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LONG RANGE PROGRAM PLAN

Agency for Health Care Administration
Tallahassee, Florida 32308

September 30, 2013

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201 Capitol
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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 2014-2015 through Fiscal Year 2018-2019. 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.

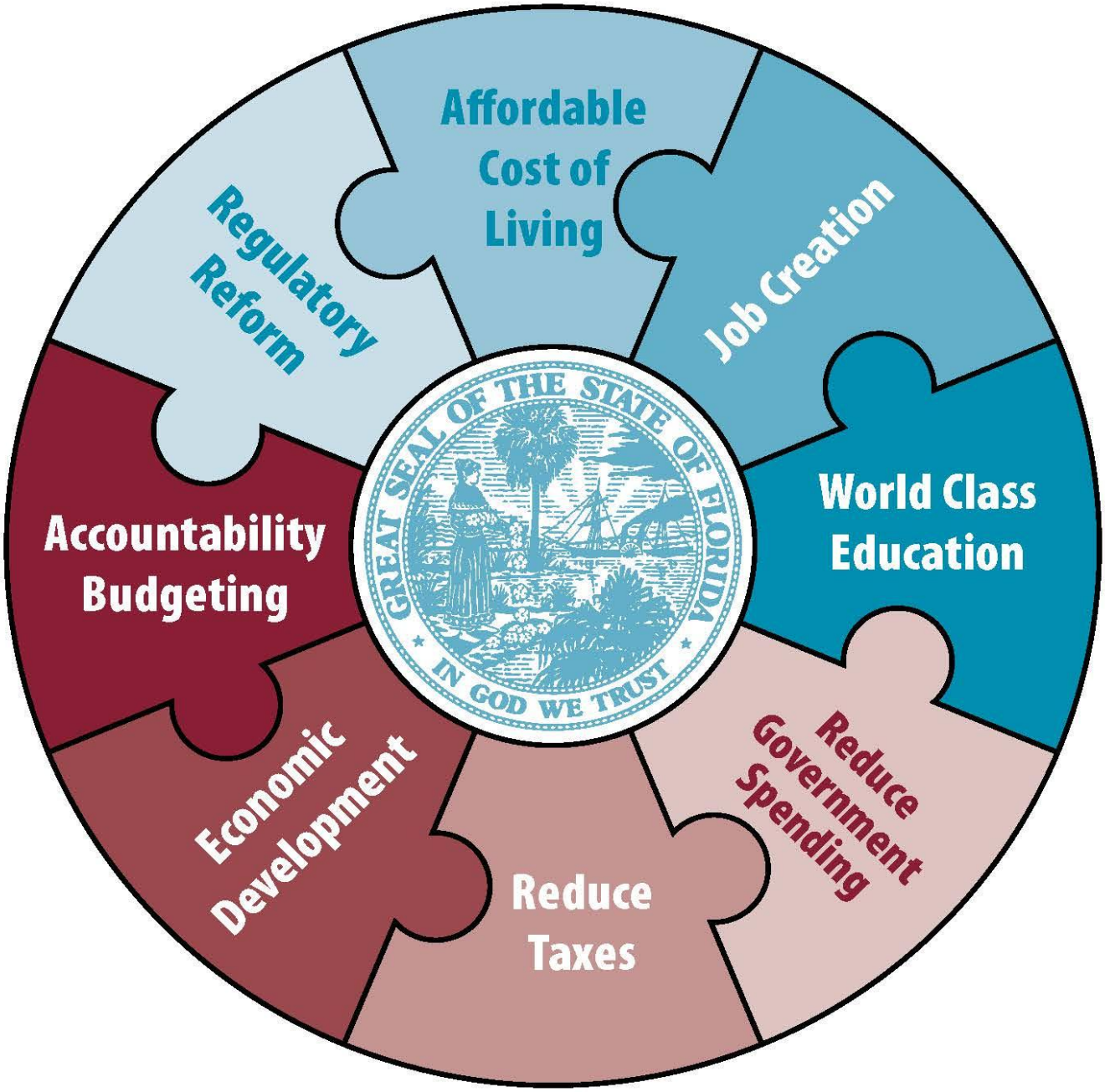
Tonya Kidd

Tonya Kidd
Deputy Secretary for Operations

AGENCY FOR HEALTH CARE ADMINISTRATION

LONG RANGE PROGRAM PLAN

FISCAL YEAR 2014 - 2015 THROUGH FISCAL YEAR 2018 - 2019



AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

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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 2018-2019.

Objective 1.B: To reduce by 50 percent the number of Division of Health Quality Assurance public record requests manually processed by Fiscal Year 2018-2019.

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 2018-2019.

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 2018-2019.

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 2018-2019.

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 (SMMC) through Fiscal Year 2018-2019.

Objective 3.B: To limit the growth in total long-term care expenditures to less than eight percent over the Base Year (Fiscal Year 2012-2013) by Fiscal Year 2016-2017.

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 2018-2019.

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 2018-2019.

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 2012-2013	FY 2014-2015	FY 2015-2016	FY 2016-2017	FY 2017-2018	FY 2018-2019
20,461	2,046	5,115	10,231	15,346	17,392
Percent of increase in the average number of license applications received via Internet	10%	25%	50%	75%	85%

The Agency for Health Care Administration 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 record requests handled by the Agency for Health Care Administration's (Agency's/AHCA's) Division of Health Quality Assurance (HQA).

Performance Projection Table 1.B:

Baseline Year FY 2012-2013	FY 2014-2015	FY 2015-2016	FY 2016-2017	FY 2017-2018	FY 2018-2019
3,497	3,147	2,798	2,448	2,098	1,749
Percent of reduction in the annual number of public record requests processed by HQA	10%	20%	30%	40%	50%

This measure represents the Agency's 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: Division of Information Technology's (IT's) annual human resource retention rate.

Performance Projection Table 1.C:

Baseline Year FY 2012–2013	FY 2014-2015	FY 2015-2016	FY 2016-2017	FY 2017-2018	FY 2018-2019
82%	85%	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.

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 2014-2015	FY 2015-2016	FY 2016-2017	FY 2017-2018	FY 2018-2019
$35,700,000*	$47,858,082	$49,293,824	$53,730,268	$58,565,992	$63,836,931
Projected Increase in Percent	9%	9%	9%	9%	9%

**Fiscal Year 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 2014-2015	FY 2015-2016	FY 2016-2017	FY 2017-2018	FY 2018-2019
$18,900,000	$25,327,808	$26,594,198	$27,923,908	$29,320,103	$30,786,108
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 fiscal year.

Performance Projection Table 3.A:

Baseline Year FY 2012-2013	FY 2014-2015	FY 2015-2016	FY 2016-2017	FY 2017-2018	FY 2018-2019
$527.28	$615.02	$664.22	$717.36	$774.75	$836.73
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 2014-2015	FY 2015-2016	FY 2016-2017	FY 2017-2018	FY 2018-2019
$4,657 Medicaid Long-Term Care Expenditures ($ Millions)	$4,994.32	$5,089.65	$5,187.44	$5,187.44	$4,994.32
Projected Annual Growth	2.30%	1.91%	1.92%	N/A	2.30%
Projected Overall Growth from Base Year	6.75%	8.79%	10.88%	N/A	6.75%

*Long-term care forecast only extends through Fiscal Year 2015-2016. Projected Long-Term Care program expenditures, in millions.

Service Outcome Measure 3.C: Percent of Medicaid recipients who needed specialty care and reported on the Consumer Assessment of Health Providers and Systems (CAHPS) survey it was “usually or always easy” to obtain specialty care.

Performance Projection Table 3.C:

Baseline Year FY 2010-2011	FY 2014-2015	FY 2015-2016	FY 2016-2017	FY 2017-2018	FY 2018-2019
81.4%	84%	86%	88%	90%	90%

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 2014-2015	FY 2015-2016	FY 2016-2017	FY 2017-2018	FY 2018-2019
Number of outcome measures 20	19	19	19	19	19
Number of outcome measures maintained or improved 15	17	18	19	19	19
Percent of outcomes maintained or improved 79%	89%	95%	100%	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 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 performance/outcome measures will amount to 17. 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

The Division of Health Quality Assurance (HQA) shares the Agency's mission of "Better Health Care for All Floridians" by administering oversight of regulated health care providers, monitoring managed care provider networks, and implementing health information provisions. 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. Additionally, the Agency 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 this, 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 (ALFs), 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 the population aged 65 and over were in Florida. Of the 5.1 million forecasted population growth by 2030, Florida's elderly 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 the current volumes thereby 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

The Agency created the Assisted Living Workgroup (AL Workgroup) in response to Governor Rick Scott's directive to examine the regulation and oversight of ALFs in Florida. The objective of the AL Workgroup was to make recommendations to the Governor and Legislature to improve the monitoring of safety in ALFs in order to help ensure the well-being of residents.

The AL Workgroup was conducted in two phases. Phase I resulted in recommendations relating to consumer information, 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 AL Workgroup felt could be addressed immediately were considered Phase I recommendations. For the other issues that required more evaluation time, the AL Workgroup recommended that they be examined by a Phase II Workgroup. Phase II was designed to utilize the information and recommendations gathered during Phase I and to develop recommendations for future legislation. Phase II included four statewide meetings and two conference calls. There were 21 public comments heard, and 11 state agency presentations were made. The AL Workgroup dedicated two full days to mental health issues during the October 2012 meeting as a result of tremendous public testimony and potential mental health recommendations raised at the ALF/Limited Mental Health and Community Mental Health Center Summit held in Tallahassee.

The AL Workgroup has concluded its review, and all of the written resources used by the Workgroup along with the minutes for the meetings and the Final Report and Recommendations are available to view at: http://ahca.myflorida.com/SCHS/CommiteesCouncils/ALWG/index.shtml.

Assisted Living Facilities/Adult Family Care Home Initiatives in Fiscal Year 2012-2013

As a result of the findings of the AL Workgroup, additional efforts have been made to investigate and monitor compliance in ALFs through a large-scale investigation and enforcement projects. These efforts included staff from the Agency's Bureau of Medicaid Program Integrity (MPI), HQA, and federal Centers for Medicare and Medicaid Services/Medicaid Integrity Group (MIG) as well as other state and local law enforcement agencies. The Miami-Dade County ALF Project, conducted in Fiscal Year 2011-2012, focused on Medicaid billing practices in ALFs and resulted in referrals for patient care and other licensure related issues. The project yielded 175 sanctions totaling $932,500 in fines. Additionally, two more initiatives were conducted in Fiscal Year 2012-2013: the Jacksonville ALF/Adult Family Care Home (AFCH) Initiative and the Tampa ALF/Assistive Care Services Initiative. These initiatives focused on assistive care services providers regarding Medicaid billing practices, background screening, and resident health and safety from communicable diseases including tuberculosis. The Jacksonville ALF/AFCH Initiative was conducted in October 2012 and resulted in 38 sanctions totaling $233,000 in fines as well as two providers being terminated from the Medicaid program. The Tampa ALF/Assistive Care Services Initiative was conducted in March 2013 and yielded 24 sanctions totaling $108,500 in fines. 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 and reduce the overlap and duplication of work. This collaboration will extend beyond ALFs 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. It also strengthened 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 enforcing 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 MPI and the Medicaid Fraud Control Unit (MFCU) as well as the number of MPI referrals made to HQA and MFCU. These reports include the number of license applications denied due to applicant(s) or person(s) with controlling interest being disqualified because of termination for cause from the Medicaid program, a conviction, or a plea of guilty/nolo contendere to Medicaid fraud, regardless of adjudication. 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. The monthly press releases can be viewed on the Agency's website under Communications/Media Relations.

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 provides federal funding for the administration of the Medicaid Electronic Health Record (EHR) Incentive Payment program and the Cooperative Agreement with the Office of the National Coordinator for Health Information Technology (ONC). 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 on the development of a health care clinical information exchange that is privacy-protected, is 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 with the exception of those allocated to the Florida Center. However, from Fiscal Year 2008-2009 to Fiscal Year 2011-2012, HQA's number of licensed, registered, certified, and regulated service providers and facilities continued to increase from 37,755 to 45,304 with a slight decline to 44,525 in Fiscal Year 2012-2013 resulting from the deregulation of certain Homemaker and Companion Services providers (Table 1-2). Overall, this represents an 18 percent increase in regulated providers despite the fact that five to ten percent of licensees are failing to renew each year.

