 409.911(10, F.S.	Low Income Pool Council annually submits findings and recommendations on the financing of the Low-Income Pool and the disproportionate share program and the distribution of funds.	Ongoing responsibilities
69.	section 409.912(28), F.S.	EPSDT (Child Health Check Up) Screening Rates	Ongoing responsibilities

Performance Measures and Standards – LRPP Exhibit II

LRPP Exhibit II: Performance Measures and Standards

Approved Performance Measures for FY 2012-2013 (Words)		Approved Prior Year Standards FY 2011-2012 (Numbers)	Prior Year Actual FY 2011-2012 (Numbers)	Approved Standards for FY 2012-2013 (Numbers)	Requested FY 2013-2014 Standard (Numbers)
Program: Administration and Support			**Code: 68200000**		
1	Administrative costs as a percent of total agency costs	0.11%	0.06%	0.11%	0.11%
2	Administrative positions as a percent of total agency positions	11.45%	10.94%	11.45%	11.45%
Program: Health Care Services			**Code: 68500000**		
Service/Budget Entity: Children's Special Health Care			**Code: 68500100**		
3	Percent of hospitalizations for conditions preventable by good ambulatory care	7.70%	See New Measure 3A Below	7.70%	DELETE[4]
3A	New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): CMSN enrollees (Title XIX and Title XXI)	N/A	19.10%	20.00%	20.00%
4	Percent of eligible uninsured children receiving health benefits coverage	100.00%	See New Measure 4A Below	100.00%	DELETE[4]
4A	New Measure - Percentage of all Title XXI KidCare enrollees eligible for renewal who either renew KidCare coverage or maintain health care coverage from another source	N/A	91.00%	90.00%	90.00%
5	Percent of children enrolled with up-to-date immunizations	85.00%	N/A	85.00%	DELETE[4]

	Approved Performance Measures for FY 2012-2013 (Words)	Approved Prior Year Standards FY 2011-2012 (Numbers)	Prior Year Actual FY 2011-2012 (Numbers)	Approved Standards for FY 2012-2013 (Numbers)	Requested FY 2013-2014 Standard (Numbers)
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	97.00%	N/A	97.00%	DELETE[4]
7	Percent of families satisfied with the care provided under the program	95.00%	91.20%	95.00%	90.00%[4]
8	Total number of Title XXI-eligible children enrolled in KidCare	228,159	291,292	228,159	Per Estimates[1]
9	Number of Title XXI-eligible children enrolled in Florida Healthy Kids	195,867	233,606	195,867	Per Estimates[1]
10	Number of Title XXI-eligible children enrolled in MediKids	2,100	35,019	21,000	Per Estimates[1]
11	Number of Title XXI-eligible children enrolled in Children's Medical Services Network	111,292	22,667	22,500	Per Estimates[1]
Program: Health Care Services			**Code: 68500000**		
Service/Budget Entity: Executive Direction and Support Services			**Code: 68500200**		
12	Program administrative costs as a percent of total program costs	1.44%	2.51%	1.44%	2.50%[4]
13	Average number of days between receipt of clean Medicaid claim and payment	15	8.3	15	15
14	Number of Medicaid claims received	145,101,035	167,000,000	145,101,035	Per Estimates[1]

Approved Performance Measures for FY 2012-2013 (Words)		Approved Prior Year Standards FY 2011-2012 (Numbers)	Prior Year Actual FY 2011-2012 (Numbers)	Approved Standards for FY 2012-2013 (Numbers)	Requested FY 2013-2014 Standard (Numbers)
Program: Health Care Services			**Code: 68500000**		
Service/Budget Entity: Medicaid Services - Individuals			**Code: 68501400**		
15	Percent of hospitalizations that are preventable by good ambulatory care	11.00%	See New Measures15A and 15B Below	11.00%	DELETE[4]
15A	New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Ages 1 to 20 enrolled in Fee-for-Service, MediPass, and Provider Service Networks	N/A	29.90%	25.00%	25.00%
15B	New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Ages 21 and Over enrolled in Fee-for-Service, MediPass, and Provider Service Networks	N/A	22.20%	20.00%	25.00%
16	Percent of women receiving adequate prenatal care	86.00%	84.40%	86.00%	86.00%
17	Neonatal mortality rate per 1000	4.70%	4.80%	4.70%	4.70%

Approved Performance Measures for FY 2012-2013 (Words)		Approved Prior Year Standards FY 2011-2012 (Numbers)	Prior Year Actual FY 2011-2012 (Numbers)	Approved Standards for FY 2012-2013 (Numbers)	Requested FY 2013-2014 Standard (Numbers)
18	Average number of months between pregnancies for those receiving family planning services	35.00%	See New Measure 18A Below	50.00%	DELETE[4]
18A	New Measure - Percentage of women with an Interpregnancy Interval (IPI) greater than or equal to 28 months.	N/A	56.20%	50.00%	50.00%
19	Percent of eligible children who received all required components of EPSDT screening	64.00%	65.00%	64.00%	64.00%
20	Number of children ages 1-20 enrolled in Medicaid	1,249,276	2,188,843	1,249,276	Per Estimates[1]
21	Number of children receiving EPSDT services	407,052	548,364	407,052	Per Estimates[1]
22	Number of hospital inpatient services provided to children	92,960	173,311	92,960	Per Estimates[1]
23	Number of physician services provided to children	6,457,900	9,616,292	6,457,900	Per Estimates[1]
24	Number of prescribed drugs provided to children	4,444,636	6,739,746	4,444,636	Per Estimates[1]
25	Number of hospital inpatient services provided to elders	100,808	109,712	100,808	Per Estimates[1]
26	Number of physician services provided to elders	1,436,160	1,029,400	1,436,160	Per Estimates[1]
27	Number of prescribed drugs provided to elders	15,214,293	1,425,107	15,214,293	Per Estimates[1]
28	Number of children enrolled in the Medicaid Expansion	1,227	0	1,227	DELETE[4]

Approved Performance Measures for FY 2012-2013 (Words)		Approved Prior Year Standards FY 2011-2012 (Numbers)	Prior Year Actual FY 2011-2012 (Numbers)	Approved Standards for FY 2012-2013 (Numbers)	Requested FY 2013-2014 Standard (Numbers)
Program: Health Care Services			**Code: 68500000**		
Service/Budget Entity: Medicaid Long Term Care			**Code: 68501500**		
29	Percent of hospitalizations for conditions preventable with good ambulatory care	12.60%	See New Measure 29A Below	12.60%	DELETE[4]
29A	New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Institutional Care and Waiver Programs	N/A	20.30%	20.00%	20.00%
30	Number of case months (home and community-based services)	550,436	892,205	550,436	Per Estimates[1]
31	Number of case months services purchased (Nursing Home)	619,387	514,044	619,387	Per Estimates[1]
Program: Health Care Services			**Code: 68500000**		
Service/Budget Entity: Medicaid Prepaid Health Plan			**Code: 68501600**		
32	Percent of hospitalizations for conditions preventable by good ambulatory care	16.00%	See New Measures 33A and 33B Below	16.00%	DELETE[4]

Approved Performance Measures for FY 2012-2013 (Words)		Approved Prior Year Standards FY 2011-2012 (Numbers)	Prior Year Actual FY 2011-2012 (Numbers)	Approved Standards for FY 2012-2013 (Numbers)	Requested FY 2013-2014 Standard (Numbers)
33	Percent of women and child hospitalizations for conditions preventable with good ambulatory care	16.00%	See New Measure 33A Below	16.00%	DELETE[4]
33A	New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Ages 1-20 in full service capitated managed health care plans	N/A	24.99%	25.00%	25.00%
33B	New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Ages 21 and over in full service capitated managed health care plans	N/A	19.14%	20.00%	20.00%
34	Number of case months services purchased (elderly and disabled)	1,877,040	238,464	1,877,040	DELETE[4]
35	Number of case months services purchased (families)	9,850,224	7,708,416	9,850,224	DELETE[4]

Program: Program: Health Care Regulation	**Code: 68700700**
Service/Budget Entity: Health Care Regulation	**Code: 68700700**

Approved Performance Measures for FY 2012-2013 (Words)		Approved Prior Year Standards FY 2011-2012 (Numbers)	Prior Year Actual FY 2011-2012 (Numbers)	Approved Standards for FY 2012-2013 (Numbers)	Requested FY 2013-2014 Standard (Numbers)
36	Percent of nursing home facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0.00%	3.10%	0.00%	DELETE[4]
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	4.00%	0.00%	4.00%	DELETE[4]
38	Percent of Priority I consumer complaints about licensed facilities and programs that are investigated within 48 hours	100.00%	See New Measure 38A Below	100.00%	REVISE[4]
38A	New Measure - Percent of Priority I consumer complaints about licensed facilities and programs that are investigated within two business days	N/A	99.60%	100.00%	100.00%
39	Percent of accredited hospitals and ambulatory surgical centers cited for not complying with life safety, licensure, or emergency access standards	25.00%	23.80%	25.00%	DELETE[4]
40	Percent of validation surveys that are consistent with findings noted during the accreditation survey	98.00%	100.00%	98.00%	DELETE[4]