Table 1-1:

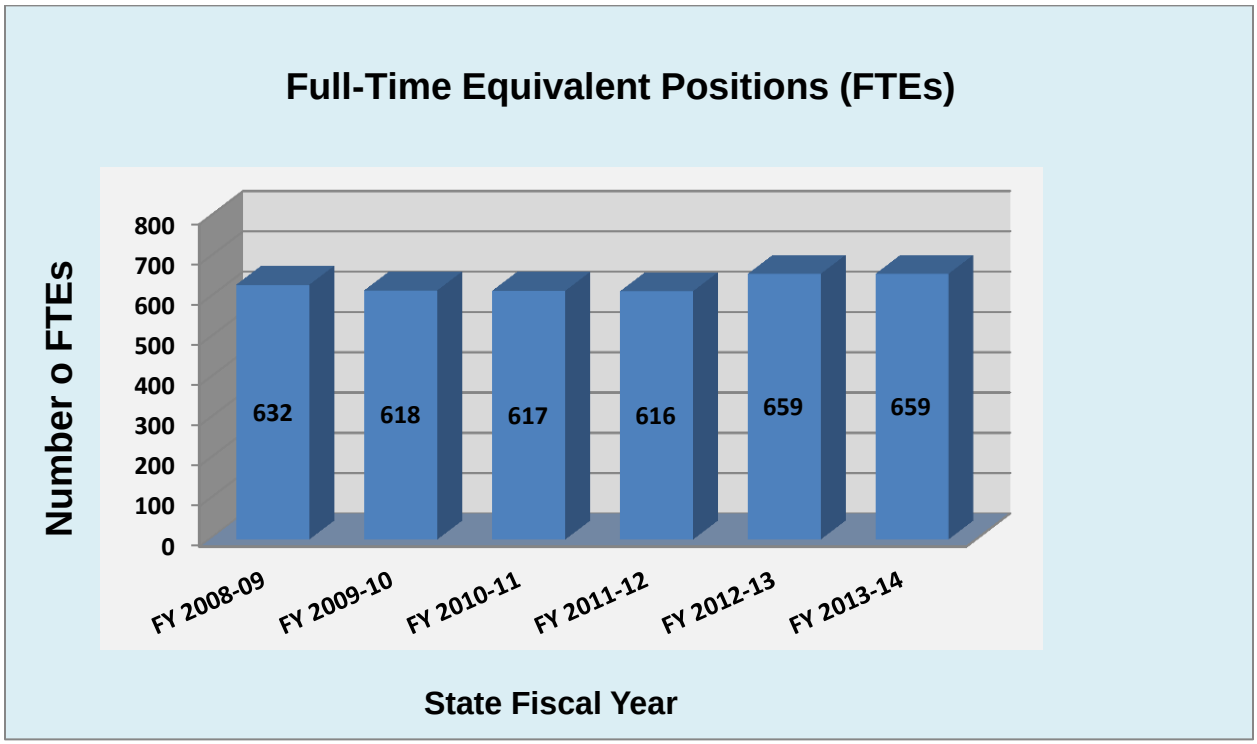
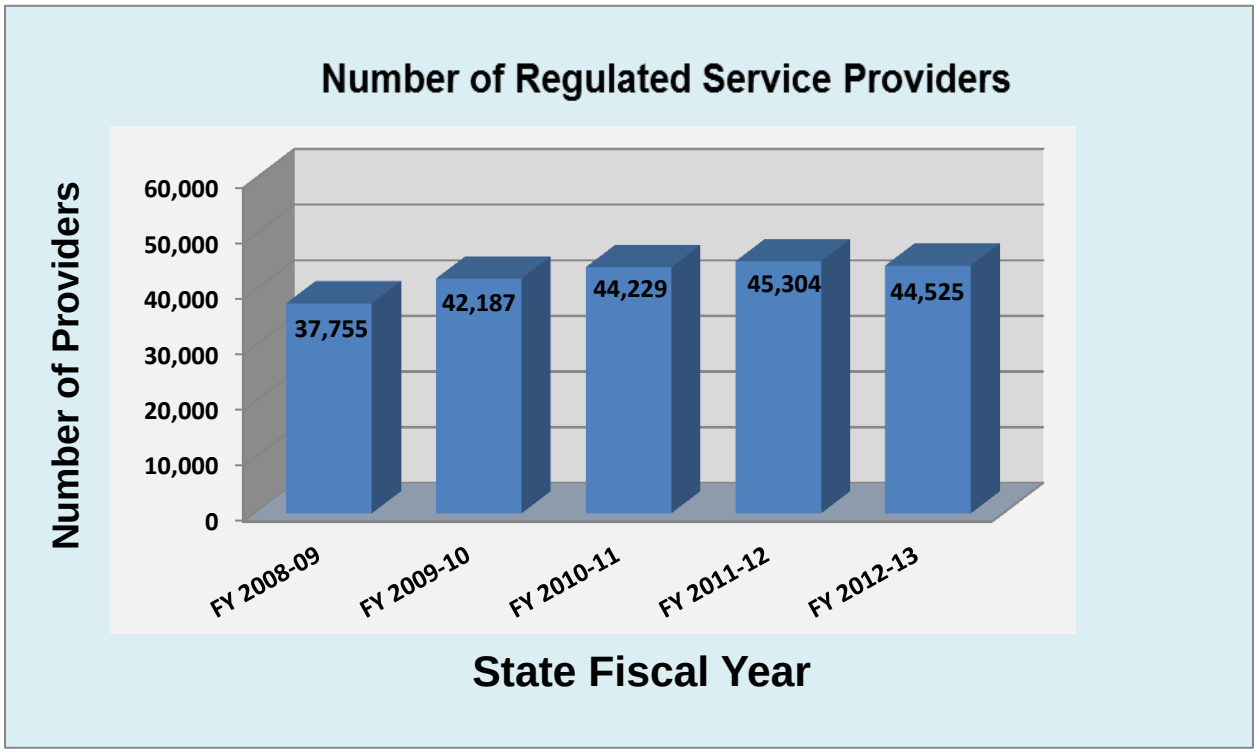


Table 1-2:



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. Legislation passed in 2013 made several streamlining updates, including the following:

- Eliminated references to specific health care accreditation organizations and instead provided a revised definition of "accrediting organization." This allows greater flexibility for providers seeking to obtain accreditation for licensure purposes, allows for accrediting organizations that have changed names, and allows the state to recognize new, national accrediting organizations, such as those approved by the Centers for Medicare and Medicaid Services (CMS).

- Expanded the scope of practice in the area of pharmaceutical and laboratory services for Florida licensed optometrists.

- Removed unnecessary rulemaking authority from several statutes.

- Reduced the fine for late submission of the home health agency quarterly report required in section 400.474, F.S., and also exempted all home health agencies that are not Medicare or Medicaid providers and do not share a controlling interest with other licensed providers that bill Medicaid or Medicare for submitting the report.

- Authorized specialty-licensed children's hospitals that have a licensed neonatal intensive care unit to provide obstetrical services, including labor and delivery care, to up to ten women of any age with certain restrictions.

- Allowed additional exemptions for pediatric cardiology, perinatology, and anesthesia clinical facilities and revised the requirements for current exemptions relating to corporately-owned entities.

- Revised the definition of "level II trauma center" and "trauma center" and delineated criteria for designating level II trauma centers in areas with limited access to trauma services.

- Provided an exemption from certificate of need review for the addition of nursing home beds located within a specified retirement community.

The Agency plans to request additional legislative changes during the 2014 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.

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 three years. As a further enhancement to this process, the Legislature passed chapter 2012-73, Laws of Florida, in 2012 which allows for retained prints. More importantly, this legislation 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 the following agencies: AHCA, Agency for Persons with Disabilities (APD), Department of Elder Affairs (DOEA), Department of Children and Families (DCF), Department of Health (DOH), Department of Juvenile Justice (DJJ), and Vocational Rehabilitation at the Department of Education (DOE). For the included agencies and persons subject to background screenings, the elimination of duplicative screenings for employees working in long-term care and other health care related provider types will result in an overall cost savings. Integration with the state agencies began in January 2013 and is expected to be completed during 2014. The Clearinghouse includes 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. As of July 31, 2013, the Clearinghouse has resulted in cost savings of over $102,000 for the Agency's regulated providers and over $470,000 for individuals licensed by DOH.

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 document management system. It will also incorporate a seamless interface with delinquent money owed to the Agency to facilitate collections before licenses are issued or renewed. The 2013 Legislature appropriated the third year of funding for the three-year online licensing 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 Performance Projection 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-based 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 have 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 utilization of corresponding information previously recorded 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 eliminate the need for redundant data entry. The provider will input the data directly into the system, and it will be placed in pending status until it is reviewed and either approved or denied.

The internal Agency version of the Skilled Nursing Home renewal application is in use now; the external public version is scheduled for release in October 2013. All licensure types are scheduled to be available for online applications by mid-2014. Although initial submission of online applications will be voluntary, we anticipate significant adoption as there will be additional features to encourage use.

Increasing 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 (F.A.C.), and federal regulations in a manner that protects the health and safety of their residents or patients. As part of ongoing 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 2012-2013 resulted in a substantial rise in public record requests, particularly in the areas of health care clinics and long-term care facilities. The rise of 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; therefore, 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. Additionally, the Agency is working to improve and expand the functionality and search criteria for AHCA Docs by allowing the public

to search for surveys performed at unlicensed facilities and allowing a search by complaint number instead of only by facility name. This information will also be linked to Florida Health Finder so the public has more than one outlet for obtaining information.

In addition to publishing inspection reports, AHCA Docs now includes legal orders issued against providers. These include final 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. Florida Health Finder lists enforcement actions against providers including emergency orders and fines assessed against providers with live links back to the legal orders. By providing greater access to documents of public record and making the systems more user-friendly, transparency is heightened and staff workload on responding to public record requests is reduced.

As the popularity of Florida Health Finder continues to grow, so does the website's features. Significant efforts have been made to increase accessibility of consumer information for nursing homes and other health care facilities regulated by the Agency. The Agency has introduced several landing pages with a compendium of inspection, facility, and educational information specific to the licensure types and programs, beginning with ALFs, nursing homes, and hospitals and expanding to health plans in 2014. The Nursing Home landing page includes links to educational information, such as "How to Select a Nursing Home" and "Alternatives to Nursing Homes." Additionally, consumers can compare inspection ratings, find emergency actions, and view facilities on the "Nursing Home Watch List." There are links to see a star rating of any nursing home in the state based upon regulatory violations and to see how a nursing home compares to other facilities in their region. The Agency expects to expand the facility/provider search functionality to also include closed facilities. Additionally, the site has launched both English and Spanish speaking webinars to extend the outreach of consumers and providers accessing the information available on Florida Health Finder.

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 consolidation of multiple pieces of information into a single location on the Agency's website.

Improving the Continuum of Care through Information Exchange

The ARRA funding has been used for the development and maintenance of electronic health record (EHR) technology and the administration of the Medicaid Incentive Payment program to eligible Medicaid professional providers and hospitals that adopt and use certified EHR technology. The incentive payment program will be operational through 2021. Eligible professional providers and hospitals have until 2016 to begin participating in the program. The program runs six years for professional providers and three years for hospitals. To date, 5,371 Medicaid professional providers and 164 hospitals are participating.

Through the cooperative agreement with the ONC, the Agency implemented the statewide health information exchange infrastructure, known as the Florida Health Information Exchange (Florida HIE). To date, the Florida HIE utilizes two health information exchange services: the Patient Look-Up (PLU) Services and Direct Secure Messaging (DSM). The Agency continues

to work with professional associations and local stakeholders to make providers aware of Florida HIE services, understand their technical capabilities, and encourage participation. Florida is the first state to close its Florida HIE Cooperative Agreement with the ONC. The cooperative agreement ended in September 2013; however, the Agency's governance of the Florida HIE will continue through fee-based sustainment of HIE services. Florida HIE adoption statistics are reported on the project evaluation website at: http://floridahie-eval.fiu.edu.

The PLU enables providers to query for patient health records made available for look-up by other participating health care organizations and data sources. The PLU connects provider organizations, hospital networks, Regional Health Information Organizations, federally-qualified health center networks, and the Florida Department of Health. As of July 2013, 20 health care organizations are in the process of connecting to the PLU with four already in production: Strategic Health Intelligence, Atlantic Coast Health Information Exchange, Florida Hospital Adventist in Orlando, and Shands Hospital at the University of Florida (UF).

The DSM enables providers to send encrypted clinical documents and other patient information related to treatment, payment, and health care operations to other providers and health plans via a web-based portal. As of July 2013, 861 organizations have registered for the DSM service which includes 6,584 users. Other health information service providers (HISPs) can connect to Florida's DSM HISP. Florida's DSM HISP has connected to HISPs in nine other states and two vendor HISPs: Quest Diagnostics and SureScripts.

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), to regulate managed care organizations. The Agency is charged with monitoring plan networks, quality, and 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 20 Health Maintenance Organizations (HMO) and eight PSNs are contracted with Medicaid to provide services in all 67 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 1.46 million in July 2012 to 1.51 million in July 2013. 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)	26	26	20
Exclusive Provider Organization (EPO)	7	3	0
Prepaid Health Clinic (PHC)	5	0	0
Provider Services Network (PSN)	0	0	8

More than one product or service may be provided by a single HMO or EPO. PSNs can also offer Medicare products if approved.

During Fiscal Year 2013-2014 and in future fiscal years, the Agency will continue to design and implement new regulations related to expansion of the Statewide Medicaid Managed Care (SMMC) program to include statewide enrollment of Medicaid recipients in the Long-Term Care (LTC) component of the SMMC and Managed Medical Assistance (MMA) programs. The new contract standards developed for incorporation into the Invitations to Negotiate (ITNs) are 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 also allow for more refinement and enforcement of network adequacy and access standards.

The LTC program is comprised of HMOs and PSNs and is being implemented on a regional basis, with 11 regions enrolling in the program. The LTC program went live on August 1, 2013, and the final region will enroll on March 1, 2014.

The MMA program will provide acute care services to Medicaid recipients. The MMA plans are currently being chosen through a competitive bid process. Once the Agency has selected the plans that may participate in the MMA program, the Agency will begin notifying and transitioning eligible Medicaid recipients into the program. It is anticipated that the MMA program will be available in all areas by 2014.

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 worked 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 was released in Spring 2013. The PNV has automated numerous manual checks currently performed during network reviews 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. The system also assists in the identification of data gaps across multiple systems to improve data integrity. Data that is verified by the system is used by Medicaid recipients when determining which

plans meet their needs. Additional functions of the system include reporting for users, the users' plans, and a communication link between the Agency and the plans.

The Agency intends to submit LBR issues to procure client management and complaint intake systems. These systems will allow the Agency to connect and collapse existing systems and data into a single touch-point as well as to have a centralized complaint tracking system with the ability for single point complaint intake. The overall scope of these systems will move the Agency towards its strategic goal of consolidating systems and resources to better serve Floridians in a comprehensive and efficient manner.

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 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 customers and the public. IT's overall goal is to maximize the Agency's efficiency through technology. Currently, there are three functional bureaus, each with clear and distinct responsibilities, which are: Customer Service and Support, Application Development and Support, and Information Technology Strategic Planning and Security. Previously, IT had a fourth bureau entitled 'Enterprise Infrastructure'; however, as a part of the statewide Data Center Consolidation Initiative, our Agency's data center was consolidated into the Northwood Shared Resource Center resulting in the deletion of this bureau.

As Florida's population continues to age and grow, finding new and more cost efficient ways to support vital health care services are 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 (ROI), efficiency, and customer service. To meet these goals, the Agency will focus on its mission, with a heightened regard for information technology and its capacity to strengthen and streamline the Agency's internal operations and services to customers. Attributes that will help to maintain focus on important initiatives within IT include: qualified staff; technical adaptability; customer service standards; frontline employee communication; and collaboration skills and efforts.