Approved Performance Measures for FY 2012-2013 (Words)		Approved Prior Year Standards FY 2011-2012 (Numbers)	Prior Year Actual FY 2011-2012 (Numbers)	Approved Standards for FY 2012-2013 (Numbers)	Requested FY 2013-2014 Standard (Numbers)
41	Percent of assisted living facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0.00%	1.30%	0.00%	DELETE[4]
42	Percent of home health facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0.00%	0.04%	0.00%	DELETE[4]
43	Percent of clinical laboratories with deficiencies that pose a serious threat for not complying with life safety, licensure or emergency access standards	0.00%	0.03%	0.00%	DELETE[4]
44	Percent of ambulatory surgical centers with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0.00%	0.00%	0.00%	DELETE[4]
45	Percent of hospitals with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0.00%	2.00%	0.00%	DELETE[4]
46	Percent of hospitals that fail to report serious incidents (agency identified)	6.00%	1.70%	6.00%	DELETE[4]
47	Percent of new Medicaid recipients voluntarily selecting managed care plan	50.00%	N/A	50.00%	DELETE[4,5] (This is a Medicaid program- Health Care Services/ Executive Direction and Support Services/ 68500200

Approved Performance Measures for FY 2012-2013 (Words)		Approved Prior Year Standards FY 2011-2012 (Numbers)	Prior Year Actual FY 2011-2012 (Numbers)	Approved Standards for FY 2012-2013 (Numbers)	Requested FY 2013-2014 Standard (Numbers)
48	Percent of complaints of HMO patient dumping received that are investigated[2]	100.00%	See New Measure 48A Below	100.00%	DELETE[4]
48A	New Measure - Percent of complaints of HMO access to care received that are investigated.	N/A	100%	100.00%	100.00%
49	Percent of complaints of facility patient dumping received that are investigated	100.00%	100%	100.00%	100.00%
50	Number of inquiries to the call center regarding practitioner licensure and disciplinary information[3]	30,000	N/A	30,000	DELETE[4]
51	Total number of full facility quality-of-care surveys conducted	7,550	6,586	7,550	DELETE[4]
52	Average processing time (in days) for Subscriber Assistance Program cases.	53	20	53	53
53	Number of construction reviews performed (plans and construction)	4,500	4,869	4,500	4500

Approved Performance Measures for FY 2012-2013 (Words)		Approved Prior Year Standards FY 2011-2012 (Numbers)	Prior Year Actual FY 2011-2012 (Numbers)	Approved Standards for FY 2012-2013 (Numbers)	Requested FY 2013-2014 Standard (Numbers)
54	Number of new enrollees provided with choice counseling	520,000	372,458	520,000	TRANSFER[4,5] Per Estimates[1] (This is a Medicaid program and should be moved to Health Care Services/Executive Direction and Support Services/ 68500200

[1] These estimates are established by Estimating Conference and represent anticipated counts and are not performance measures.

[2] 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.

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

[4] The Agency proposes to modify this measure through a budget amendment in accordance with section 216.1827, F.S., prior to June 30, 2013.

[5] This measure is being transferred to correct BE.

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 #3: Percent of Hospitalizations for Conditions Preventable by Good Ambulatory Care.

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
7.7%	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 on Title XXI children outside of MediKids is unavailable and not within the control of Medicaid. Measure should be deleted.

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

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☐ Other (Identify)
Recommendations: Deletion in favor of a more relevant measure.

Office of Policy and Budget – July 2012

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 #4: Percent of Eligible Uninsured Children Receiving Health Benefits Coverage.

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

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

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect ☒ Other (Identify)
Explanation: The exact number of uninsured children cannot be determined and therefore this measure cannot be calculated.

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: Data is unavailable.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☒ Technology
☐ Personnel ☐ Other (Identify)
Recommendations: This measure should be deleted in favor of a more relevant measure.

Office of Policy and Budget – July 2012

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 #5: Percent of Children Enrolled with Up-to-Date Immunizations.

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
85%	N/A	N/A	N/A

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

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

Explanation: Information previously reported has been based on a composite measure developed from the Annual KidCare Evaluation Report and does not accurately reflect immunization levels. Immunization information is not collected every year and was not collected for the current reporting period. Due to the inconsistency of getting data for this measure, it should be deleted.

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: Inconsistent data collection.

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

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

Recommendations: This measure should be deleted due to the difficulty in gathering consistent data.

Office of Policy and Budget – July 2012

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 #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.

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
97%	N/A	N/A	N/A

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☐ Staff Capacity
☐ Level of Training
☒ Other (Identify)
Explanation: Due to the nature of the Medicaid population moving in and out of eligibility, the many resources available to Medicaid recipients for seeking routine and preventive care, various ways these procedures can appear in the claims data, and various patterns of patient compliance, it is impossible to accurately track provisions of care with the specificity to make this a meaningful measure.

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: Inconsistent data collection and the lack of unique, specific data to calculate this measure.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☒ Technology
☐ Other (Identify)
Recommendations: This measure should be deleted due to the difficulty in gathering required data with consistency.

Office of Policy and Budget – July 2012

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#7: Percent of Families Satisfied with Care Provided under the Program.

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
95%	91.2%	3.8%	4.2%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect ☒ Other (Identify)
Explanation: The approved standard exceeds the national standard by 5%. Results are in line with expectations for a program of this type.

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: Results are higher than the national standard.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☒ Technology
☐ Personnel ☐ Other (Identify)
Recommendations: Standard should be changed to reflect the national standard.

Office of Policy and Budget – July 2012

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#11: Number of Title XXI-Eligible Children Enrolled in Children's Medical Services Network.

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
111,292	22,667	(88,625)	80%

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

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

Explanation:

External Factors (check all that apply):

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

Explanation: Enrollment in Children's Medical Services Network is based upon current law and current legislative policy.

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

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

Recommendations: It is recommended that this output is changed to 22,500 to reflect the actual enrollment expectations based upon the Social Services Estimating Conference.

Office of Policy and Budget – July 2012

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Executive Direction & Support/68500200
Measure #12: 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%	2.51%	1.07%	74%

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 requested that the standard be revised to 2.5%. The current administrative costs are higher than average due to preparations for conversion to Statewide Medicaid Managed Care (SMMC) while maintaining current activity levels in the currently structured Medicaid program.

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 remain higher than trends 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: Revise the standard to 2.5% per year until SMMC is fully implemented then set the standard at 2% going forward.

Office of Policy and Budget – July 2012

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 #15: Percent of Hospitalizations that are Preventable by Good Ambulatory Care.

Action:

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
11.0%	N/A	N/A	N/A

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

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

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

External Factors (check all that apply):

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

Explanation: Existing measure does not sufficiently reflect the Medicaid populations.

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

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

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

Office of Policy and Budget – July 2012

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 #16: Percent of Women Receiving Adequate Prenatal Care.

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
86%	84.4%	1.6%	1.9%

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

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

Office of Policy and Budget – July 2012

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 #17: Neonatal Mortality Rate per 1000.

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
4.7	4.8	0.1	2.1%

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

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: National standard is 5.0. Reported performance result is within expected variance levels of target and is indicative of meeting program goals.

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

Office of Policy and Budget – July 2012

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 #18: Average number of months between pregnancies for those receiving family planning services.

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
35	25	(10)	28.6%

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

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 calculated as the Total Number of Months Between Births/Total Number of Subsequent Births. Data is not available for the entire range of women receiving family planning services. There is a data lag in receiving Vital Statistics data of almost 24 months. This means that women in the Family Planning Waiver, who gave birth four years ago, only have 2 years' worth of follow up data available to determine whether they had a subsequent birth. This further means by default that any woman who gave birth four years ago and who subsequently had a second birth (to be included in the denominator) had 24 months or less between pregnancies. Those that have not given birth in those 24 months are excluded from the calculation because no data are available, even if they had a second pregnancy anywhere from 25 to 48 months after their first pregnancy. This artificially truncates the available period at a point below the target standard for this measure. While an alternative could theoretically be to only consider women who had been in the program at least 36 months after their first pregnancy and were therefore even technically able to achieve the standard, that bases the performance measure on something that could have happened five years in the past. A better measure (proposed elsewhere) would be to look at the percentage of women who have at least 24-28

Measure #18: Average number of months between pregnancies for those receiving family planning services – Page 2

months between pregnancies (a minimum of 24 months being one of the program goals of the Family Planning Waiver).

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

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

Recommendations: This Measure should be deleted in favor of a more meaningful measure. The real goal is to have at least 2 years to 28 months between births and this measure should be deleted/replaced with a measure reflective of that goal.

Office of Policy and Budget – July 2012

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services for Individuals/68501400
Measure #26: Number of Physician Services Provided to Elders.

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
1,436,160	1,029,400	(406,760)	28%

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

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix the Problem
☐ Current Laws Are Working Against the Agency Mission
☐ Technological Problems
☐ Natural Disaster
☒ Other (Identify)
Explanation: Amount of physician services provided to elders is based upon current law and current legislative policy.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☒ Other (Identify)
Recommendations: It is recommended that this output is changed to reflect the actual number expected based upon the Social Services Estimating Conference.

Office of Policy and Budget – July 2012

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 #27: Number of Prescribed Drugs to Elders.

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
15,214,293	1,425,107	(13,789,186)	90.6%

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

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: Since Medicare Part D was enacted, the number of prescriptions to elders has dropped significantly. Approved standard has not been changed to reflect legal changes to Medicare.

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

Recommendations: Standard should be revised to account for lower numbers of prescribed drugs due to changes in Medicare Part D.

Office of Policy and Budget – July 2012

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 #28: Number of Uninsured Children Enrolled in the Medicaid Expansion.

Action:

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
1,227	0	1,227	100%

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

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

Explanation:

External Factors (check all that apply):

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

Explanation: This was an expansion group for a specific population of children. The expansion was not renewed and all of the participating children have aged out of the program.

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

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

Recommendations: This is an old eligibility expansion population in a category that was not renewed. All members have since aged out and the measure should be deleted.

Office of Policy and Budget – July 2012

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Long Term Care/ 68501500
Measure #29: Percent of Hospitalizations for Conditions Preventable with Good Ambulatory Care.

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
12.6%	N/A	N/A	N/A

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect ☒ Other (Identify)
Explanation: This measure includes populations for which data is not available. A new measure is being proposed that more accurately reflect the current population of Medicaid and programmatic structure.

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: Current measure is not reflective of the population.

M**anagement Efforts to Address Differences/Problems** (check all that apply):
☐ Training ☒ Technology
☐ Personnel ☐ Other (Identify)
Recommendations: While ambulatory sensitive hospitalizations remain an accepted national standard as part of an overall evaluation of access and preventive care services, the population group previously defined in the Long-Range Program plan did not accurately address the issue along programmatic lines. The existing measure is therefore being deleted in favor of a measure that will more directly reflect program decisions, policies, and services.

Office of Policy and Budget – July 2012

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 #32: Percent of Hospitalizations for Conditions Preventable with Good Ambulatory Care.

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
16%	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: The existing categories of "women and children", and "children" do not encompass all populations receiving care in managed care plans and are partially redundant. New measures are being proposed for two new groups, adults and children, so that all population groups are measured and the measures themselves fall along more relevant programmatic lines.

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: Existing measure does not sufficiently reflect the Medicaid population.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: While ambulatory sensitive hospitalizations remain an accepted national standard as part of an overall evaluation of access and preventive care services, the defined population groups did not accurately address the issue along programmatic lines. The existing measures are, therefore, recommended for deletion in favor of measures that will more directly reflect program decisions, policies, and services.

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 #33: Percent of Women and Child Hospitalizations for Conditions Preventable with Good Ambulatory Care.

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
16%	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: The existing categories of "women and children," and "children" do not encompass all populations receiving care in managed care plans and are partially redundant. New measures are being proposed for two new groups, adults and children, so that all population groups are measured and the measures themselves fall along more relevant programmatic lines.

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: Existing measure does not sufficiently reflect the Medicaid populations.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: While ambulatory sensitive hospitalizations remain an accepted national standard as part of an overall evaluation of access and preventive care services, the defined population groups do not accurately address the issue along programmatic lines. The existing measures are, therefore, recommended for deletion in favor of measures that will more directly reflect program decisions, policies, and services.

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 #34: Number of Case Months Services Purchased (Elderly and Disabled).

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
1,877,040	238,464	(1,638,576)	87.3%

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

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☒ Target Population Change
☐ This Program/Service Cannot Fix the Problem
☐ Current Laws Are Working Against the Agency Mission
☐ Technological Problems
☐ Natural Disaster
☒ Other (Identify)
Explanation: Target population changed and the provided standards are wrong and were not changed to reflect programmatic changes.

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

Recommendations: The target population and activity group have changed. The measure should be deleted.

Office of Policy and Budget – July 2012

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 #35: Number of Case Months Services Purchased (Families).

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
9,850,224	7,708,416	(2,141,808)	21.7%

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

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

Explanation:

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: Number of case months purchased is based upon current law and current legislative policy.

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

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

Recommendations: The target population and activity group have changed. The measure should be deleted.

Office of Policy and Budget – July 2012

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #36: Percent of Nursing Home Facilities with Deficiencies that Pose a Serious Threat to the Health, Safety, or Welfare of the Public.

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0%	3.1%	3.1% Over	3.1%

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

Explanation: 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 2012

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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	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: 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 2012

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #38: Percent of Priority 1 Consumer Complaints about Licensed Facilities and Programs that are Investigated within 48 Hours.

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
100%	99.80%	0.20% (Under)	0.20%

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

Explanation: The individual surveyor was sent a P1 complaint via email and it was placed on the surveyor's calendar. Surveyor was not made aware timely that a P1 complaint was assigned and therefore it was conducted on the 3rd. business day, one day outside the required timeframe. The Field Office Management, upon awareness of this situation immediately counseled the individual surveyor and also implemented a new process by which when a P1 complaint is received, in addition to emailing the individual surveyor of the assignment, the assigning supervisor will contact the individual surveyor to make them aware.

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

Explanation:

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

Recommendations:
The Agency is requesting to revise the measure from 48 hours to two business days.

Office of Policy and Budget – July 2012

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #38A: 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%	99.80%	0.20% (Under)	0.20%

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

Explanation: The individual surveyor was sent a P1 complaint via email and it was placed on the surveyor's calendar. The surveyor was not made aware timely that a P1 complaint was assigned and therefore it was conducted on the 3rd. business day, one day outside the required timeframe. The Field Office Management, upon awareness of this situation immediately counseled the individual surveyor and also implemented a new process by which when a P1 complaint is received, in addition to emailing the individual surveyor of the assignment, the assigning supervisor will contact the individual surveyor to make them aware.

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

Explanation:

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

Recommendations:

Office of Policy and Budget – July 2012

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #39: Percent of Accredited Hospitals and Ambulatory Surgical Centers Cited for not Complying with Life Safety, Licensure, or Emergency Access Standards.

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
25%	23.8%	1.2% (Under)	1.2%

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

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

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ Technological Problems
☐ Natural Disaster
☐ 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
☐ Personnel
☐ Technology
☒ Other (Identify)

Recommendations: The Agency is requesting this measure be deleted.

Office of Policy and Budget – July 2012

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure#40: Percent of Validation Surveys that are Consistent with Findings Noted during the Accreditation Survey.

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

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

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

Explanation: The standard measures the performance of the accrediting organization, not the performance of the Agency.

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

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

Office of Policy and Budget – July 2012

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #41: Percent of Assisted Living Facilities with Deficiencies that Pose a Serious Threat to the Health, Safety, or Welfare of the Public.

Action:

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0%	1.3	1.3% Over	1.3%

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 be deleted.

Office of Policy and Budget – July 2012

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #42: Percent of Home Health Agencies with Deficiencies that Pose a Serious Threat to the Health, Safety, or Welfare of the Public.

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

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

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 be deleted.

Office of Policy and Budget – July 2012

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #43: 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%	0.03%	0.03%(Over)	0.03%

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

Office of Policy and Budget – July 2012

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #44: Percent of Ambulatory Surgical Centers with Deficiencies that Pose a Serious Threat to the Health, Safety, or Welfare of the Public.

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

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

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

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

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☒ 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 2012

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #45: 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%	2.0%	2.0% Over	2.0%

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: 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 be deleted.

Office of Policy and Budget – July 2012

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation
Measure #46: 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
6.0	1.7	Under	4.3%

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

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

Office of Policy and Budget – July 2012

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Executive Direction & Support/68500200
Measure #47: Percent of New Medicaid Recipients Voluntarily Selecting Managed Care Plan.

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
50%	N/A	N/A	N/A

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☐ Staff Capacity
☐ Level of Training
☒ Other (Identify)
Explanation: This information is no longer collected.

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: Information is no longer collected.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☐ Other (Identify)
Recommendations: Measure should be deleted as information is no longer collected.

Office of Policy and Budget – July 2012

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Bureau of Managed Health Care
Program: Managed Health Care
Service/Budget Entity: Health Care Regulation/68700700
Measure #48: 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 is requesting this measure to be deleted.

Office of Policy and Budget – July 2012

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation
Measure #50: Number of Inquiries to the Call Center Regarding Practitioner Licensure and Disciplinary Information.