Strategic Planning, Vision, Oversight

The Agency recognizes the need for critical routine operations in order to provide consistent and reliable services to internal and external customers as well as to service providers. There are several factors that strongly influence the Agency's mission to fulfill its current responsibilities and achieve its future goals. Of the many factors the Agency contends with each year, there

are three which most significantly influence the Agency's use of information technology to support efforts and reach goals:

- The rapidly growing need for IT 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 information technology public sector labor market.

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

- Strategic planning for the integration of disparate systems; and
- Automation of regulatory processes.

The second trend influencing the Agency's strategic vision 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. 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 analyses, developing policies and procedures, conducting security audits, and providing end-user training. This statute also instructs agencies to address a process for detecting, reporting, and responding to security incidents and procuring security services.

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 valuable staff employed by the Agency and is a significant component of employee job satisfaction. In previous years when the state economy flourished, Agency employees were often lost to the private sector. Currently, recessionary trends have had a minimal effect on the Health Industry and Information Technology sectors.

In the past three years, IT has been challenged with replacing valuable human resources and institutional knowledge lost to both the private sector and other state agencies. Due to varying appropriations, some state agencies have the ability to offer a higher compensatory package and are in a position to draw valuable skill sets away from the Agency. A recent review of comparable position titles between state agencies showed the Agency's IT staff to be compensated at about ten to twelve percent below the state average. The public sector has traditionally experienced difficulties in competing with the private sector for skilled information technology workers. Private sector compensation packages have ranged from 25 to 50 percent higher based on exit interviews and information received from state vendors.

The Agency's Management Team (AMT) 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. It is the responsibility of the Agency Chief Information Officer (CIO), governed by section 282.3055 F.S., to coordinate and facilitate the management and planning of the Agency's information technology services.

Agency Objective 1.C should be accomplished as part of the overall effort to strengthen the Agency's data security capabilities. Upon completion, any data stored on or passing through division-managed resources will be secure according to the Agency's security standards regarding access, encryption, and backup.

In order to better serve the Agency and to align IT with its core mission, it is the vision of the CIO to make improvements in two major areas. The first is to find new and more effective ways to support health care services, such as salary increases to retain and attract competent IT staff. The second is to better leverage that staff through a thorough business case process to improve the governance process.

The Agency's long-term policy intentions, with regard to the ways in which IT is leveraged, are further demonstrated by the efforts of the AMT to consolidate all information technology purchases and other significant related issues, with the exception of the Medicaid program Fiscal Agent Florida Medicaid Management Information System/Decision Support System (FMMIS/DSS). This is a key factor aligned with the Agency's Project Governance (APG) Initiative, an ongoing effort to streamline and eliminate redundancy and inefficiency across all of the Agency's regulatory and operational practices and procedures.

IT will seek assistance from the private sector to better equip management and the APG through thorough business case analyses to include the development of the ROI for each project engaged. The AMT and APG provide direction and oversight to the Agency by reviewing all proposed projects and prioritizing them according to need. It is the express purpose of these bodies to align all information technology initiatives with the ongoing mission of the Agency.

Statutorily Required Primary Data Center Consolidation Relocation

Expenses for the use of the Northwood Shared Resource Center (NSRC) are forecasted to increase during Fiscal Year 2013-2014. In order to make necessary adjustments to the budget, the increase in expenditures will be addressed on a statewide level. However, the Agency plans to submit a Legislative Budget Request (LBR) issue for Fiscal Year 2014-2015 to alleviate the shortfall.

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 for the Medicaid program, in part, by the MPI. In this program, the key indicator of fraud and abuse is overpayments. The Florida Medicaid program is a $20.7 billion program with an estimated total of 80,200 enrolled providers

as of July 2013. The program is made up of 21 HMOs and nine PSNs that provided Medicaid services to approximately 3.3 million recipients/enrollees during Fiscal Year 2012-2013.

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 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 the states' program integrity efforts and ensuring that states have the necessary processes in place to prevent and detect improper payments.

All divisions of the Agency work with the Attorney General's MFCU, 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; prosecutorial agencies; and the Medicaid and Public Assistance Fraud Strike Force (created during the 2010 Legislative Session) in order 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. The Agency intends to submit an LBR issue to request funding for enhanced data analytical subscription services in order to better identify fraud, waste, and abuse within the Florida Medicaid program.

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 with other state and federal agencies to achieve its goals. MPI will continue generating quality referrals by its 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 also provide oversight for managed care by reviewing the compliance of various plans with applicable contract language, recommending new system enhancements to related contract language, and developing an audit program.

Prevention, Detection and Recovery

MPI strives to increase prevention, detection, and recovery efforts, as described below, in order to identify improper billing and fraudulent schemes in the Medicaid program.

- **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.

During Fiscal Year 2011-2012, MPI prevention efforts resulted in cost savings of $27.9 million. Actual overpayments recovered through the efforts of MPI totaled $32.2 million for the same fiscal year.

Health Care Services (Division of Medicaid)

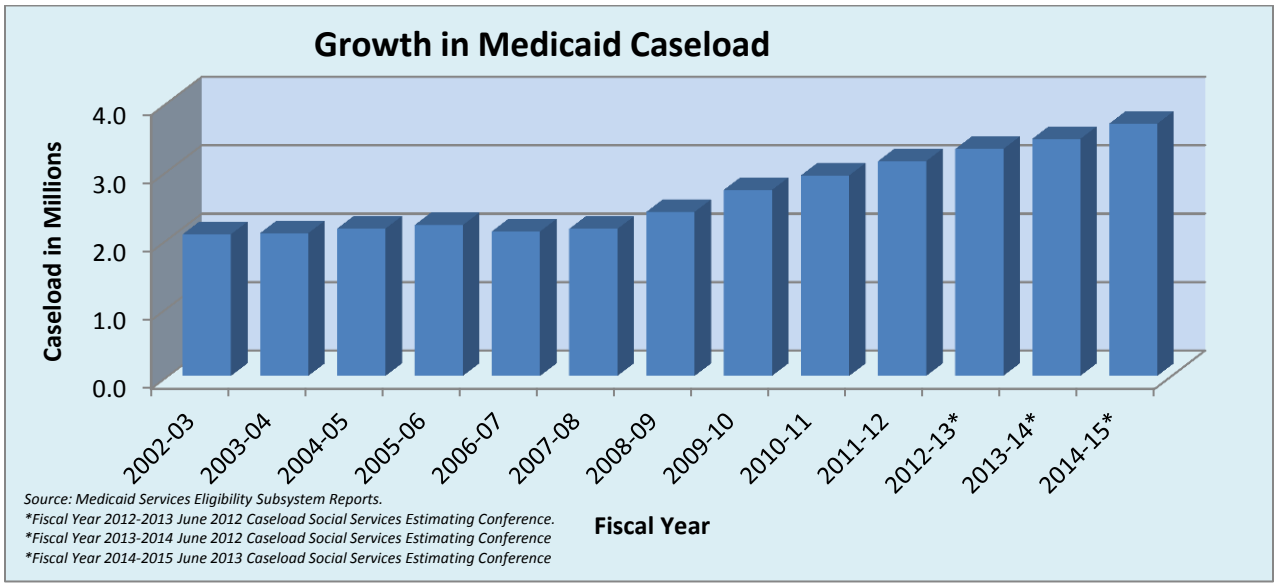
Authority for the Florida Medicaid program is established in chapter 409, F.S., (Social and Economic Assistance) and chapter 59G, F.A.C., (Medicaid). Other relevant statutes that mandate the management and administration of state and federal Medicaid programs and child health insurance programs as well as 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, 58.67 percent of the expenditures for most Medicaid services were reimbursed with federal funds in Fiscal Year 2012-2013. 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. Based on the 2010 U.S. Census, the population of Florida is estimated to be approximately 19.3 million in 2012, 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 U.S. 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 order to help manage the growth in the demand for long-term care services and to provide greater predictability of long-term care cost increases, Florida implemented the LTC component of the SMMC program in 2013.

In Fiscal Year 2012-2013, it is estimated that Medicaid will have served 3.3 million beneficiaries and paid claims to approximately 76,000 enrolled providers. With a budget of $23.1 billion in Fiscal Year 2013-2014, Medicaid is the largest single program in the state, accounting for more than 31 percent of the state's total budget. It is also the largest source of federal funding for the state. Medicaid caseloads in Fiscal Year 2012-2013 were more than 59 percent higher than a decade ago (Table 3-1). The caseload increased by 5.5 percent in Fiscal Year 2012-2013 over the prior fiscal year and is projected to increase in Fiscal Year 2013-2014 by more than 5.1 percent compared to Fiscal Year 2012-2013. 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. As of June 2013, the statewide unemployment rate was 7.1 percent.

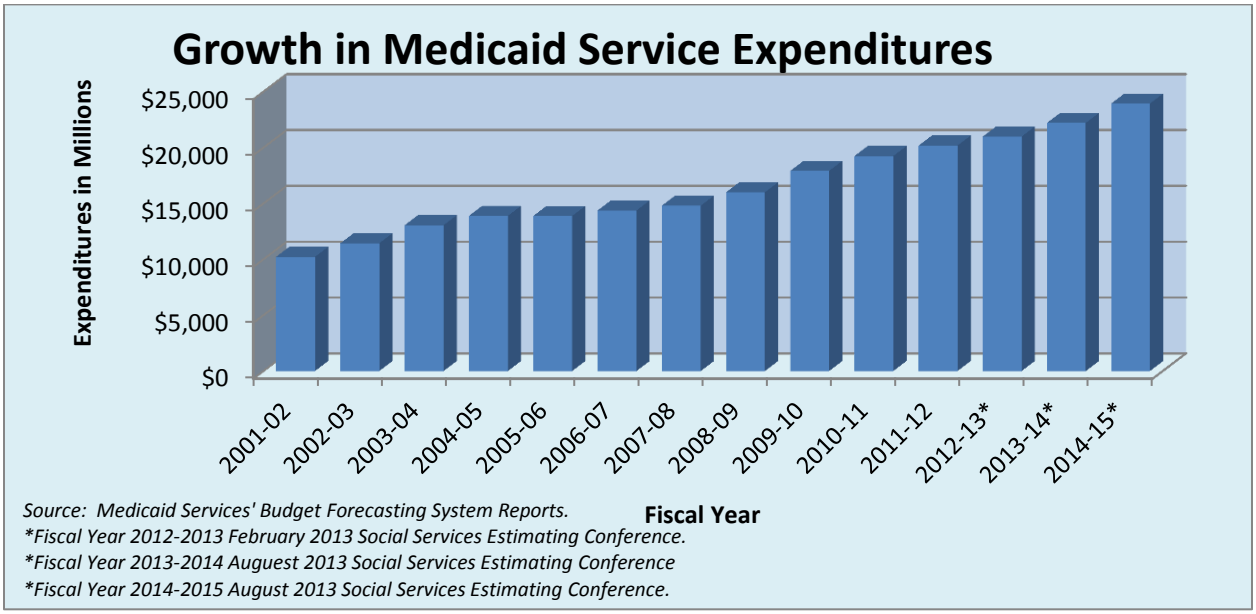
Table 3-1



In the last ten years, expenditures in the Medicaid program grew from almost $13.1 billion in Fiscal Year 2003-2004 to $23.1 billion budgeted in Fiscal Year 2013-2014, close to doubling in that time period (Table 3-2). The primary factors contributing to expenditure growth have been the cost of prescription drugs, an increase in the costs to provide medical services and long-term care, and an increase in enrollment. The largest expenditure categories for Fiscal Year 2013-2014 are:

- Prepaid Health Plans ($4.5 billion);
- Hospital Inpatient Services ($3.5 billion);
- Nursing Home Care ($2.9 billion);
- Prescription Services ($2.0 billion);
- Physician Services ($1.5 billion);
- Supplemental Medical Insurance ($1.3 billion);
- Hospital Outpatient Services ($1.2 billion);
- Home/Community Based Services ($1.1 billion); and
- Low Income Pool (LIP) ($1.0 billion).

Table 3-2



Source: Medicaid Services' Budget Forecasting System Reports.
**Fiscal Year 2012-2013 February 2013 Social Services Estimating Conference.*
**Fiscal Year 2013-2014 August 2013 Social Services Estimating Conference*
**Fiscal Year 2014-2015 August 2013 Social Services Estimating Conference.*

During Fiscal Year 2009-2010, the FMMIS received full federal certification from the CMS. The certification allows Florida 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 enrollment has 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. Even with improved economic conditions, Medicaid enrollment is likely to remain higher due to the Affordable Care Act (ACA) on the federal level and the roll out of SMMC on the state level. Both have increased awareness of the availability of Medicaid, and many of those already eligible will likely join the Medicaid program. Increased enrollment is not the only factor that influences Medicaid expenditures. Health care cost inflation has surpassed cost increases in other economic sectors for years. The 2011 Legislature passed an act related to SMMC, chapter 2011-134, Laws of Florida, directing the Agency to implement the SMMC program as a statewide, integrated managed care program for all covered medical assistance and long-term care services. The SMMC will provide greater predictability in costs while ensuring Medicaid recipients continue to have access to quality health care services. The LTC component of SMMC was launched in 2013, and the MMA component of SMMC is scheduled to begin in 2014.

Structure, Functions, and Current Activities

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

Program Finance, and Field Operations. Core functions of the Division of Medicaid can be summarized as:

- 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.

The Bureau of Health Systems Development (HSD) is responsible for the development and oversight of Medicaid's managed care programs, including:

- Managing contracts with HMOs, PSNs, the prepaid dental health plan, and the MediPass program;
- Monitoring the Disease Management Initiative for the MediPass population;
- Managing the 1915(b) Managed Care Waiver and 1115 Medicaid Reform Waiver;
- Preparing federal Medicaid managed care waiver requests;
- Developing and implementing SMMC policies;
- Overseeing contracts, applications, and procedures along with other special projects;
- Developing SMMC administrative rules;
- Coordinating SMMC policy development with other departmental entities;
- Monitoring public and SMMC programs;
- Preparing budget justification for programmatic issues;
- Performing impact analyses for new and amended state and federal laws and rules related to managed care; and
- Incorporating new federal and state legislation into current managed care operations.