Action:

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
30,000	0	30,000	100%

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

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

Explanation:

External Factors (check all that apply):

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

Explanation AHCA discontinued handling practitioner-related calls effective July 1, 2009 because the Department of Health (DOH) had already established an active toll-free number for these types of calls. To reduce costs, an agreement was made with DOH that the AHCA Call Center would discontinue these services for DOH and that callers would be referred to the DOH hotline.

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

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

Recommendations: The Agency is requesting this measure be deleted.

Office of Policy and Budget – July 2012

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #51: Total Number of Full Facility Quality-of-Care Surveys Conducted.

Action:

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
7,550	6,586	964 (Under)	12.8%

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

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

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

External Factors (check all that apply):

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

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

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

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

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

Office of Policy and Budget – July 2012

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Executive Direction and Support Services/68500200
Measure #54: Number of New Enrollees Provided with Choice Counseling.

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
520,000	372,458	147,542	28.4%

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: Approved Standard is incorrect. Approved standard does not reflect program estimates from estimating conference.

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: New enrollees provided choice counseling is an output measure (i.e., not a Performance/Outcome Measure) which is entirely dependent on Medicaid enrollment and other factors outside the control of the Agency.

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

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

Recommendations: Standard should be based on actual estimates and reflect programmatic changes when they occur. This is an output measure based on external factors and measurement assessments should not be necessary.

Office of Policy and Budget – July 2012

Performance Measure Validity and Reliability -

LRPP Exhibit IV

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Children's Special Health Care (CMSN)/ 68500100
Measure #3A: Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): CMSN enrollees (Title XIX and Title XXI)

Action (check one):

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

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

Data Sources and Methodology:
Hospitalizations are extracted from Medicaid Encounter data and Medicaid Claims data by the Bureau of Medicaid Program Analysis. Hospital data are then matched against Medicaid eligibility files to determine Medicaid eligibility group. Ambulatory sensitive conditions are identified by ICD-9 diagnosis codes, using the algorithm and methodology outlined by the federal Health and Human Services (HHS) Agency for Healthcare Research and Quality (AHRQ). The percentage of hospitalizations that occur for Ambulatory Sensitive Conditions within an eligibility group are divided by the total hospitalizations for that group to arrive at a percentage. This measure is calculated annually for the Long Range Program Plan (LRPP) based on prior calendar year Encounters/Claims (e.g., CY2011 for the LRPP published in 2012).

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

Validity:
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. A condition is considered ambulatory sensitive if the provision of quality preventive 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.

Measure #3A: Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): CMSN enrollees (Title XIX and Title XXI) – Page 2

The ambulatory sensitive conditions are identified using the algorithm and methodology outlined by AHRQ. AHRQ is a federal HHS 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 the codes. Similarly, the eligibility information provided by the Department of Children and Families through Medicaid Contract Management is reliable for identification of eligibility group. Eligibility information is used to approve and pay for benefits and therefore must be accurate.

Office of Policy and Budget – July, 2012

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 #4A: Percent of eligible uninsured children receiving health benefits coverage

Action (check one):

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

Proposed Change to Measure:
The Agency proposes to change the measure to "Percentage of all Title XXI KidCare enrollees eligible for renewal who either renew KidCare coverage or maintain health care coverage from another source."

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

Data Sources and Methodology:
Data are provided to the Florida Institute for Child Health Policy (ICHP) by the Florida Healthy Kids Corporation as part of their annual KidCare evaluation. Based on the combined monthly re-enrollment data, ICHP calculates an annual percentage of children eligible for re-enrollment who actually re-enroll in the KidCare program. (Re-enrollees divided by Total Eligible for Re-Enrollment).

ICHP also conducts an annual survey of caregivers (e.g., the child's parents) in the KidCare program. As part of the annual evaluation process, they will conduct interviews of caregivers for eligible children who do not re-enroll to ascertain their insurance status and can add those children who maintain health insurance back into the denominator. The final calculation for this measure is therefore: (Re-Enrolled Children + Otherwise insured children) / Total Number of Children Eligible for Re-Enrollment.

This measure is reported annually and is a LRPP only measure.

Proposed Standard/Target:
90 percent

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

Measure #4A: Percent of eligible uninsured children receiving health benefits coverage – Page 2

Reliability:
Data are provided by Florida Healthy Kids (FHK) from their program administrative files. FHK is responsible for the reliability and validity of their data and the data provided to ICHP are assumed to be reliable.

Discussion:
Once children are enrolled in a KidCare program, every effort is made to ensure that children eligible for the program remain enrolled unless they have found alternative sources of health care coverage. Having health insurance is a key factor in obtaining preventive care as well as acute care services. Prior to the renewal date (date a child must re-enroll to maintain coverage), the caregiver of a child enrolled in KidCare is mailed a renewal form that must be completed, signed and returned with appropriate income documentation so that continued eligibility can be determined. The caregiver is given approximately 2 months to complete the process.

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

Office of Policy and Budget – July 2012

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 #7: Percent of families satisfied with the care provided under the program

Action (check one):

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

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

Data Sources and Methodology:
To assess KidCare program satisfaction, the Institute for Child Health Policy (ICHP) conducts a telephone interview survey, as part of the annual KidCare Evaluation, with caregivers whose children have been receiving health care coverage through one of the KidCare program components for at least 12 consecutive months. The survey population includes children receiving the following coverage: Medicaid enrolled with an HMO, Medicaid enrolled with a MediPass provider, and the Title XXI programs (MediKids, Healthy Kids and Children's Medical Services Network). The Consumer Assessment of Healthcare Providers and Services (CAHPS) is used to address aspects of care in the 6 months preceding the interview. The survey addresses obtaining routine care and specialized services, general health care experiences, health plan customer service and dental care. For this measure, the standard reflects the percentage of caregivers who rate their plan 7 or higher on a 10-point scale. This is a nationally recognized measure and standard developed and reported by the Agency for Health Care Research and Quality, a federal HHS department responsible for state and national health policy research.

Proposed Standard/Target: 90 percent

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

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

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

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Children's Special Health Care/68500100
Measure #11: Number of children enrolled in Children's Medical Services Network

Action (check one):

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

Proposed Change to Measure:
Proposed standard should be changed to 22,500 to reflect actual enrollment expectations.

Data Sources and Methodology:
This is an administrative change only.

Proposed Standard/Target:
22,500 or Per Estimating Conference

Validity:
N/A

Reliability:
N/A

Discussion:
This is an administrative change to correct an erroneous performance standard.

Office of Policy and Budget – July 2012

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Executive Direction and Support Services/68500200
Measure #12: Program administrative costs as a percent of total program costs

Action (check one):

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

Data Sources and Methodology:
The Agency's financial data is maintained in the Florida Accounting Information Resource (FLAIR) system. The programs administrative costs are first identified and then segregated from the program's total costs. The administrative costs are divided by the entire program's costs to arrive at the measurement. Actual rather than projected budget will be used to calculate the measure.

Proposed Standard/Target: 2.5%
As Statewide Medicaid Managed Care is implemented in FY 2013 through 2014, it will be necessary to handle transition activities, new program activities, and maintain current fee for service based activities. The percentage of costs relative to overall program costs will likely be slightly higher until full program transition is complete.

Validity:
The measure is a valid tool to determine what percentage the program's administrative costs are of its total costs.

Reliability:
The FLAIR data can only be accessed by authorized personnel. The data is reconciled on a regular basis, ensuring accuracy and reliability.

Office of Policy and Budget – July, 2012

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Service to Individuals/68501400
Measure #15A: Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Ages 1 to 20 enrolled in Fee-for-Service, MediPass, and Provider Service Networks

Action (check one):

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

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

Data Sources and Methodology:
Hospitalizations are extracted from Medicaid Encounter data and Medicaid Claims data by the Bureau of Medicaid Program Analysis. Hospital data are then matched against Medicaid eligibility files to determine Medicaid eligibility group. Ambulatory sensitive conditions are identified by ICD-9 diagnosis codes, using the algorithm and methodology outlined by the federal Health and Human Services (HHS) Agency for Healthcare Research and Quality (AHRQ). The percentage of hospitalizations that occur for Ambulatory Sensitive Conditions within an eligibility group are divided by the total hospitalizations for that group to arrive at a percentage. This measure is calculated annually for the Long Range Program Plan (LRPP) based on prior calendar year Encounters/Claims (e.g., CY2011 for the LRPP published in 2012).

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

a. Sixth Omnibus Budget Reconciliation Act (SOBRA) Pregnant women;
b. Medicaid Recipients domiciled or residing in an institution, including nursing facilities, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an Intermediate Care Facility/Developmentally Disabled (ICF-DD);
c. Medicaid Recipients whose Medicaid eligibility was determined through the medically needy program,
d. Qualified Medicare Beneficiaries ("QMBs"),

Measure #15A: Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Ages 1 to 20 enrolled in Fee-for-Service, MediPass, and Provider Service Networks – Page 2

e. Special Low Income Medicare Beneficiaries (SLMBs), or Qualified Individuals at Level 1 (QI-1s).

f. Title XXI-funded children with chronic conditions who are enrolled in Children's Medical Services Network,
g. Women eligible for Medicaid due to breast and/or cervical cancer.
h. Individuals eligible under a hospice-related eligibility group.

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

Validity:
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. A condition is considered ambulatory sensitive if the provision of quality preventive 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 ambulatory sensitive conditions are identified using the algorithm and methodology outlined by AHRQ. AHRQ is a federal HHS 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 the codes. Similarly, the eligibility information provided by the Department of Children and Families through Medicaid Contract Management is reliable for identification of eligibility group. Eligibility information is used to approve and pay for benefits and therefore must be accurate.

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Service to Individuals/68501400
Measure #15B: Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Ages 21 and Over enrolled in Fee-for-Service, MediPass, and Provider Service Networks

Action (check one):

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

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

Data Sources and Methodology:
Hospitalizations are extracted from Medicaid Encounter data and Medicaid Claims data by the Bureau of Medicaid Program Analysis. Hospital data are then matched against Medicaid eligibility files to determine Medicaid eligibility group. Ambulatory sensitive conditions are identified by ICD-9 diagnosis codes, using the algorithm and methodology outlined by the federal Health and Human Services (HHS) Agency for Healthcare Research and Quality (AHRQ). The percentage of hospitalizations that occur for Ambulatory Sensitive Conditions within an eligibility group are divided by the total hospitalizations for that group to arrive at a percentage. This measure is calculated annually for the Long Range Program Plan (LRPP) based on prior calendar year Encounters/Claims (e.g., CY2011 for the LRPP published in 2012).

Enrollees/beneficiaries are divided into Ages 1 to 20 and over 21 age groups because the Medicaid benefit package varies for adults and children. This measure is focused on adults, age 21 and older. The following groups would be excluded from this measure:

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

Measure #15B: Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Ages 21 and Over enrolled in Fee-for-Service, MediPass, and Provider Service Networks – Page 2

g. Women eligible for Medicaid due to breast and/or cervical cancer.

h. Individuals eligible under a hospice-related eligibility group.

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

Validity:
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. A condition is considered ambulatory sensitive if the provision of quality preventive 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 ambulatory sensitive conditions are identified using the algorithm and methodology outlined by AHRQ. AHRQ is a federal HHS 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 the codes. Similarly, the eligibility information provided by the Department of Children and Families through Medicaid Contract Management is reliable for identification of eligibility group. Eligibility information is used to approve and pay for benefits and therefore must be accurate.

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #18A: Percentage of women with an Inter-pregnancy Interval (IPI) of greater than or equal to 28 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:
This is a new measure. The Healthy Start and Family Planning Waiver program both advocate 24 to 28 months between pregnancies in order to ensure the best environment for children and mothers.

Data Sources and Methodology:
The data source is the Medicaid claims data from the Florida Medicaid Management Information System (FMMIS) that has been merged with a data set maintained by the University of Florida, Family Data Center which contains Medicaid eligibility, birth certificate, death certificate, and Healthy Start data related to women giving birth in Florida for each year since 1991. Medicaid extracts claims each year, which contains the social security number of the person. University of Florida compares this information to the number of women giving birth in the following year and identifies those who had a birth. The inter-pregnancy interval for the women so identified is then calculated by summing the number of months between pregnancies for all women with a subsequent birth and dividing by the number of women with a subsequent birth. Those with an interpregnancy interval of 28 months or more are then divided by the total number of women with a subsequent birth to arrive at a percentage.

Proposed Standard/Target:
50%

Validity:
This is a valid measure for the effectiveness of family planning services. Lengths between pregnancies of at least 24 months are encouraged by Healthy Start and the Family Planning Waiver program and are preferable due to the demonstrated benefits for growth and healthy development of young children.

Reliability:
The reliability is considered high is high for women who have maintained Medicaid coverage between pregnancies since it is based on claims data and birth records. Although the potential for inaccuracies on the birth certificate exist, they are not serious enough to jeopardize comparisons between programs or over time.

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/ 68501400
Measure #27: Number of prescribed drugs provided to elders

Action (check one):

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

Proposed Change to Measure:
The number of prescribed drugs provided to elders is based upon current law and current legislative policy. The Agency is requesting that the standard be changed to reflect expectations based upon the Social Services Estimating Conference.

Data Sources and Methodology:
Number of prescribed drugs is based on submitted Medicaid Claims and Encounter data. Data from the Florida Medicaid Management Information System (FMMIS) system are queried by the Agency Bureau of Medicaid Program Analysis to determine the number of prescribed drugs provided.

Proposed Standard/Target:
Proposed standard should reflect expectations based upon the Social Services Estimating Conference.

Validity:
Validity is high as the count is based on actual claims and encounter submission data.

Reliability:
Reliability is high as the count is based on actual claims and encounter submission data.

Discussion:
The current Approved Standard does not reflect actual expectations and has not accounted for changes in policy (particularly the implementation of Medicare Part D) that have impacted the number of prescribed drugs provided to elders. Standard should reflect both current law and actual expectations.

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Long-Term Care / 68501500
Measure #29A: Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Institutional Care and Waiver Programs

Action (check one):

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

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

Data Sources and Methodology:
Hospitalizations are extracted from Medicaid Encounter data and Medicaid Claims data by the Bureau of Medicaid Program Analysis. Hospital data are then matched against Medicaid eligibility files to determine Medicaid eligibility group. Ambulatory sensitive conditions are identified by ICD-9 diagnosis codes, using the algorithm and methodology outlined by the federal Health and Human Services (HHS) Agency for Healthcare Research and Quality (AHRQ). The percentage of hospitalizations that occur for Ambulatory Sensitive Conditions within an eligibility group are divided by the total hospitalizations for that group to arrive at a percentage. This measure is calculated annually for the Long Range Program Plan (LRPP) based on prior calendar year Encounters/Claims (e.g., CY2011 for the LRPP published in 2012).

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

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

Measure #29A: Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Institutional Care and Waiver Programs – Page 2

Validity:
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. A condition is considered ambulatory sensitive if the provision of quality preventive 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 ambulatory sensitive conditions are identified using the algorithm and methodology outlined by AHRQ. AHRQ is a federal HHS 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 the codes. Similarly, the eligibility information provided by the Department of Children and Families through Medicaid Contract Management is reliable for identification of eligibility group. Eligibility information is used to approve and pay for benefits and therefore must be accurate.

Office of Policy and Budget – July, 2012

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Service to Individuals/68501400
Measure #33A: Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Ages 1-20 in full service capitated managed health care plans

Action (check one):

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

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

Data Sources and Methodology:
Hospitalizations are extracted from Medicaid Encounter data and Medicaid Claims data by the Bureau of Medicaid Program Analysis. Hospital data are then matched against Medicaid eligibility files to determine Medicaid eligibility group. Ambulatory sensitive conditions are identified by ICD-9 diagnosis codes, using the algorithm and methodology outlined by the federal Health and Human Services (HHS) Agency for Healthcare Research and Quality (AHRQ). The percentage of hospitalizations that occur for Ambulatory Sensitive Conditions within an eligibility group are divided by the total hospitalizations for that group to arrive at a percentage. This measure is calculated annually for the Long Range Program Plan (LRPP) based on prior calendar year Encounters/Claims (e.g., CY2011 for the LRPP published in 2012).

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

a. Sixth Omnibus Budget Reconciliation Act (SOBRA) Pregnant women;
b. Medicaid Recipients domiciled or residing in an institution, including nursing facilities, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an Intermediate Care Facility/Developmentally Disabled (ICF-DD);
c. Medicaid Recipients whose Medicaid eligibility was determined through the medically needy program,
d. Qualified Medicare Beneficiaries ("QMBs"),

Measure #33A: Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Ages 1-20 in full service capitated managed health care plans – Page 2

e. Special Low Income Medicare Beneficiaries (SLMBs), or Qualified Individuals at Level 1 (QI-1s).
f. Title XXI-funded children with chronic conditions who are enrolled in Children's Medical Services Network,
g. Women eligible for Medicaid due to breast and/or cervical cancer.
h. Individuals eligible under a hospice-related eligibility group.

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

Validity:
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. A condition is considered ambulatory sensitive if the provision of quality preventive 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 ambulatory sensitive conditions are identified using the algorithm and methodology outlined by AHRQ. AHRQ is a federal HHS 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 the codes. Similarly, the eligibility information provided by the Department of Children and Families through Medicaid Contract Management is reliable for identification of eligibility group. Eligibility information is used to approve and pay for benefits and therefore must be accurate.