The Bureau of Pharmacy Services is responsible for administration, management, and oversight of the Medicaid Pharmacy Services program, which includes:

- Policy development and implementation;

- Necessary rulemaking to implement statutes to optimize drug therapy for Medicaid recipients by ensuring access to pharmaceuticals that are clinically efficient and cost effective while producing desired outcomes; and

- Fiscal and operational analyses of policy and legislative proposals to determine the impact to the program and statutory reports for the Legislature.

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.

- MCM, over the past year, implemented the change from Version 4010 to Version 5010 of the Health Insurance Portability and Accountability Act (HIPAA) standard transactions as federally mandated. MCM also met the July 1, 2013 Florida Legislative requirement to implement and begin reimbursement of hospital inpatient services using Diagnosis Related Groups (DRGs). The provider enrollment process became fully automated with the implementation of the Enrollment Wizard and requirements for all new providers to enroll through the web-based portal.

- MCM met several requirements of the ACA by implementing primary care provider payment increases and by implementing Phase I of the operating rules, which provide additional specifications for electronic transactions in January 2013. The ACA creates a new national Medicaid minimum eligibility and the federal facilitated exchange (FFE) to receive and process health care coverage applications. The MCM is implementing system changes and working with the DCF and Florida Healthy Kids (FHK) to meet the requirements related to Modified Adjusted Gross Income (MAGI), the transitioning of the Children's Health Insurance Program (CHIP) recipients to Medicaid, and the new DCF eligibility interface.

- 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). During the past year, the analysis phase was completed and the remediation phase is 89 percent complete. MCM and the fiscal agent have been coordinating system changes and provider training and outreach for this project. The Agency requested year three funding in its LBR. The implementation date is October 1, 2014.

- MCM is heavily involved in the transition to the SMMC program. MCM and the fiscal agent implemented the system changes for the implementation of the LTC program, with Phase I implemented on August 1, 2013. System changes are ongoing for the implementation of the MMA program.

- MCM continues to follow the Agency's progress to align to the MITA 3.0 Version/Rule, set the roadmap for future business and systems interoperability planning and development, and maintain ongoing federal funding for developmental projects. MCM, in conjunction with the Florida Center, continues with enhancements to the EHR Incentive Payment program to provide payments to hospitals and eligible professionals

enrolled in the Florida Medicaid program. ARRA funding is being used to enhance and purchase EHR capability.

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 below for "Reorganization for Statewide Medicaid Managed Care"). MPA's responsibilities include:

- Encounter data collection and analysis; and
- Multiple administrative and analysis functions for which that data is used.

MPF is responsible for budget and fiscal planning, administering the LIP and Disproportionate Share program, and setting rates for institutional providers who are reimbursed on a cost basis.

The Medicaid Field Office staff is located in 11 different area offices throughout the state and represents a blend of divergent geographical, cultural, social and economic conditions. Core functions or the Medicaid Field Offices are summarized as:

- Providing local operational management and facilitation of the Medicaid provider networks;
- Conducting provider training;
- Handling provider and beneficiary relations;
- Overseeing community resource development;
- Processing exceptional claims;
- Authorizing certain beneficiary services;
- Monitoring programs; and
- Conducting program audits.

As the Agency transforms its organizational structure based on a functional model to support the fully implemented SMMC program, staff in the field will be realigned to support the new organizational structure.

Reorganization for Statewide Medicaid Managed Care

In August 2011, the Agency completed and submitted to the Florida Legislature a statutorily required report titled "Realignment of Medicaid Administrative Resources Necessary for the Implementation of House Bill 7107 and House Bill 7109." This report was an initial assessment of the likely administrative changes and the anticipated reorganization that will be necessary for the transition to and full implementation of the SMMC program.

The Agency contracted with North Highland to conduct a SMMC Reorganizational Study to provide additional guidance. The purpose of the SMMC Reorganization Study and the resulting report was to "conduct an independent unbiased assessment of the Agency's organizational and workforce needs required to fully implement a Florida SMMC program and transition the State Medicaid recipients from a Fee-for-Service (FFS) delivery model to a managed care service delivery model as provisioned in HB 7107 and HB 7109." In May 2013, the Agency's contract with North Highland culminated with the submission of a report entitled "Agency for Health Care Administration Medicaid Reorganization Study: Final Report."

Methodology/Core Concepts:

Based on our initial analysis and the recommendations included in the North Highland report, Agency staff is completing a plan for the reorganization of its Medicaid related functions to respond to changes in functional responsibilities and priorities necessary for implementation and management of the SMMC program.

Continuing discussions with North Highland have validated that our approach is in line with best practices. Staff working on this project have incorporated many of the key concepts outlined in the report titled "Agency for Health Care Administration Medicaid Reorganization Study: Final Report" (North Highland), including:

- Moving from a programmatic based model of organization to a functional based model;
- Utilization of process improvement activities, such as RACI (responsibility, accountability, consulted and informed) analysis;
- Ongoing discussion with the vendor regarding the planning process utilized has worked to ensure that best practices are followed;
- Conclusion that "roles will migrate from claims payment oversight (for example, prior authorization and utilization management) to a focus on enhancing current monitoring capabilities, improving plan accountability and allowing an increased focus on quality outcomes;"
- Conclusion that "the Agency must have staff with the appropriate expertise and experience to address the demands of the expanded managed care delivery model, which requires developing the requisite skill sets among existing staff or recruiting new staff;" and
- Recommendation that all of the Agency's divisions be included in the planning.

Key considerations during the development of the proposed functional organizational model included:

(1) Once SMMC is implemented, managed care will not be part of the Florida Medicaid program – the Florida Medicaid program will be a managed care program.

(2) A core understanding that different skill sets are needed to support the SMMC program. There will be a need for staff with the following skills:

- Data manipulation;
- Trend analysis;
- Financial analysis (e.g., forensic accounting);
- Actuarial;
- Technical writing;
- Outcome measurement;
- Program evaluation;
- Performance measurement; and
- Policy research and development.

(3) A core understanding that some functions will decline or be eliminated; others will increase.

(4) A core understanding that there will be less need for staff presence in the regions.

Reorganization Plan:

Based on the core concepts listed above and the methodologies outlined by North Highland, the Agency has developed a model centered around the following key functional areas:

- Plan Management;
- Medicaid Systems Management;
- Financial Monitoring and Budget;
- Data Analytics;
- Recipient and Provider;
- Policy;
- Quality; and
- Support/Shared Services.

Based on the components to be included in the plan referenced above, the Agency intends to submit an issue in the LBR for Fiscal Year 2014-2015. The issue will include:

- A request for authority to transition select Other Personal Services (OPS) positions to FTE career service employees;

- A request for authority to transfer positions between various divisions within the Agency and between various bureaus within the Division of Medicaid;

- A request for additional rate in order to recruit staff with specific skill sets needed to accommodate the new managed care environment and the increased financial monitoring and data analysis necessary for ensuring proper oversight of the SMMC program; and

- A request for additional funding in contracted services to support the information technology needs associated with the transition/reorganization.

In January 2014, the Agency will submit a plan for a new organizational structure that will be in place by July 2015, as follows:

- All eligible recipients will be transitioned to the SMMC program by July 2014; and

- During Fiscal Year 2014-2015, obsolete or diminished programs and contracts will be shut down or amended as appropriate; the submission and processing of FFS claims will conclude thereby allowing the reduction or transfer of resources; transfer, reclassification, and retraining of staff; and physical movement.

In order to maximize efficient use of existing resources and skills, the Agency is conducting a detailed cross-functional analysis between various divisions and bureaus. A request for additional resources or positions will not be made if those resources or skill sets are available for transfer. The cross-functional analysis will ensure that all possible areas for efficiencies and resources are identified.

Organizational Change to Date:

Since passage of the legislation authorizing the SMMC program in 2011, the Division of Medicaid has made a number of organizational changes in preparation for a Medicaid program that is a fully managed care program.

Fall 2011/ January 2012:

(1) Creation of an Actuary Position for the Division of Medicaid. This position is a direct report to the Deputy Secretary for Medicaid.

(2) Creation of the Bureau of Medicaid Field Operations. Previously, the 11 separate field offices reported individually to the Assistant Deputy Secretary of Operations.

(3) Creation of the Bureau of Medicaid Finance. Several functions previously under the Bureau of Medicaid Program Analysis were moved to the new bureau.

(4) Responsibility for Medicaid encounter data moved to the Bureau of Medicaid Program Analysis.

June 2012:

(1) Creation of an Assistant Deputy Secretary for the HSD.

(a) Responsibility for Choice Counseling moved to the Assistant Deputy Secretary for the HSD. This function was previously under the Bureau of Contract Management.

(b) Responsibility for the Bureau of Medicaid Field Operations moved to the Assistant Deputy Secretary for the HSD. This function was previously under the Assistant Deputy Secretary for Operations.

(c) Responsibility for the HSD moved to the Assistant Deputy Secretary for the HSD. This function was previously under the Assistant Deputy Secretary for Operations.

(2) Elimination of the Bureau of Medicaid Quality Assurance.

(a) Responsibility for Medicaid encounter data had previously been moved from this bureau to the Bureau of Program Analysis.

(b) Responsibility for Research Contracts and Evaluations moved to the Assistant Deputy Secretary for Operations.

(c) Responsibility for Project Management and Process Improvement moved to the External Affairs Unit in the Office of the Medicaid Director.

June 2013:

(1) Creation of a LTC Managed Care Contracting Unit within the HSD.

(2) Responsibility for the coordination of federal authorities moved to the Bureau of Medicaid Services.

(3) Creation of Medicaid Managed Care Lead Counsel position in the Agency's Office of the General Counsel.

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 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. Currently, the LTC component of the SMMC is currently being rolled out and will be fully implemented by April 1, 2014. Approximately 85,000 frail elders and adults with disabilities who receive services are in the process of being notified, educated, and counseled about managed care plan choices. The implementation of the MMA component of the SMMC program is on the horizon. The ITN was issued December 29, 2012, and the Agency anticipates plan awards during Fall 2013. It is anticipated that approximately two million Medicaid recipients will enroll during Fiscal Year 2014-2015.

Other significant activities will include implementing new quality and fraud fighting initiatives statewide, such as the comprehensive care management pilot project. The Division of Medicaid will be managing a FMMIS transition through the procurement of a new fiscal agent contract and either a takeover of existing FMMIS architecture or new FMMIS. Planning will start in 2013 and will end July 1, 2018 with the start of the new fiscal agent contract. The Division of Medicaid will

also be working with the Florida Healthy Kids (FHK) Corporation as they transition to a new third party administrator, effective October 2013, to ensure a smooth transition for file transmissions and Title XXI eligibility determinations. In addition, the Division of Medicaid will be working with both the FHK and DCF on system modifications to comply with ACA eligibility system requirements being implemented on October 1, 2013.

MCM continues to work on the transition from the ICD-9 to ICD-10 code set for year three of the project. Completion of all code translations is on schedule for November 2013 and work on FMMIS coding changes has already started. Testing is planned from April 2014 to September 2014 to meet the October 1, 2014 federal compliance deadline. The provider outreach, which began in 2013, will be expanded to include Florida Medicaid-specific training beginning in January 2014.

In addition to ongoing MITA work, the SMMC implementation, ICD-10 conversion, and FMMIS procurement projects, MCM will plan and implement several other projects to comply with known federal mandates, such as Transformed Medicaid Statistical Information System (T-MSIS) reporting, ACA provider enrollment/screening requirements, operating rules for HIPAA health care transactions (required by the ACA), and Health Plan Identifier. The table below lists known activities anticipated for Fiscal Year 2013-2014 through Fiscal Year 2017-2018.

ACTIVITY	DESCRIPTION	DEADLINE
FMMIS Procurement/Takeover	Planning through new Fiscal Agent (FA) contract	September 2013-July 2018
ACA-Minimum Essential Coverage	Interfaces with DCF system and FHK for federal exchange communication	October 2013
Operating Rules Certification	Part 1 – Eligibility and Claim Status	December 31, 2013
Operating Rules Implementation	EFT and Remittance Advice	January 1, 2014
ACA-Eligibility System	Changes to support DCF Medicaid Elig System	January 1, 2014
SMMC-LTC	Complete state regional rollout	March 2014
Operating Rules - Penalties	Penalties can be assessed for noncompliance	April 1, 2014
CMS-1500 Claim Form	CMS-1500 form updated for ICD-10 coding; January 1, 2014 implementation for dual use	April 1, 2014
SMMC-MMA	Complete state regional rollout	July 2014
T-MSIS Reporting	ACA-required enhanced data reporting to CMS	July 2014
ICD-10 Code Transition	Mandated use begins	October 1, 2014
Health Plan Identifier (HPID)	Large health plans (Medicaid) must obtain HPID	November 5, 2014
FMMIS Encounter Gateway	Enhanced encounter data reporting	December 31, 2014
Operating Rules Certification – Part 2	Claims/encounters, plan enrollment, premium payments, claims attachments, referral certification/authorization (PA)	December 31, 2015
Operating Rules Implementation	Part 2	January 1, 2016
ACA- Provider Enrollment/Screening	Enrollment/re-enrollment risk screening, fee collection	March 24, 2016
Health Plan Identifier (HPID)	Large health plans (Medicaid) must begin to use HPID	November 7, 2016

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	All Payer Claims Database	The issue will seek to enhance and expand current data collection efforts to include an All Payer Claims Database (APCD) for the Agency. The collection of the data needed for an APCD is currently authorized in section 408.061 (1)(c), F.S. By enhancing the current data collected to include paid claims data from all payers, the Agency will be able to give consumers actual prices and quality for health care services across the continuum of health care services, including and beyond hospitals and ambulatory surgery centers. APCDs are large scale databases that include data derived from medical claims, pharmacy claims, and dental claims from private and public third party payers.	The inability to complete this project would result in the loss of an opportunity to improve service delivery and communication with citizens and the health care community.

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
2	Medicaid Client and Data Management System and Complaint Intake and Tracking System	These systems will allow the Agency to connect and collapse existing systems and data into a single touch-point as well as to have a centralized complaint tracking system with the ability for single point complaint intake. The overall scope of these systems will move the Agency towards its strategic goal of consolidating systems and resources to better serve Floridians in a comprehensive and efficient manner.	If the issue is not funded, the Agency will have to continue utilizing separate systems and will have limited abilities to detect and prevent fraud as well as to track and resolve complaints.
Division of Information Technology			
3	None		

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
Office of the Inspector General			
4	Advanced Data Analytics and Detection Services	These services will modernize detection abilities by using advanced statistical methods and graph pattern analysis methods to identify aberrant billing patterns due to fraud or errors for the Agency. CMS has identified the need to find ways to identify fraud, waste, and abuse in the Medicaid program. Schemes, trends, and fraud are increasingly difficult to detect as perpetrators use elaborate schemes, hidden relationships, and straw owners to shield their activities. In Fiscal Year 2013-2014, the Legislature awarded the Agency $3 million in nonrecurring funds for the procurement of enhanced data analytics services in order to better identify fraud, waste, and abuse with the Florida Medicaid system. This appropriation was nonrecurring and any service procured will cease June 30, 2014.	If the issue is not funded, the advanced data analytics program procured as a result of the Fiscal Year 2013-2014 appropriation will cease on June 30, 2014. Additionally, the Agency will lose an opportunity for a 90/10 federal match. The initial funding for this project for Fiscal Year 2013-2014 was nonrecurring.

Number	List of Potential Policy Changes	Describe the Legislative Budget Requests (LBR) or Governor's Recommended Budget Item(s) Affected	Describe the Potential Impact if the LBR or the Governor's Recommended Budget Recommendation is not Approved
Division of Medicaid			
5	SMMC Program	This issue allows for the Agency's reorganization of its Medicaid related functions to respond to changes in functional responsibilities and priorities necessary for implementation and management of the SMMC program.	If this issue is not approved, the Agency will not have the necessary skill sets to support the SMMC 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. The changes 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.

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
7	Consulting Services for Continued Support of DRG Payment Methodology	This issue proposes continued consulting services for one year of DRG implementation. The Fiscal Year 2012-2013 Legislature via section 409.905 (5) (f), F.S., as amended by House Bill 5301, authorized the Agency to develop a plan to convert Medicaid inpatient hospital rates to a prospective payment system that categorizes each case into DRGs and assigns a payment weight based on the average resources used to treat Medicaid patients in that DRG. The Agency was appropriated $1 million in Fiscal Year 2013-2014 to continue the consulting services related to the DRG payment method implementation.	If this LBR issue is not approved and no funding is made available to the Agency, current staff would have to perform these functions without the detailed expertise needed and would take away from the ability to perform their current workload.

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 including 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.	section 1004.435(4), F.S.	Florida Cancer Control and Research Advisory Council	Annually/February 15
5.	http://myfloridachoices.org/ section 408.910, F.S.	Florida Health Choices Corporation	Ongoing responsibilities
6.	section 627.6699(1), F.S.	Florida Health Reinsurance Program	Ongoing responsibilities

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
7.	section 624.91, F.S.	Florida Healthy Kids Corporations Board of Directors	Ongoing responsibilities
8.	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
9.	section 395.40, F.S.	Florida Trauma System Plan Advisory Council	Ongoing responsibilities
10.	chapter 2008-211, Laws of Florida	Florida Health and Transition Services (HATS) Task Force	Ongoing responsibilities
11.	section 409.1451 (7), F.S.	Independent Living Advisory Council	Ongoing responsibilities
12.	sections 395.3025, 405.01, and 405.03, F.S.	Pregnancy-Associated Mortality Review (PAMR) Team	Ongoing responsibilities
13.	section 427.013, F.S.	Commission for the Transportation Disadvantaged	Ongoing responsibilities
14.	section 14.2019, F.S.	Florida Suicide Prevention Coordinating Council	Ongoing responsibilities

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
15.	section 624.351, F.S.	Medicaid and Public Assistance Fraud Strike Force	Annually/October 1
16.	chapter 2012-120, Laws of Florida	Statewide Task Force on Prescription Drug Abuse and Newborns	Final Report/January 15, 2015
17.	section 893.055, F.S.	Prescription Drug Monitoring Program	Ongoing responsibilities
18.	Executive Order No. 07-148	Commission on Disabilities	Ongoing responsibilities
19.	http://floridamentalhealth.org/	Florida State Mental Health Planning Council	Ongoing responsibilities
20.	Executive Order No. 08-36	Governor's Taskforce on Autism	Ongoing responsibilities
21.	section 893.0551, F.S.	Program Implementation and Oversight Taskforce on Prescription Drug Monitoring	Ongoing responsibilities
22.	Supreme Court of Florida No. AOSC13-8	Taskforce on Substance Abuse and Mental Health Issues in the Court	Ongoing responsibilities

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
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	Annually/January 1
24.	section 408.7057(2)(g)2., F.S.	Annual Report on the Cases of the Statewide Managed Care Dispute Resolution Program	Annually/February 1
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
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 402.281, F.S.	Governor's Panel on Excellence in Long-Term Care (Gold Seal Program)	Ongoing responsibilities

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
33.	section 408.7056 and section 408.7057, F.S.	Statewide Provider and Subscriber Assistance Panel	Ongoing responsibilities
34.	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
35.	section 20.055(5)(i), F.S.	Schedules engagement for the upcoming fiscal year	Annually/September 30
36.	section 20.055(7), F.S.	Summary of all activities within the Office of the Inspector General for the previous fiscal year	Annually/September 30
37.	section 429.19, F.S.	Assisted Living Facilities Annual Report on Fines	Annually/July 30
38.	section 408.05(8), F.S.	State Consumer Health Information and Policy Advisory Council	Ongoing responsibilities
39.	section 627.6699, F.S.	Florida Health Insurance Advisory Board (FHIAB)	Ongoing responsibilities
Division of Information Technology			
40.	None		

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
Division of Medicaid			
41.	section 409.913, F.S.	Annual Medicaid Fraud and Abuse Report	Ongoing responsibilities
42.	section 409.91211, F.S.	Enhanced Benefits Panel	Ongoing responsibilities
43.	section 409.818, F.S.	Florida KidCare Grievance Committee	Ongoing responsibilities
44.	section 409.91213, F.S.	Low Income Pool (LIP)	Quarterly progress reports and annual reports for 1115 waivers
45.	section 409.911, F.S.	LIP Council	Ongoing responsibilities
46.	section 409.91211, F.S.	Medicaid Reform Technical Advisory Panel	Ongoing responsibilities
47.	section 381.0602, F.S.	Organ Transplant Advisory Council	Ongoing responsibilities
48.	section 400.235, F.S.	Pharmaceutical and Therapeutics Committee	Ongoing responsibilities
49.	section 16.615, F.S.	Council on the Social Status of Black Men and Boys	Ongoing responsibilities

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
50.	section 393.002, F.S.	Florida Developmental Disabilities Council's Health Care/Prevention Task Force	Ongoing responsibilities
51.	section 409.818(2)(c), F.S.	Kid Care Coordinating Council (Membership Only)	Ongoing responsibilities
52.	section 409.8177(2), F.S.	Florida KidCare Enrollment Report on enrollment for each component of Florida KidCare Program	Ongoing responsibilities
53.	section 409.908(2)(b)5, F.S.	Nursing Care Cost Report: Annual Report on direct and indirect care costs	Ongoing responsibilities
54.	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
55.	section 409.91213, F.S.	Medicaid Reform Quarterly Report: Agency analysis and the status of various operational areas	Ongoing responsibilities
56.	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

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
57.	section 409.912 (44), F.S.	HSD annual report of audit results to ensure cost effectiveness relating to Medicaid Managed Care	Ongoing responsibilities
58.	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
59.	section 409.912(15)(e), F.S.	CARES Program Operation Annual Report: AHCA & DOEA submit annual report on operation of CARES	Ongoing responsibilities
60.	section 409.911(10, F.S.	LIP Council annually submits findings and recommendations on the financing of the LIP and the disproportionate share program and the distribution of funds	Ongoing responsibilities
61.	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 2013-2014 (Words)	Approved Prior Year Standards FY 2012-2013 (Numbers)	Prior Year Actual FY 2012-2013 (Numbers)	Approved Standards for FY 2013-2014 (Numbers)	Requested FY 2014-2015 Standard (Numbers)
Program: Administration and Support			**Code: 68200000**		
1	Administrative costs as a percent of total agency costs	0.11%	0.07%	0.11%	0.11%
2	Administrative positions as a percent of total agency positions	11.45%	10.88%	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	17.98%	20.00%	20.00%

	Approved Performance Measures for FY 2013-2014 (Words)	Approved Prior Year Standards FY 2012-2013 (Numbers)	Prior Year Actual FY 2012-2013 (Numbers)	Approved Standards for FY 2013-2014 (Numbers)	Requested FY 2014-2015 Standard (Numbers)
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	71.20%	90.00%	90.00%
5	Percent of children enrolled with up-to-date immunizations	85.00%	N/A	85.00%	DELETE[4]
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%	89.30%	95.00%	90.00%[4]
8	Total number of Title XXI-eligible children enrolled in KidCare	228,159	298,082	228,159	Per Estimates[1]
9	Number of Title XXI-eligible children enrolled in Florida Healthy Kids	195,867	240,282	195,867	Per Estimates[1]
10	Number of Title XXI-eligible children enrolled in MediKids	2,100	35,319	21,000	Per Estimates[1]
11	Number of Title XXI-eligible children enrolled in Children's Medical Services Network	111,292	22,481	10,053	Per Estimates[1]

	Approved Performance Measures for FY 2013-2014 (Words)	Approved Prior Year Standards FY 2012-2013 (Numbers)	Prior Year Actual FY 2012-2013 (Numbers)	Approved Standards for FY 2013-2014 (Numbers)	Requested FY 2014-2015 Standard (Numbers)
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%	1.09%	1.44%	1.44%
13	Average number of days between receipt of clean Medicaid claim and payment	15	8	15	15
14	Number of Medicaid claims received	145,101,035	178,968,209	145,101,035	Per Estimates[1]
Program: Health Care Services			**Code: 68500000**		
Service/Budget Entity: Medicaid Services to 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]

Approved Performance Measures for FY 2013-2014 (Words)		Approved Prior Year Standards FY 2012-2013 (Numbers)	Prior Year Actual FY 2012-2013 (Numbers)	Approved Standards for FY 2013-2014 (Numbers)	Requested FY 2014-2015 Standard (Numbers)
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	28.76%	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	22.54%	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%
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%

	Approved Performance Measures for FY 2013-2014 (Words)	Approved Prior Year Standards FY 2012-2013 (Numbers)	Prior Year Actual FY 2012-2013 (Numbers)	Approved Standards for FY 2013-2014 (Numbers)	Requested FY 2014-2015 Standard (Numbers)
19	Percent of eligible children who received all required components of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening	64.00%	48.00%	64.00%	64.00%
20	Number of children ages 1-20 enrolled in Medicaid	1,249,276	2,274,388	1,249,276	Per Estimates[1]
21	Number of children receiving EPSDT services	407,052	571,493	407,052	Per Estimates[1]
22	Number of hospital inpatient services provided to children	92,960	208,418	92,960	Per Estimates[1]
23	Number of physician services provided to children	6,457,900	11,675,133	6,457,900	Per Estimates[1]
24	Number of prescribed drugs provided to children	4,444,636	7,153,297	4,444,636	Per Estimates[1]
25	Number of hospital inpatient services provided to elders	100,808	108,100	100,808	Per Estimates[1]
26	Number of physician services provided to elders	1,436,160	1,154,083	1,436,160	Per Estimates[1]
27	Number of prescribed drugs provided to elders	15,214,293	1,273,468	15,214,293	Per Estimates[1]
28	Number of uninsured children enrolled in the Medicaid Expansion	1,227	0	1,227	DELETE[4]

	Approved Performance Measures for FY 2013-2014 (Words)	Approved Prior Year Standards FY 2012-2013 (Numbers)	Prior Year Actual FY 2012-2013 (Numbers)	Approved Standards for FY 2013-2014 (Numbers)	Requested FY 2014-2015 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	971,150	550,436	Per Estimates[1]
31	Number of case months services purchased (Nursing Home)	619,387	525,744	619,387	Per Estimates[1]
Program: Health Care Services			**Code: 68500000**		
Service/Budget Entity: Medicaid Prepaid Health Plan			**Code: 68501600**		

Approved Performance Measures for FY 2013-2014 (Words)		Approved Prior Year Standards FY 2012-2013 (Numbers)	Prior Year Actual FY 2012-2013 (Numbers)	Approved Standards for FY 2013-2014 (Numbers)	Requested FY 2014-2015 Standard (Numbers)
32	Percent of hospitalizations for conditions preventable by good ambulatory care	16.00%	See New Measures 33A and 33B Below	16.00%	DELETE[4]
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	20.26%	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	16.99%	20.00%	20.00%
34	Number of case months services purchased (elderly and disabled)	1,877,040	257,736	1,877,040	DELETE[4]
35	Number of case months services purchased (families)	9,850,224	8,478,888	9,850,224	DELETE[4]

	Approved Performance Measures for FY 2013-2014 (Words)	Approved Prior Year Standards FY 2012-2013 (Numbers)	Prior Year Actual FY 2012-2013 (Numbers)	Approved Standards for FY 2013-2014 (Numbers)	Requested FY 2014-2015 Standard (Numbers)
Program: Health Care Regulation			**Code: 68700000**		
Service/Budget Entity: Health Care Regulation			**Code: 68700700**		
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	99.80%	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]

	Approved Performance Measures for FY 2013-2014 (Words)	Approved Prior Year Standards FY 2012-2013 (Numbers)	Prior Year Actual FY 2012-2013 (Numbers)	Approved Standards for FY 2013-2014 (Numbers)	Requested FY 2014-2015 Standard (Numbers)
40	Percent of validation surveys that are consistent with findings noted during the accreditation survey	98.00%	100.00%	98.00%	DELETE[4]
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]

	Approved Performance Measures for FY 2013-2014 (Words)	Approved Prior Year Standards FY 2012-2013 (Numbers)	Prior Year Actual FY 2012-2013 (Numbers)	Approved Standards for FY 2013-2014 (Numbers)	Requested FY 2014-2015 Standard (Numbers)
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)
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	100.00%	100.00%	100.00%
49	Percent of complaints of facility patient dumping received that are investigated	100.00%	100.00%	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 Statewide Provider and Subscriber Assistance Panel cases	53	20	53	53

	Approved Performance Measures for FY 2013-2014 (Words)	Approved Prior Year Standards FY 2012-2013 (Numbers)	Prior Year Actual FY 2012-2013 (Numbers)	Approved Standards for FY 2013-2014 (Numbers)	Requested FY 2014-2015 Standard (Numbers)
53	Number of construction reviews performed (plans and construction)	4,500	4,869	4,500	4,500
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, 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 the Agency.