Office of Policy and Budget – July, 2012

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Service to Individuals/68501400
Measure #33B: Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Ages 21 and over in full service capitated managed health care plans

Action (check one):

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

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

Data Sources and Methodology:
Hospitalizations are extracted from Medicaid Encounter data and Medicaid Claims data by the Bureau of Medicaid Program Analysis. Hospital data are then matched against Medicaid eligibility files to determine Medicaid eligibility group. Ambulatory sensitive conditions are identified by ICD-9 diagnosis codes, using the algorithm and methodology outlined by the federal Health and Human Services (HHS) Agency for Healthcare Research and Quality (AHRQ). The percentage of hospitalizations that occur for Ambulatory Sensitive Conditions within an eligibility group are divided by the total hospitalizations for that group to arrive at a percentage. This measure is calculated annually for the Long Range Program Plan (LRPP) based on prior calendar year Encounters/Claims (e.g., CY2011 for the LRPP published in 2012).

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

a. Sixth Omnibus Budget Reconciliation Act (SOBRA) Pregnant women;
b. Medicaid Recipients domiciled or residing in an institution, including nursing facilities, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an Intermediate Care Facility/Developmentally Disabled (ICF-DD);
c. Medicaid Recipients whose Medicaid eligibility was determined through the medically needy program,
d. Qualified Medicare Beneficiaries ("QMBs"),

Measure #33B: Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Ages 21 and over in full service capitated managed health care plans – Page 2

e. Special Low Income Medicare Beneficiaries (SLMBs), or Qualified Individuals at Level 1 (QI-1s).
f. Title XXI-funded children with chronic conditions who are enrolled in Children's Medical Services Network,
g. Women eligible for Medicaid due to breast and/or cervical cancer.
h. Individuals eligible under a hospice-related eligibility group.

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

Validity:
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. A condition is considered ambulatory sensitive if the provision of quality preventive 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 ambulatory sensitive conditions are identified using the algorithm and methodology outlined by AHRQ. AHRQ is a federal HHS 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 the codes. Similarly, the eligibility information provided by the Department of Children and Families through Medicaid Contract Management is reliable for identification of eligibility group. Eligibility information is used to approve and pay for benefits and therefore must be accurate.

Office of Policy and Budget – July, 2012

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 #38: Percent of Priority 1 consumer complaints about licensed facilities and programs that are investigated within 48 hours.

Action (check one):
☒ Requesting revision to approved performance measure – from 48 hours to two business days.
☐ 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.

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 #38A: 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 – from 48 hours to two business days.
☐ 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.

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 #48A: 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:
There have been no HMO patient dumping complaints received for several years. Any complaints received would be investigated. However, complaints regarding HMO access to care are received and investigated. This information is currently tracked in the CIRTS data base.

Validity: There have been no HMO patient dumping complaints received for several years. Any complaints received would be investigated. A more relevant measure would be percent of complaints of HMO access to care received that are investigated.

Reliability: Complaints regarding HMO access to care are received and investigated. This information is currently tracked in the CIRTS data base.

Recommendation: The Agency is requesting a revision to this performance measure.

Office of Policy and Budget – July 2012

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #54: Number of new enrollees provided with choice counseling

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:
Program Should be Changed to: Health Care Services Service/Budget Entity should be changed to: Executive Direction and Support Services/68500200

Data Sources and Methodology:
This is an administrative change only.

Proposed Standard/Target:
Per Estimating Conference

Validity:
N/A

Reliability:
N/A

Discussion:
This is an administrative change to the Service/Budget Entity only.

Office of Policy and Budget – July 2012

Associated Activities Contributing to Performance Measures -

LRPP Exhibit V

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

Approved Performance Measures for FY 2012-2013 (Words)		Associated Activities Title
Program: Administration and Support		**Code: 68200000**
1	Administrative costs as a percent of total agency costs	Executive Direction ACT0010; General Counsel/Legal ACT0020 External Affairs ACT0040; Inspector General ACT0060 Director of Administration ACT0080; Planning & Budgeting ACT0090 Grants Management ACT0190; Finance & Accounting ACT0100; Personnel Services/HR ACT0110; Mail Rm ACT0130; Contract Adm ACT0180; Procurement ACT0200; Gen Srvs Adm ACT2090
2	Administrative positions as a percent of total agency positions	Executive Direction ACT0010; General Counsel/Legal ACT0020 External Affairs ACT0040; Inspector General ACT0060 Director of Administration ACT0080; Planning & Budgeting ACT0090 Grants Management ACT0190; Finance & Accounting ACT0100; Personnel Services/HR ACT0110; Mail Rm ACT0130; Contract Adm ACT0180; Procurement ACT0200; Gen Srvs Adm ACT2090
Children's Special Health Care		**Code: 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

Approved Performance Measures for FY 2012-2013 (Words)		Associated Activities Title
		Purchase Children's Medical Services Network Services ACT5130
3A	New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): CMSN enrollees (Title XIX and Title XXI)	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
4A	New Measure - Percentage of all Title XXI KidCare enrollees Eligible for renewal who either renew KidCare coverage or maintain health care coverage from another source	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

Approved Performance Measures for FY 2012-2013 (Words)		Associated Activities Title
6	Percent of compliance with the standards established in the Guidelines for Health Supervision of Children and Youth as developed by the American Academy of Pediatrics for children eligible under the program	Purchase MediKids Program Services ACT5110 Purchase Children's Medical Services Network Services ACT5120 Purchase Children's Medical Services Network Services ACT5130
7	Percent of families satisfied with the care provided under the program	Purchase MediKids Program Services ACT5110 Purchase Children's Medical Services Network Services ACT5120 Purchase Children's Medical Services Network Services ACT5130
8	Total number of Title XXI-eligible 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 Title XXI-eligible 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

	Approved Performance Measures for FY 2012-2013 (Words)	Associated Activities Title
10	Number of Title XXI-eligible 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 Title XXI-eligible children enrolled in Children's Medical Services Network	Purchase MediKids Program Services ACT5110 Purchase Children's Medical Services Network Services ACT5120 Purchase Children's Medical Services Network Services ACT5130
Executive Director/Support Services		**Code: 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

	Approved Performance Measures for FY 2012-2013 (Words)	Associated Activities Title
14	Number of Medicaid claims received	Fiscal Agent Contract ACT5260
Medicaid Services - Individuals		**Code: 68501400**
15	Percent of hospitalizations that are preventable by good ambulatory care	Hospital Inpatient -Elderly and Disabled/fee for service ACT4010 Hospital Inpatient ACT4210 Hospital Inpatient ACT 4510 Hospital Inpatient ACT 4710
15A	New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Ages 1 to 20 enrolled in Fee-for-Service, MediPass, and Provider Service Networks	Hospital Inpatient -Elderly and Disabled/fee for service ACT4010 Hospital Inpatient ACT4210 Hospital Inpatient ACT 4510 Hospital Inpatient ACT 4710
15B	New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Ages 21 and Over enrolled in Fee-for-Service, MediPass, and Provider Service Networks	Hospital Inpatient -Elderly and Disabled/fee for service ACT4010 Hospital Inpatient ACT4210 Hospital Inpatient ACT 4510 Hospital Inpatient ACT 4710

	Approved Performance Measures for FY 2012-2013 (Words)	Associated Activities Title
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
18A	New Measure - Percentage of women with an Interpregnancy Interval (IPI) greater than or equal to 28 months	Physician Services ACT4230 Case Management ACT4280

	Approved Performance Measures for FY 2012-2013 (Words)	Associated Activities Title
19	Percent of eligible children who received all required components of EPSDT screen	Prescribed Medicines ACT4220 Physician Services ACT4230 Early Periodic Screening Diagnosis & Treatment ACT4260 Therapeutic Services for Children ACT4310
20	Number of children ages 1-20 enrolled in Medicaid	Purchase MediKids Program Services ACT5110 Purchase Children's Medical Services Network Services ACT5120 Purchase Children's Medical Services Network Services ACT5130
21	Number of children receiving EPSDT services	Physician Services ACT4230 Early Periodic Screening Diagnosis & Treatment ACT4260 School Based Services ACT4310 Clinic Services ACT4330
22	Number of hospital inpatient services provided to children	Hospital Inpatient ACT4210 Therapeutic Services for Children ACT4310

	Approved Performance Measures for FY 2012-2013 (Words)	Associated Activities Title
23	Number of physician services provided to children	Physician Services ACT4230 Therapeutic Services for Children ACT4310
24	Number of prescribed drugs provided to children	Prescribed Medicines 4220 School Based Services ACT4320
25	Number of hospital inpatient services provided to elders	Hospital Inpatient -Elderly and Disabled/fee for service ACT4010 Prescribed Medicines- Elderly and Disabled/fee for service ACT4020 Physician Services-Elderly and Disabled/fee for service ACT4030 Hospital Insurance Benefit-Elderly and Disabled /Fee for service ACT4140
26	Number of physician services provided to elders	Physician Services-Elderly and Disabled/fee for service ACT4030 Supplemental Medical Insurance-Elderly and Disabled/fee for service ACT4050 Prescribed Medicines- Elderly and Disabled/fee for service ACT4020