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

[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
☐ 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
7.70%	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 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
☐ Legal/Legislative Change
☐ Target Population Change
☒ This Program/Service Cannot Fix the Problem
☐ Current Laws Are Working Against the Agency Mission
☐ Technological Problems
☐ Natural Disaster
☐ Other (Identify)
Explanation: Not solely a Medicaid program.

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 relevant measure. New measure 3A created to reflect current, measurable data.

Office of Policy and Budget – July 2013

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
100.00%	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; 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. New measure 4A created to reflect current, measurable data.

Office of Policy and Budget – July 2013

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 #4A: Percentage of all Title XXI KidCare Enrollees Eligible for Renewal who Either Renew KidCare Coverage or Maintain Health Care Coverage from Another Source

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
90.00%	71.20%	18.80%	20.90%

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: There are no internal factors that affect this 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: Families of children in KidCare that receive Title XXI premium assistance must participate in a coverage renewal process every 12 months, which includes confirmation of the child's continued eligibility for the program. As each family's renewal anniversary approaches, the KidCare program sends parents detailed information about the renewal process and required documentation. If families do not respond or they are unable to confirm their child's continued eligibility, the child is unenrolled from KidCare health insurance coverage. Successful completion of the coverage renewal process is an important step in retaining KidCare coverage.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☐ Other (Identify)
Recommendations: None

Office of Policy and Budget – July 2013

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
85.00%	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 is collected.

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 2013

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
97.00%	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, makes it 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 is collected, and there is a 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 2013

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
95.00%	89.30%	5.70%	6.00%

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 should be 90% which reflects a performance goal in line with national averages.

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: Actual performance is very close to anticipated levels. In any situation where a level of care determination needs to be made, parents and caregivers will not always agree with what a doctor or provider recommends. It is very difficult, if not impossible, to please all people at all times. The reported near-90 percent levels demonstrate a very high level of satisfaction with the program.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: State agencies will continue to work with providers to ensure that appropriate levels of care are provided to all beneficiaries.

Office of Policy and Budget – July 2013

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	22,481	88,811	80.00%

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: There are no internal factors that affect the actual enrollment numbers.

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 targets should be based on estimating conference predictions developed the previous year from anticipated economic and population indicators. Measures such as this are not performance measures and only provide an indication of the size and scope of the various program components.

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 2013

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
11.00%	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 LRPP did not accurately address the issue along programmatic lines. Therefore, the existing measures are 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: This measure should be deleted in favor of a more relevant measure. New measures 15A and 15B have been created to reflect current, measurable data.

Office of Policy and Budget – July 2013

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
86.00%	84.40%	1.60%	1.90%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect ☐ Other (Identify)
Explanation: There are no internal factors that affect this measure.

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: Women are often not aware of their eligibility for public programs and do not enroll in Medicaid for prenatal and birth-related care until well into their pregnancy. Women also do not appear to be taking full advantage of the services available to them.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: The Agency will continue the Family Planning Waiver and will seek methods to ensure women receive appropriate information about the benefits of adequate prenatal care.

Office of Policy and Budget – July 2013

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
4.70%	4.80%	0.10%	2.10%

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: There are no internal factors that affect this 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: Very little is known about the causes for high mortality rates in the United States compared to other countries. The neonatal mortality rates are extremely variable and not always directly attributable to program policies. Poor birth outcomes can be linked to inadequate prenatal care and unhealthy behaviors, such as smoking during pregnancy. Poor birth outcomes can also be a result of hereditary and/or environmental factors which are beyond the Agency's control. The target standard should be 5.00 percent to reflect national standards for neonatal mortality; however, the reported mortality rate is indicative of meeting program goals.

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

Office of Policy and Budget – July 2013

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
35.00%	25.00%	10.00%	28.60%

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: There are no internal factors that affect this 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: 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 two year's 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 in Exhibit IV - Measure 18A) would be to look at the percentage of women who

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

have at least 24-28 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 one. The real goal is to have at least two years to 28 months between births, and this measure should be deleted/replaced with one that reflects the goal.

Office of Policy and Budget – July 2013

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 #19: Percent of Eligible Children who Received all Required Components of EPSDT Screening

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
64.00%	48.00%	16.00%	25.00%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect ☐ Other (Identify)
Explanation: There are no internal factors that affect this measure.

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: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening is largely dependent on parental compliance with standards. Medicaid physicians are required to provide educational information on the importance of EPSDT screening.

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

Recommendations: The Agency needs to continue to stress the importance of well-child care, including screening and regular check-ups. Under SMMC, the health plan will be responsible for ensuring appropriate levels of care in most cases.

Office of Policy and Budget – July 2013

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 #26: Number of Physician Services Provided to Elders

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
1,436,160	1,154,083	282,077	19.60%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect ☐ Other (Identify)
Explanation: There are no internal factors that affect this measure.

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: Utilization targets should be based on estimating conference predictions developed in the previous year from anticipated economic and population indicators. Measures such as this are not performance measures and only provide an indication of the size and scope of the various program components.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: None

Office of Policy and Budget – July 2013

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 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
15,214,293	1,273,468	13,940,825	91.60%

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: There are no internal factors that affect this 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: Utilization targets should be based on estimating conference predictions developed from anticipated economic and population indicators. Measures such as this are not performance measures and only provide an indication of the size and scope of the various program components. The standard for this measure has not been adjusted or updated since the implementation of Medicare Part D and needs to be updated to reflect actual anticipated utilization based on estimating conference predictions.

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 2013

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	100.00%

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: There are no internal factors that affect this 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: 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 2013

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
12.60%	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 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
- ☐ 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: Current measure is not reflective of the population.

M**anagement Efforts to Address Differences/Problems** (check all that apply):

- ☐ Training
- ☐ Personnel
- ☒ Technology
- ☐ 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 LRPP 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 2013

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 #31: Number of Case Months Services Purchased (Nursing Home)

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
619,387	525,744	93,643	15.10%

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: There are no internal factors that affect this 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: Utilization targets should be based on estimating conference predictions developed the previous year from anticipated economic and population indicators. Measures such as this are not performance measures and only provide an indication of the size and scope of the various program components.

M**anagement Efforts to Address Differences/Problems** (check all that apply):

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

Recommendations: None.

Office of Policy and Budget – July 2013

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
16.00%	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.

Office of Policy and Budget – July 2013

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
16.00%	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.

Office of Policy and Budget – July 2013

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	257,736	1,619,304	86.30%

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: There are no internal factors that affect this 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: Target population changed, and the provided standards are incorrect 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 2013

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	8,478,888	1,371,336	13.90%

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: There are no internal factors that affect this 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: Number of case months purchased is based upon current law and 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 2013

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
0.00%	3.10%	3.10%	3.10%

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 0.00 percent is a laudable goal, it is neither a reasonable expectation or standard nor a standard over which the Agency has 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: Although this is a legitimate measure of facility performance, it is not a reasonable measure of Agency performance.

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

Office of Policy and Budget – July 2013

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
4.00%	0.00%	4.00%	100.00%

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

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

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

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

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

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

Office of Policy and Budget – July 2013

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
100.00%	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 individual surveyor was sent a Priority 1 (P1) complaint via email, and it was placed on the surveyor's calendar. The surveyor was not made aware of the complaint assignment in a timely manner; therefore, it was conducted on the third business day, one day outside of 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 of it.

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 are no external factors that affect this measure.

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 2013

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
100.00%	99.80%	0.20%	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 Priority 1 (P1) complaint via email, and it was placed on the surveyor's calendar. The surveyor was not made aware of the complaint assignment in a timely manner; therefore, it was conducted on the third 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 of it.

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 are no external factors that affect this measure.

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 2013

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
25.00%	23.80%	1.20%	4.80%

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: 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 that this measure be deleted.

Office of Policy and Budget – July 2013

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
98.00%	100.00%	2.00%	2.00%

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 health care 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 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 and 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 that this measure be deleted.

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #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
0.00%	1.30%	1.30%	1.30%

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 0.00 percent is a laudable goal, it is neither a reasonable expectation or standard nor a standard over which the Agency has 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: The Agency has no control over whether there will be serious deficiencies in health care facilities. We can only site and require correction of these deficiencies.

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

Office of Policy and Budget – July 2013

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 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
0.00%	0.04%	0.04%	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: Although 0.00 percent is a laudable goal, it is neither a reasonable expectation or standard nor a standard over which the Agency has 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: The Agency has no control over whether there will be serious deficiencies. We can only site and require correction of these deficiencies.

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

Office of Policy and Budget – July 2013

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 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
0.00%	0.03%	0.03%	0.03%

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 0.00 percent is a laudable goal, it is neither a reasonable expectation or standard nor a standard over which the Agency has 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: The Agency has no control over whether there will be serious deficiencies. We can only site and require correction of these deficiencies.

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

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #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
0.00%	0.00%	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: Although 0.00 percent is a laudable goal, it is neither a reasonable expectation or standard nor a standard over which the Agency has 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: The Agency has no control over whether there will be serious deficiencies. We can only site and require correction of these deficiencies.

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

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #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
0.00%	2.00%	2.00%	2.00%

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 0.00 percent is a laudable goal, it is neither a reasonable expectation or standard nor a standard over which the Agency has 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: The Agency has no control over whether there will be serious deficiencies. We can only site and require correction of these deficiencies.

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

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #46: Percent of Hospitals that Fail to Report Serious Incidents (Agency Identified)

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
6.00%	1.70%	4.30%	71.70%

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: There are no internal factors that affect this 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: The Agency's ability to meet this standard is entirely dependent upon external factors that it 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
☐ Personnel
☐ Technology
☒ 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) related to the reporting of "serious incidents". The Agency is requesting that this measure be deleted.

Office of Policy and Budget – July 2013

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #47: Percent of New Medicaid Recipients Voluntarily Selecting Managed Care Plan

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
50.00%	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 information is no longer collected.

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: Information is no longer collected.

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

Office of Policy and Budget – July 2013

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
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
100.00%	100.00%	0.00%	0.00%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect ☐ Other (Identify)
Explanation: There are no internal factors that affect this measure.

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 that this measure be deleted.

Office of Policy and Budget – July 2013

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #50: Number of Inquiries to the Call Center Regarding Practitioner Licensure and Disciplinary Information

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
30,000	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: There are no internal factors that affect this measure.

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 discontinued handling practitioner-related calls effective July 1, 2009 because 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 Agency 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 ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: The Agency is requesting that this measure be deleted.

Office of Policy and Budget – July 2013

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	12.80%

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: The Agency has no control over the number of facilities that either desire licensure or no longer wish to be licensed and discontinue operations. The total number of surveys conducted each year will fluctuate with the total number of licensed facilities. This 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 that this measure be deleted because it measures workload not performance.

Office of Policy and Budget – July 2013

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #54: Number of New Enrollees Provided with Choice Counseling

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
520,000	372,458	147,542	28.40%

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

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: 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 ☐ Technology
☐ Personnel ☒ 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 2013

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/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 is then matched against Medicaid eligibility files to determine eligibility groups. 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 LRPP based on prior calendar year encounters/claims (e.g., Calendar Year 2011 for the LRPP published in 2012).

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

Validity:
This 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 the Agency and must certify that it is accurate. The ICD-9 codes are used for billing and hospital report cards. Therefore, hospitals have incentives to be accurate in their use of the codes. Similarly, the eligibility information provided by DCF through MCM is reliable for identification of eligibility group. Eligibility information is used to approve and pay for benefits and must be accurate.

Office of Policy and Budget – July, 2013

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/68500100
Measure #4A: Percentage of all Title XXI KidCare Enrollees Eligible for Renewal Who Either Renew KidCare Coverage or Maintain Health Care Coverage from Another Source

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 100.00 percent to 90.00 percent and modifying the data source.

Data Sources and Methodology:
Data is provided to the Florida Institute for Child Health Policy (ICHP) by the FHK 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 measure only for the LRPP.

Proposed Standard/Target:
90.00 percent

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

Measure #4A: Percentage of all Title XXI KidCare Enrollees Eligible for Renewal Who Either Renew KidCare Coverage or Maintain Health Care Coverage from Another Source – Page 2

Reliability:
Data is provided by FHK from their program administrative files. FHK is responsible for the reliability and validity of their data, and the data provided to ICHP is 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 continuous eligibility can be determined. The caregiver is given approximately two months to complete the process.

While this measure should be as close to 100.00 percent 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 100.00 percent is ideal, it is not a realistic goal.

Office of Policy and Budget – July 2013

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 #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 seven out of ten on the annual satisfaction surveys". This will bring the measure in line with national standards.

Data Sources and Methodology:
To assess KidCare program satisfaction, the 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 CAHPS is used to address aspects of care in the six months preceding the interview and 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 seven or higher on a ten-point scale. This is a nationally recognized measure and standard developed and reported by the AHRQ, a federal HHS department responsible for state and national health policy research.

Proposed Standard/Target:
90.00 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 Title XXI-Eligible Children Enrolled in Children's Medical Services Network

Action (check one):

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

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.

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #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 is then matched against Medicaid eligibility files to determine eligibility groups. Ambulatory sensitive conditions are identified by ICD-9 diagnosis codes, using the algorithm and methodology outlined by the federal HHS, 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 LRPP based on prior calendar year encounters/claims (e.g., Calendar Year 2011 for the LRPP published in 2012).

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

a. Sixth Omnibus Budget Reconciliation Act (SOBRA) for 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 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 CMSN;
g. Women eligible for Medicaid due to breast and/or cervical cancer; and
h. Individuals eligible under a hospice-related eligibility group.

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

Validity:
This 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 the Agency and must certify that it is accurate. The ICD-9 codes are used for billing and hospital report cards. Therefore, hospitals have incentives to be accurate in their use of the codes. Similarly, the eligibility information provided by DCF through MCM is reliable for identification of eligibility group. Eligibility information is used to approve and pay for benefits and 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 Services 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 is then matched against Medicaid eligibility files to determine eligibility groups. Ambulatory sensitive conditions are identified by ICD-9 diagnosis codes, using the algorithm and methodology outlined by the federal HHS, 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 LRPP based on prior calendar year encounters/claims (e.g., Calendar Year 2011 for the LRPP published in 2012).

Enrollees/beneficiaries are divided into ages one 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) for 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 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 CMSN;

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

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

Validity:
This 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 the Agency and must certify that it is accurate. The ICD-9 codes are used for billing and hospital report cards. Therefore, hospitals have incentives to be accurate in their use of the codes. Similarly, the eligibility information provided by DCF through MCM is reliable for identification of eligibility group. Eligibility information is used to approve and pay for benefits and must be accurate.

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #18A: Percentage of Women with an Inter-Pregnancy Interval (IPI) 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 FMMIS that has been merged with a data set maintained by the UF, 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. UF 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 identified women 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:
50.00 percent

Validity:
This is a valid measure for the effectiveness of family planning services. Lengths between pregnancies of at least 24 months are encouraged by the Healthy Start and 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 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 Health Care 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 is then matched against Medicaid eligibility files to determine eligibility groups. Ambulatory sensitive conditions are identified by ICD-9 diagnosis codes, using the algorithm and methodology outlined by the federal HHS, 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 LRPP based on prior calendar year encounters/claims (e.g., Calendar Year 2011 for the LRPP published in 2012).

The target group for this measure is Medicaid beneficiaries eligible for full benefits who reside in nursing 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. The institution is responsible for coordinating care and ensuring appropriate care for its residents. 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, the Agency regulates nursing facilities and is responsible 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. The waiver programs are designed to guarantee comparable levels of care.

Proposed Standard/Target:
20.00 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:
This 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 the Agency and must certify that it is accurate. The ICD-9 codes are used for billing and hospital report cards. Therefore, hospitals have incentives to be accurate in their use of the codes. Similarly, the eligibility information provided by DCF through MCM is reliable for identification of eligibility group. Eligibility information is used to approve and pay for benefits and must be accurate.

Office of Policy and Budget – July, 2013

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #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 is then matched against Medicaid eligibility files to determine eligibility groups. Ambulatory sensitive conditions are identified by ICD-9 diagnosis codes, using the algorithm and methodology outlined by the federal HHS, 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 LRPP based on prior calendar year encounters/claims (e.g., Calendar Year 2011 for the LRPP published in 2012).

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

a. Sixth Omnibus Budget Reconciliation Act (SOBRA) for 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 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 CMSN;
g. Women eligible for Medicaid due to breast and/or cervical cancer; and
h. Individuals eligible under a hospice-related eligibility group.

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

Validity:
This 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 the Agency and must certify that it is accurate. The ICD-9 codes are used for billing and hospital report cards. Therefore, hospitals have incentives to be accurate in their use of the codes. Similarly, the eligibility information provided by DCF through MCM is reliable for identification of eligibility group. Eligibility information is used to approve and pay for benefits and must be accurate.

Office of Policy and Budget – July, 2013

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #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 is then matched against Medicaid eligibility files to determine eligibility groups. Ambulatory sensitive conditions are identified by ICD-9 diagnosis codes, using the algorithm and methodology outlined by the federal HHS, 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 LRPP based on prior calendar year encounters/claims (e.g., Calendar Year 2011 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 one to 20 and over 21 age groups because the Medicaid benefit package varies for adults and children. Children under one year of age have almost no hospitalizations that fit these criteria. Further, many do not have established Medicaid identifications at the time of hospitalization and cannot be matched to Medicaid eligibility files. These measures, therefore, concentrate on the children ages one to 20 where appropriate. The following groups would be excluded from this measure:

a. Sixth Omnibus Budget Reconciliation Act (SOBRA) for 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 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 CMSN;
g. Women eligible for Medicaid due to breast and/or cervical cancer; and
h. Individuals eligible under a hospice-related eligibility group.

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

Validity:
This 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 the Agency and must certify that it is accurate. The ICD-9 codes are used for billing and hospital report cards. Therefore, hospitals have incentives to be accurate in their use of the codes. Similarly, the eligibility information provided by DCF through MCM is reliable for identification of eligibility group. Eligibility information is used to approve and pay for benefits and must be accurate.

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 #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, which have not been investigated, and whether or not a complaint was confirmed or not confirmed. The percent of P1 consumer complaints that are investigated within two business days comes from a series of computations. First, the length of time the P1 is received to when it is investigated is computed. The length of time is calculated by subtracting the received date from the survey start date. Second, from the listing of complaints, the number of complaints that have a length of time that is two or fewer business days is determined. 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 P1 consumer 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 in order to be investigated. Complaints received by the Call Center are entered into FRAES/VR by the appropriate staff. Written complaints are tracked through CorrFlow, the Agency's correspondence tracking system. They are entered into the FRAES/VR database by facility unit staff. Then, the complaints are sent to the survey staff for investigation and input into the CMS/ACO database.

Reliability:
The measure is as reliable as the input of data into the FRAES/VR and CMS/ACO databases. If a complaint is missed for inputting, it will also be missed for tracking purposes. All reports for this data is 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, which have not been investigated, and whether or not a complaint was confirmed or not confirmed. The percent of P1 consumer complaints that are investigated within two business days comes from a series of computations. First, the length of time the P1 is received to when it is investigated is computed. The length of time is calculated by subtracting the received date from the survey start date. Second, from the listing of complaints, the number of complaints that have a length of time that is two or fewer business days is determined. 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 P1 consumer 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 in order to be investigated. Complaints received by the Call Center are entered into FRAES/VR by the appropriate staff. Written complaints are tracked through CorrFlow, the Agency's correspondence tracking system. They are entered into the FRAES/VR database by facility unit staff. Then, the complaints are sent to the survey staff for investigation and input into the CMS/ACO database.

Reliability:
The measure is as reliable as the input of data into the FRAES/VR and CMS/ACO databases. If a complaint is missed for inputting, it will also be missed for tracking purposes. All reports for this data is 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 #48A: Percent of Complaints of HMO Access to Care Received that are Investigated

Action (check one):

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

Data Sources and Methodology:
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 Complaints/Issues Reporting and Tracking System (CIRTS) database.

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 database.

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

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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 #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, and 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 Program and Service/Budget Entity only.

Office of Policy and Budget – July 2013

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 2013-2014 (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 2013-2014 (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 2013-2014 (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 2013-2014 (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 Direction and 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 2013-2014 (Words)		Associated Activities Title
14	Number of Medicaid claims received	Fiscal Agent Contract ACT5260
Medicaid Services to 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 2013-2014 (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 2013-2014 (Words)	Associated Activities Title
19	Percent of eligible children who received all required components of EPSDT screening	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 2013-2014 (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 ACT4220 School Based Services ACT4320
25	Number of hospital inpatient services provided to elders	Hospital Inpatient -Elderly and Disabled/Fee for Service ACT4010 Prescribed Medicines- Elderly and Disabled/ Fee for Service ACT4020 Physician Services-Elderly and Disabled/ Fee for Service ACT4030 Hospital Insurance Benefit-Elderly and Disabled / Fee for Service ACT4140
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 2013-2014 (Words)	Associated Activities Title
27	Number of prescribed drugs provided to elders	Prescribed Medicines- Elderly and Disabled/fee for service ACT4020
28	Number of uninsured children enrolled in the Medicaid Expansion	Purchase MediKids Program Services ACT5110 Purchase Children's Medical Services Network Services ACT5120 Purchase Children's Medical Services Network Services ACT5130
Medicaid Long-Term Care		**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 2013-2014 (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
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

Approved Performance Measures for FY 2013-2014 (Words)		Associated Activities Title
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**
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

Approved Performance Measures for FY 2013-2014 (Words)		Associated Activities Title
37	Percent of investigations of alleged unlicensed facilities and programs that have been previously issued a cease and desist order that are confirmed as repeated unlicensed activity	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
38	Percent of Priority I consumer complaints about licensed facilities and programs that are investigated within 48 hours	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
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 cited for not complying with life safety, licensure or emergency access standards	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020

Approved Performance Measures for FY 2013-2014 (Words)		Associated Activities Title
40	Percent of validation surveys that are consistent with findings noted during the accreditation survey	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
41	Percent of assisted living facilities with deficiencies that pose a serious threat to the health, safety or welfare of the public	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
42	Percent of home health facilities with deficiencies that pose a serious threat to the health, safety or welfare of the public	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
43	Percent of clinical laboratories with deficiencies that pose a serious threat for not complying with life safety, licensure or emergency access standards	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020

	Approved Performance Measures for FY 2013-2014 (Words)	Associated Activities Title
44	Percent of ambulatory surgical centers with deficiencies that pose a serious threat to the health, safety or welfare of the public	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
45	Percent of hospitals with deficiencies that pose a serious threat to the health, safety or welfare of the public	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
46	Percent of hospitals that fail to report serious incidents (agency identified)	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
47	Percent of new Medicaid recipients voluntarily selecting managed care plan	Health Facilities and Practitioner Regulation - Medicaid Choice Counseling ACT7150
48	Percent of complaints of HMO patient dumping received that are investigated	Managed Health Care ACT7090

Approved Performance Measures for FY 2013-2014 (Words)		Associated Activities Title
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 the Agency. Was transferred to DOH in 2009 with renewal of call center contract.
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