	Approved Performance Measures for FY 2012-2013 (Words)	Associated Activities Title
27	Number of prescribed drugs provided to elders	Prescribed Medicines- Elderly and Disabled/fee for service ACT4020
28	Number of children enrolled in the Medicaid Expansion	Purchase MediKids Program Services ACT5110 Purchase Children's Medical Services Network Services ACT5120 Purchase Children's Medical Services Network Services ACT5130
Medicaid Long Term Care		**Code: 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
29A	New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Institutional Care and Waiver Programs	Nursing Home Care ACT5020 Home and Community Based Services ACT5030 Capitates Nursing Home Diversion Waiver ACT5060

	Approved Performance Measures for FY 2012-2013 (Words)	Associated Activities Title
30	Number of case months (home and community-based services)	Home and Community Based Services ACT5030 Capitates Nursing Home Diversion Waiver ACT5060
31	Number of case months services purchased (Nursing Home)	Nursing Home Care ACT5020 Other ACT5070
Medicaid Prepaid Health Plan		**Code: 68501600**
32	Percent of hospitalizations for conditions preventable by good ambulatory care	Prepaid Health Plans Elderly and Disabled ACT1620 Prepaid Health Plans - Family ACT1650
33	Percent of women and child hospitalizations for conditions preventable with good ambulatory care	Prepaid Health Plans - Family ACT1650

Approved Performance Measures for FY 2012-2013 (Words)		Associated Activities Title
33A	New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Ages 1-20 in full service capitated managed health care plans	Prepaid Health Plans - Family ACT1650
33B	New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Ages 21 and over in full service capitated managed health care plans	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
Program: Health Care Regulation		**Code: 68700700**

Approved Performance Measures for FY 2012-2013 (Words)		Associated Activities Title
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
38A	New Measure - Percent of Priority I consumer complaints about licensed facilities and programs that are investigated within two business days	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	Health Facility Regulation (Compliance, Complaints) - Field Offices

Approved Performance Measures for FY 2012-2013 (Words)		Associated Activities Title
	cited for not complying with life safety, licensure or emergency access standards	Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
40	Percent of validation surveys that are consistent with findings noted during the accreditation survey	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
41	Percent of assisted living facilities with deficiencies that pose a serious threat to the health, safety or welfare of the public	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
42	Percent of home health facilities with deficiencies that pose a serious threat to the health, safety or welfare of the public	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
43	Percent of clinical laboratories with deficiencies that pose a serious threat for not complying with life safety, licensure or emergency access standards	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030

Approved Performance Measures for FY 2012-2013 (Words)		Associated Activities Title
		Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
44	Percent of ambulatory surgical centers with deficiencies that pose a serious threat to the health, safety or welfare of the public	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
45	Percent of hospitals with deficiencies that pose a serious threat to the health, safety or welfare of the public	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
46	Percent of hospitals that fail to report serious incidents (agency identified)	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
47	Percent of new Medicaid recipients voluntarily selecting managed care plan	Health Facilities and Practitioner Regulation - Medicaid Choice Counseling ACT7150

Approved Performance Measures for FY 2012-2013 (Words)		Associated Activities Title
48	Percent of complaints of HMO patient dumping received that are investigated	Managed Health Care ACT7090
48A	New Measure - Percent of complaints of HMO access to care received that are investigated	Managed Health Care ACT7090
49	Percent of complaints of facility patient dumping received that are investigated	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
50	Number of inquiries to the call center regarding practitioner licensure and disciplinary information	Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020 This measure is no longer handled by AHCA. Was transferred to DOH in 2009 with renewal of call center contract.

	Approved Performance Measures for FY 2012-2013 (Words)	Associated Activities Title
51	Total number of full facility quality-of-care surveys conducted	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
52	Average processing time (in days) for Statewide Provider and Subscriber Assistance Panel cases	Subscriber/Beneficiary Assistance Panel ACT7130
53	Number of construction reviews performed (plans and construction)	Plans & Construction ACT7080
54	Number of new enrollees provided choice counseling	Health Facilities and Practitioner Regulation - Medicaid Choice Counseling ACT7150

Agency-Level Unit Cost Summary -

LRPP Exhibit VI

LRPP Exhibit VI: Agency-Level Unit Cost Summary

AGENCY FOR HEALTH CARE ADMINISTRATION — FISCAL YEAR 2011-12

SECTION I: BUDGET	OPERATING	FIXED CAPITAL
TOTAL ALL FUNDS GENERAL APPROPRIATIONS ACT	22,319,933,599	0
ADJUSTMENTS TO GENERAL APPROPRIATIONS ACT (Supplementals, Vetoes, Budget	32,283,154	0
FINAL BUDGET FOR AGENCY	22,352,216,753	0