Approved Performance Measures for FY 2013-2014 (Words)		Associated Activities Title
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 with 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 2012-13			
SECTION I: BUDGET	OPERATING			FIXED CAPITAL
TOTAL ALL FUNDS GENERAL APPROPRIATIONS ACT			22,287,814,862	0
ADJUSTMENTS TO GENERAL APPROPRIATIONS ACT (Supplementals, Vetoes, Budget			-51,087,459	0
FINAL BUDGET FOR AGENCY			22,236,727,403	0
SECTION II: ACTIVITIES * MEASURES	Number of Units	(1) Unit Cost	(2) Expenditures (Allocated)	(3) FCO
Executive Direction, Administrative Support and Information Technology (2)				0
Prepaid Health Plans - Elderly And Disabled *	2,169,936	919.33	1,994,881,643	
Prepaid Health Plans - Families*	13,660,920	125.46	1,713,835,894	
Elderly And Disabled/ Fee For Service/ Medipass - Hospital Inpatient * Number of case months Medicaid program services	498,052	3,620.23	1,803,064,537	
Elderly And Disabled/ Fee For Service/ Medipass - Prescribed Medicines* Number of case months Medicaid program services	498,052	2,035.65	1,013,861,310	
Elderly And Disabled/ Fee For Service/ Medipass - Physician Services* Number of case months Medicaid program services	498,052	1,123.51	559,565,929	
Elderly And Disabled/ Fee For Service/ Medipass - Hospital Outpatient * Number of case months Medicaid program services	498,052	852.66	424,666,933	
Elderly And Disabled/ Fee For Service/ Medipass - Supplemental Medical Insurance * Number of case months Medicaid program	365,598	2,817.51	1,030,076,599	
Elderly And Disabled/ Fee For Service/ Medipass - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	90,901	243.01	22,089,528	
Elderly And Disabled/ Fee For Service/ Medipass - Patient Transportation* Number of case months Medicaid program services	498,052	132.69	66,084,261	
Elderly And Disabled/ Fee For Service/ Medipass - Case Management * Number of case months Medicaid program services	498,052	184.27	91,776,119	
Elderly And Disabled/ Fee For Service/ Medipass - Home Health Services* Number of case months Medicaid program services	498,052	136.05	67,759,812	
Elderly And Disabled/ Fee For Service/ Medipass - Therapeutic Services For Children* Number of case months Medicaid program	90,901	295.74	26,882,916	
Elderly And Disabled/ Fee For Service/ Medipass - Hospital Insurance Benefit * Number of case months Medicaid program	287,092	415.32	119,235,121	
Elderly And Disabled/ Fee For Service/ Medipass - Hospice* Number of case months Medicaid program services purchased	498,052	369.66	184,112,028	
Elderly And Disabled/ Fee For Service/ Medipass - Private Duty Nursing* Number of case months Medicaid program services	90,901	1,877.62	170,677,503	
Elderly And Disabled/ Fee For Service/ Medipass - Other * Number of case months Medicaid program services purchased	498,052	1,356.62	675,665,489	
Women And Children/ Fee For Service/ Medipass - Hospital Inpatient * Number of case months Medicaid program services	1,055,374	1,361.89	1,437,302,923	
Women And Children/ Fee For Service/ Medipass - Prescribed Medicines* Number of case months Medicaid program services	1,055,374	312.15	329,429,771	
Women And Children/ Fee For Service / Medipass - Physician Services* Number of case months Medicaid program services	1,055,374	673.83	711,144,588	
Women And Children/ Fee For Service / Medipass - Hospital Outpatient * Number of case months Medicaid program services	1,055,374	546.52	576,778,011	
Women And Children/ Fee For Service / Medipass - Supplemental Medical Insurance* Number of case months Medicaid program	1,152	163,396.70	188,232,996	
Women And Children/ Fee For Service / Medipass - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	821,562	322.26	264,757,535	
Women And Children/ Fee For Service / Medipass - Patient Transportation* Number of case months Medicaid program	1,055,374	70.80	74,723,129	
Women And Children/ Fee For Service / Medipass - Case Management * Number of case months Medicaid program services	1,055,374	10.58	11,170,017	
Women And Children/ Fee For Service / Medipass - Home Health Services* Number of case months Medicaid program services	1,055,374	111.52	117,697,776	
Women And Children/ Fee For Service / Medipass - Therapeutic Services For Children * Number of case months Medicaid	821,562	97.79	80,337,651	
Women And Children/ Fee For Service / Medipass - Clinic Services* Number of case months and Medicaid program services	1,055,374	109.23	115,275,919	
Women And Children/ Fee For Service / Medipass - Other * Number of case months Medicaid program services purchased	1,055,374	442.76	467,277,912	
Medically Needy - Hospital Inpatient * Number of case months Medicaid program services purchased	44,827	5,263.24	235,935,228	
Medically Needy - Prescribed Medicines* Number of case months Medicaid program services purchased	44,827	3,215.36	144,134,811	
Medically Needy - Physician Services* Number of case months Medicaid program services purchased	44,827	1,633.97	73,246,029	
Medically Needy - Hospital Outpatient * Number of case months Medicaid program services purchased	44,827	1,806.46	80,978,034	
Medically Needy - Supplemental Medical Insurance * Number of case months Medicaid program services purchased	5,691	1,119.02	6,368,325	
Medically Needy - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services	7,109	162.05	1,151,996	
Medically Needy - Patient Transportation* Number of case months Medicaid program services purchased	44,827	53.30	2,389,086	
Medically Needy - Case Management * Number of case months Medicaid program services purchased	44,827	36.63	1,642,034	
Medically Needy - Home Health Services* Number of case months Medicaid program services purchased	44,827	39.90	1,788,568	
Medically Needy - Therapeutic Services For Children* Number of case months Medicaid program services purchased	7,109	7.54	53,637	
Medically Needy - Other * Number of case months Medicaid program services purchased	44,827	23,075.55	1,034,407,850	
Refugees - Hospital Inpatient * Number of case months Medicaid program services purchased	6,260	643.46	4,028,044	
Refugees - Prescribed Medicines* Number of case months Medicaid program services purchased	6,260	79,040.91	494,796,106	
Refugees - Physician Services* Number of case months Medicaid program services purchased	6,260	450.12	2,817,728	
Refugees - Hospital Outpatient * Number of case months Medicaid program services purchased	6,260	323.76	2,026,751	
Refugees - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services	911	322.72	293,997	
Refugees - Patient Transportation* Number of case months Medicaid program services purchased	6,260	4.82	30,155	
Refugees - Case Management * Number of case months Medicaid program services purchased	6,260	8.18	51,197	
Refugees - Home Health Services* Number of case months Medicaid program services purchased	6,260	21.07	131,917	
Refugees - Therapeutic Services For Children* Number of case months Medicaid program services purchased	911	0.98	896	
Refugees - Other * Number of case months Medicaid program services purchased	6,260	332.25	2,079,872	
Nursing Home Care * Number of case months Medicaid program services purchased	80,029	34,615.52	2,770,245,645	
Home And Community Based Services* Number of case months Medicaid program services purchased	89,882	12,747.53	1,145,773,047	
Intermediate Care Facilities For The Developmentally Disabled - Sunland Centers* Number of case months Medicaid program	692	513,301.60	355,204,709	
Mental Health Disproportionate Share Program * Number of case months Medicaid program services purchased	720	100,064.87	72,046,704	
Capitated Nursing Home Diversion Waiver * Number of case months Medicaid program services purchased	19,327	18,576.92	359,036,110	
Purchase Medikids Program Services* Number of case months Medicaid Program services purchased	38,148	1,644.51	62,734,601	
Purchase Children's Medical Services Network Services* Number of case	22,000	6,754.92	148,608,246	
Purchase Florida Healthy Kids Corporation Services* Number of case months	206,299	1,585.92	327,172,807	
Certificate Of Need/ Financial Analysis* Number of certificate of need (CON) requests/ financial reviews conducted	2,651	657.43	1,742,841	
Health Facility Regulation (compliance, Licensure, Complaints) - Tallahassee * Number of licensure/ certification	21,317	675.56	14,400,989	
Facility Field Operations (compliance, Complaints) - Field Offices Survey Staff * Number of surveys and complaint	62,145	753.10	46,801,462	
Health Standards And Quality * Number of transactions	2,954,515	1.14	3,377,169	
Plans And Construction * Number of reviews performed	4,507	1,302.90	5,872,179	
Managed Health Care * Number of Health Maintenance Organization (HMO) and workers' compensation	59	52,898.41	3,121,006	
Background Screening * Number of requests for screenings	197,320	4.36	860,806	
Subscriber Assistance Panel * Number of cases	199	4,229.49	841,669	
TOTAL			21,744,556,101	
SECTION III: RECONCILIATION TO BUDGET				
PASS THROUGHS				
TRANSFER - STATE AGENCIES				
AID TO LOCAL GOVERNMENTS				
PAYMENT OF PENSIONS, BENEFITS AND CLAIMS				
OTHER			459,126,553	
REVERSIONS			33,044,806	
TOTAL BUDGET FOR AGENCY (Total Activities + Pass Throughs + Reversions) - Should equal Section I above. (4)			22,236,727,460	

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
(3) Information for FCO depict samounts 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

- **1115 Demonstration Waivers** - Section 1115 of the Social Security Act provides the Secretary of HHS 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 that has not been performed on a widespread basis.

- **AHCA** - The Agency for Health Care Administration is the designated state agency responsible for administering the Medicaid program, licensing and regulating health facilities, and providing information to Floridians about the quality of health care they receive.

- **AHRQ** - The Agency for Healthcare Research and Quality's mission is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. As one of 12 agencies within the Department of Health and Human Services, AHRQ supports research that helps people make more informed decisions and improves the quality of health care services.

- **ALF -** Assisted Living Facilities are housing facilities for people with disabilities. These facilities provide supervision or assistance with activities of daily living, coordinate services by outside health care providers, and monitor resident activities to help ensure their health, safety, and well-being.

- **APD** - The Agency for Persons with Disabilities is the designated state agency specifically tasked with serving the needs of Floridians with developmental disabilities.

- **APG** - Agency Project Governance is an initiative to streamline and eliminate redundancy and inefficiency across all of the Agency's regulatory and operational practices and procedures.

- **ARRA** - The American Recovery and Reinvestment Act was an economic stimulus package enacted in February 2009 in response to the Great Recession. The primary objective was to save and create jobs almost immediately.

- **CAHPS** - The Consumer Assessment of Healthcare Providers and Systems program is a multi-year initiative of the AHRQ to support and promote the assessment of consumers' experiences with health care. Initially launched in October 1995, the program has expanded beyond its original focus on health plans to address a range of health care services and to meet the information needs of health care consumers, purchasers, health plans, providers, and policymakers.

- **CHIP** - The Children's Health Insurance Program provides health coverage to nearly eight million children in families with incomes too high to qualify for Medicaid but cannot afford private coverage. Signed into law in 1997, CHIP provides federal matching funds to states to provide this coverage.

- **CIO** - Chief Information Officer is the job title given to the most senior executive in the Agency/enterprise and is responsible for the information technology and computer systems that support Agency/enterprise goals.

- **CIRTS** - The Complaints/Issues Reporting and Tracking System allows real-time, secure access through the Agency's web-based portal for Headquarters and Medicaid Local Area Office staff.

- **CMS** - Centers for Medicare and Medicaid Services is a federal agency within the U.S. Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, CHIP, and health insurance portability standards. http://www.cms.gov

- **DCF** - The Department of Children and Families is the designated state agency whose mission is to protect the vulnerable, promote strong and economically self-sufficient families, and advance personal and family recovery and resiliency.

- **DOEA** - The Department of Elder Affairs is the designated state agency responsible for promoting the well-being of Florida's elders while enabling them to remain in their homes and communities.

- **DOH** - The Department of Health is the designated state agency responsible for protecting, promoting, and improving the health of all Floridians through integrated state, county, and community efforts.

- **DRG** - Diagnosis Related Group is a patient classification system developed to identify products that a patient receives.

- **DSH** - 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.

- **DSM** - Direct Secure Messaging is a service that encrypts electronic messages and allows for the secure transmission of emails and attachments.

- **EHR** - An Electronic Health Record is a systematic collection of electronic health information about individual patients or populations recorded in a digital format that can be shared across different health care settings.

- **EPO** - An Exclusive Provider Organization is 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.

- **EPSDT** - Early and Periodic Screening, Diagnosis, and Treatment is a comprehensive, preventative child health screening for recipients from birth through age 20.

- **FFP** - Federal Financial Participation is an administrative match rate agreed upon between CMS and the state which covers claims processing, eligibility assistance and determinations, outreach, program development, and program monitoring and reporting.

- **FFS** - Fee-for-Service is a payment model where services are unbundled and paid for separately. In health care, it gives an incentive for physicians to provide more treatments because payment is dependent upon the quantity of care rather than the quality of care.

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

- **FTC** - The Federal Trade Commission is an independent agency of the U.S. government whose principal mission is the promotion of consumer protection and the elimination of non-competitive business practices.

- **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

- **HHS** - The Department of Health and Human Services is the U.S. government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

- **HIPAA** - The Health Insurance Portability and Accountability Act gives the right to privacy to individuals from age 12 through 18. Providers must have a signed disclosure from the affected before giving out any information on provided health care to anyone, including parents.

- **HISP** - Health Information Service Providers serve as gateways connecting individual EHRs.

- **HMO** - Health Maintenance Organizations are organizations that provide or arrange managed care for health insurance, self-funded health care benefit plans, individuals, and other entities and act as a liaison with health care providers on a prepaid basis.

- **HQA** - Health Quality Assurance is a division within the Agency responsible for protecting Floridians through oversight of health care providers.

- **HSD** - Health Systems Development is a bureau within the Division of Medicaid and is responsible for: developing and overseeing Medicaid's managed care programs; monitoring the Disease Management Initiative for the MediPass population; managing the 1915(b) Managed Care Waiver and 1115 Medicaid Reform Waiver; and preparing federal Medicaid managed care waiver requests.

- **iBudget Florida** - Individual Budget Florida is an enhanced entitlement allocation process implemented by the APD 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.

- **ITN** - An Invitation to Negotiate is a competitive solicitation for goods or services in which factors other than price are to be considered in the award determination. These factors may include such items as vendor experience, project plan, and design features of the product(s) offered.

- **LIP** - Low Income Pool is the federally authorized program, which was approved on October 19, 2005 as a part of Florida's Medicaid 1115 Waiver, and is a primary funding source for Medicaid participating hospitals and various non-hospital provider entities. http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/index.shtml

- **LTC** - Long-Term Care is a program comprised of two types of health plans, HMOs and PSNs.

- **MCM** - Medicaid Contract Management is a bureau within the Division of Medicaid that 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.

- **Medicaid** - Medicaid is a program funded by the U.S. federal and state governments that pay medical expenses for people who are unable to cover 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 is the name given to the statewide effort to collect, process, accept, validate, and store encounter data in a centralized location. This allows for a comprehensive view of all Florida Medicaid program services utilized.

- **MFCU** - The Medicaid Fraud Control Unit is within the Attorney General's Office and works in collaboration with the Agency to prevent, reduce, and mitigate health care fraud, waste, and abuse.

- **MITA** - Medicaid Information Technology Architecture, known as MITA 3.0, is an initiative which requires state Medicaid agencies to conduct a self-assessment of the Medicaid program to help evaluate how to better control costs and assist in measuring outcomes for care.

- **MMA** - Managed Medical Assistance is a program which will provide acute care services to Medicaid recipients.

- **MPI** - Medicaid Program Integrity is a bureau within the Agency's Office of the Inspector General that audits and investigates providers suspected of overbilling or defrauding Florida's Medicaid program, recovers overpayments, issues administrative sanctions, and refers cases of suspected fraud for criminal investigation.

- **OIG** - The Office of the Inspector General provides a central point for coordination of and responsibility for activities that promote accountability, integrity, and efficiency within the Agency.

- **OIR** - The Office of Insurance Regulation, within the Department of Financial Services, serves Floridians through its responsibilities for regulation, compliance, and enforcement of statutes related to the business of insurance. OIR also monitors statewide industry markets.

- **PHC** - Prepaid Health Clinics are plans that provide health care services to groups and individual subscribers who have made regular premium payments to the plan. These plans emphasize effective cost and quality controls.

- **PIP** - Personal Injury Protection is an extension of car insurance available in some U.S. states that covers medical expenses, and in some cases, lost wages and other damages.

- **PLU** - Patient Look-Up is a health information exchange service used within the Florida Health Information Exchange (Florida HIE).

- **PMPM** - Per Member Per Month is used when evaluating costs. Since Medicaid eligibility is not a constant and people can enroll and unenroll several times in a year, PMPM provides a stable and consistent basis for comparison.

- **PNV** - Provider Network Verification is a module used in the Choice Counseling software that will enable contracted Medicaid managed care plans to submit weekly files of their provider networks for verification of network adequacy.

- **PSN** - A Provider Service Network is a network established or organized and operated by a health care provider or group of affiliated health care providers, including minority physician networks and emergency room diversion programs that meet the requirements of section 409.912(4)(d), F.S.

- **RapBack** - RapBack is 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 the Agency in the creation of the Care Provider Background Screening Clearinghouse to screen employees' criminal history in real-time through electronic fingerprint technology and provide immediate notification to the Agency of an individual's record of arrest and prosecution.

- **ROI** - Return on Investment is the concept of an investment of some resource yielding a benefit to the investor.

- **SMMC** - In 2011, the Florida Legislature created Part IV of chapter 409, F.S., directing the Agency to create the Statewide Medicaid Managed Care program. The SMMC program has two key components: the MMA program and the LTC program. The SMMC will provide greater predictability in costs while ensuring Medicaid recipients continue to have access to quality health care services. The LTC component of SMMC was launched in 2013, and the MMA component of SMMC is scheduled to begin in 2014.

- **VPN** - Virtual Private Networks extend a private network across a public network, such as the Internet, and enable a computer to send and receive data across shared or public networks as if it were directly connected to the private network thereby benefiting from the functionality, security, and management policies of the private network.