SECTION II: ACTIVITIES * MEASURES	Number of Units	(1) Unit Cost	Expenditures	(2) Expenditures (Allocated)	(3) FCO
Executive Direction, Administrative Support and Information Technology (2)			28,242,397		0
Prepaid Health Plans - Elderly And Disabled *	2,055,276	861.93	1,771,511,702	1,771,511,702	
Prepaid Health Plans - Families *	12,678,708	114.90	1,456,728,751	1,456,728,751	
Elderly And Disabled/Fee For Service/Medipass - Hospital Inpatient * Number of case months Medicaid program services	482,926	4,300.15	2,076,655,079	2,076,655,079	
Elderly And Disabled/Fee For Service/Medipass - Prescribed Medicines * Number of case months Medicaid program services	482,926	2,166.57	1,046,293,294	1,046,293,294	
Elderly And Disabled/Fee For Service/Medipass - Physician Services * Number of case months Medicaid program services	482,926	1,044.12	504,231,612	504,231,612	
Elderly And Disabled/Fee For Service/Medipass - Hospital Outpatient * Number of case months Medicaid program services	482,926	916.08	442,397,807	442,397,807	
Elderly And Disabled/Fee For Service/Medipass - Supplemental Medical Insurance * Number of case months Medicaid program	286,731	3,813.03	1,093,312,847	1,093,312,847	
Elderly And Disabled/Fee For Service/Medipass - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	87,590	222.60	19,497,156	19,497,156	
Elderly And Disabled/Fee For Service/Medipass - Patient Transportation * Number of case months Medicaid program services	482,926	131.47	63,491,358	63,491,358	
Elderly And Disabled/Fee For Service/Medipass - Case Management * Number of case months Medicaid program services	482,926	181.11	87,492,287	87,492,287	
Elderly And Disabled/Fee For Service/Medipass - Home Health Services * Number of case months Medicaid program services	482,926	133.59	64,515,221	64,515,221	
Elderly And Disabled/Fee For Service/Medipass - Therapeutic Services For Children * Number of case months Medicaid program	87,590	203.28	17,805,636	17,805,636	
Elderly And Disabled/Fee For Service/Medipass - Hospital Insurance Benefit * Number of case months Medicaid program	274,017	438.21	120,076,710	120,076,710	
Elderly And Disabled/Fee For Service/Medipass - Hospice * Number of case months Medicaid program services purchased	482,926	366.39	176,939,920	176,939,920	
Elderly And Disabled/Fee For Service/Medipass - Private Duty Nursing * Number of case months Medicaid program services	87,590	2,556.49	223,922,684	223,922,684	
Elderly And Disabled/Fee For Service/Medipass - Other * Number of case months Medicaid program services purchased	482,926	1,364.02	658,722,197	658,722,197	
Women And Children/Fee For Service/Medipass - Hospital Inpatient * Number of case months Medicaid program services	1,013,754	1,797.23	1,821,952,299	1,821,952,299	
Women And Children/Fee For Service/Medipass - Prescribed Medicines * Number of case months Medicaid program services	1,013,754	307.60	311,835,642	311,835,642	
Women And Children/Fee For Service / Medipass - Physician Services * Number of case months Medicaid program services	1,013,754	646.00	654,880,212	654,880,212	
Women And Children/Fee For Service / Medipass - Hospital Outpatient * Number of case months Medicaid program services	1,013,754	617.00	625,485,031	625,485,031	
Women And Children/Fee For Service / Medipass - Supplemental Medical Insurance * Number of case months Medicaid program	991	201,603.02	199,788,591	199,788,591	
Women And Children/Fee For Service / Medipass - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	803,206	290.94	233,686,249	233,686,249	
Women And Children/Fee For Service / Medipass - Patient Transportation * Number of case months Medicaid program	1,013,754	75.16	76,193,573	76,193,573	
Women And Children/Fee For Service / Medipass - Case Management * Number of case months Medicaid program services	1,013,754	10.50	10,648,634	10,648,634	
Women And Children/Fee For Service / Medipass - Home Health Services * Number of case months Medicaid program services	1,013,754	103.38	104,806,910	104,806,910	
Women And Children/Fee For Service / Medipass - Therapeutic Services For Children * Number of case months Medicaid	803,206	66.25	53,210,855	53,210,855	
Women And Children/Fee For Service / Medipass - Clinic Services * Number of case months and Medicaid program services	1,013,754	126.37	128,113,081	128,113,081	
Women And Children/Fee For Service / Medipass - Other * Number of case months Medicaid program services purchased	1,013,754	444.68	450,800,666	450,800,666	
Medically Needy - Hospital Inpatient * Number of case months Medicaid program services purchased	40,687	6,635.45	269,976,373	269,976,373	
Medically Needy - Prescribed Medicines * Number of case months Medicaid program services purchased	40,687	3,353.33	136,436,884	136,436,884	
Medically Needy - Physician Services * Number of case months Medicaid program services purchased	40,687	1,575.81	64,114,826	64,114,826	
Medically Needy - Hospital Outpatient * Number of case months Medicaid program services purchased	40,687	1,963.21	79,877,238	79,877,238	
Medically Needy - Supplemental Medical Insurance * Number of case months Medicaid program services purchased	4,776	1,415.26	6,759,276	6,759,276	
Medically Needy - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services	6,457	157.47	1,016,800	1,016,800	
Medically Needy - Patient Transportation * Number of case months Medicaid program services purchased	40,687	56.41	2,295,347	2,295,347	
Medically Needy - Case Management * Number of case months Medicaid program services purchased	40,687	38.47	1,565,389	1,565,389	
Medically Needy - Home Health Services * Number of case months Medicaid program services purchased	40,687	41.85	1,702,925	1,702,925	
Medically Needy - Therapeutic Services For Children * Number of case months Medicaid program services purchased	6,457	5.50	35,526	35,526	
Medically Needy - Other * Number of case months Medicaid program services purchased	40,687	25,423.14	1,034,391,414	1,034,391,414	
Refugees - Hospital Inpatient * Number of case months Medicaid program services purchased	4,690	2,190.70	10,274,369	10,274,369	
Refugees - Prescribed Medicines * Number of case months Medicaid program services purchased	4,690	105,932.65	496,824,123	496,824,123	
Refugees - Physician Services * Number of case months Medicaid program services purchased	4,690	770.17	3,612,118	3,612,118	
Refugees - Hospital Outpatient * Number of case months Medicaid program services purchased	4,690	327.59	1,536,420	1,536,420	
Refugees - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services	683	322.74	220,430	220,430	
Refugees - Patient Transportation * Number of case months Medicaid program services purchased	4,690	17.91	83,976	83,976	
Refugees - Home Health Services * Number of case months Medicaid program services purchased	4,690	51.74	242,662	242,662	
Refugees - Other * Number of case months Medicaid program services purchased	4,690	377.87	1,772,196	1,772,196	
Nursing Home Care * Number of case months Medicaid program services purchased	73,504	37,094.12	2,726,566,334	2,726,566,334	
Home And Community Based Services * Number of case months Medicaid program services purchased	88,907	11,526.43	1,024,780,402	1,024,780,402	
Intermediate Care Facilities For The Developmentally Disabled - Sunland Centers * Number of case months Medicaid program	517	213,483.58	110,371,005	110,371,005	
Mental Health Disproportionate Share Program * Number of case months Medicaid program services purchased	720	93,274.38	67,157,553	67,157,553	
Purchase Medikids Program Services * Number of case months	29,156	2,113.98	61,635,249	61,635,249	
Purchase Children's Medical Services Network Services * Number of case months	22,960	6,535.68	150,059,173	150,059,173	
Purchase Florida Healthy Kids Corporation Services * Number of case months	200,664	1,503.85	301,768,180	301,768,180	
Certificate Of Need/Financial Analysis * Number of certificate of need (CON) requests/financial reviews conducted	3,546	454.28	1,148,646	1,610,878	
Health Facility Regulation (compliance, Licensure, Complaints) - Tallahassee * Number of licensure/certification	22,082	611.00	7,968,490	13,492,167	
Facility Field Operations (compliance, Complaints) - Field Offices Survey Staff * Number of surveys and complaint	64,929	671.38	26,027,300	43,592,130	
Health Standards And Quality * Number of transactions	2,902,773	1.07	1,873,198	3,098,114	
Plans And Construction * Number of reviews performed	4,869	1,135.18	3,770,693	5,527,176	
Managed Health Care * Number of Health Maintenance Organization (HMO) and workers' compensation	176	17,758.90	2,108,656	3,125,567	
Background Screening * Number of requests for screenings	189,756	3.13	593,911	593,911	
Subscriber Assistance Panel * Number of cases	406	2,139.53	498,865	868,651	
Health Facilities And Practitioner Regulation - Medicaid Choice Counseling * Number of new enrollees provided choice	372,458	0.87	138	323,700	
TOTAL			21,122,304,490	21,122,304,490	

SECTION III: RECONCILIATION TO BUDGET	
PASS THROUGHS	
TRANSFER - STATE AGENCIES	
AID TO LOCAL GOVERNMENTS	
PAYMENT OF PENSIONS, BENEFITS AND CLAIMS	
OTHER	1,105,751,662
REVERSIONS	124,160,696
TOTAL BUDGET FOR AGENCY (Total Activities + Pass Throughs + Reversions) - Should equal Section I above. (4)	22,352,216,848

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

- **AHCA**- Agency for Health Care Administration
- **ALF -** Assisted Living Facilities are housing facilities for people with disabilities. These facilities provide supervision or assistance with activities of daily living; coordination of services by outside health care providers; and monitoring of resident activities to help to ensure their health, safety, and well-being.
- **APD** - Agency for Persons with Disabilities
- **APG** - Agency Project Governance
- **ARRA** - American Recovery and Reinvestment Act
- **CIO** - Chief Information Officer
- **CMS** - Centers for Medicare and Medicaid Services http://www.cms.gov
- **DCF** - Department of Children and Families
- **DOEA** - Department of Elder Affairs
- **DOH** - Department of Health
- **DRG** - Diagnosis Related Groups
- **DSH** - Disproportionate Share Hospital - Medicaid disproportionate share hospital payments provide financial assistance to hospitals that serve a large number of low-income patients, such as people with Medicaid and the uninsured.
- **EHR** - Electronic Health Record
- **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.
- **EPO** - 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.

- **FFP** - Federal Financial Participation
- **FFS** - Fee-for-Service
- **FTC** - Federal Trade Commission
- **FMMIS/DSS** - Florida Medicaid Management Information System/Decision Support System. Florida's data management system and data warehouse used for collecting, processing, and storing Medicaid recipient encounter claims.
- **HEDIS** – Healthcare Effectiveness Data and Information Set 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.
- **HIPAA** - Health Insurance Portability and Accountability Act
- **HMO** - Health Maintenance Organizations
- **HQA** - Health Quality Assurance
- **HSD** - Medicaid Health Systems Development
- **Individual Budget (iBudget)**
- **iBudget Florida** – An enhanced entitlement allocation process implemented by the Agency for Persons with Disabilities to manage the Medicaid waiver system for people with developmental disabilities. iBudget Florida gives APD customers more control and flexibility to choose services that are important to them, while helping the agency to stay within its Medicaid waiver appropriation.
- **IGT** - Intergovernmental Transfers
- **ITN** - Invitations to Negotiate
- **LIP** - Low Income Pool http://ahca.myflorida.com/Medicaid/medicaid reform/lip/lip.shtml
- **MCM** - Medicaid Contract Management
- **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 people with disabilities.
- **MEDS** - Medicaid Encounter Data System
- **MFCU** - Medicaid Fraud Control Unit
- **MITA** - Medicaid Information Technology Architecture

- **MMA** - Managed Medical Assistance
- **MMIS** - Medicaid Management Information System
- **MPI** - Medicaid Program Integrity
- **OIG** - Office of the Inspector General
- **OIR** - Office of Insurance Regulation
- **PHC** - Prepaid Health Clinics
- **PIP** - Personal Injury Protection
- **PMPM** – Per Member Per Month. Usually used when evaluating costs. Since Medicaid eligibility is not a constant, and people can enroll and dis-enroll several times in a year PMPM provides a stable and consistent basis for comparison.
- **PNV** - Provider Network Verification
- **PSN** - Provider Service Networks
- **RapBack** - The background screening system used by the Agency to conduct comprehensive criminal history checks for both applicants for direct care workers and employees. This will be used by AHCA in the creation of the Care Provider Background Screening Clearinghouse to screen employees' criminal history in real-time through electronic fingerprint technology and will provide immediate notification to the Agency of an individual's record of arrest, and prosecution.
- **ROI** - Return on Investment
- **SMMC** - Statewide Medicaid Managed Care
- **VPN** - Virtual Private Network