RICK SCOTT
GOVERNOR

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SECRETARY

LONG RANGE PROGRAM PLAN

Agency for Health Care Administration
Tallahassee, Florida 32308

September 30, 2014

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1701 Capitol
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House Appropriations Committee
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Senate Budget Committee
201 Capitol
Tallahassee, FL 32399-1300

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 2015-16 through Fiscal Year 2019-2020. The internet website address that provides the link to the LRPP located on Florida Fiscal Portal is http://ahca.myflorida.com/. This submission has been approved by Elizabeth Dudek, Secretary for the Agency for Health Care Administration.

Respectfully Submitted,

Tonya Kidd

Tonya Kidd
Deputy Secretary for Operations

AGENCY FOR HEALTH CARE ADMINISTRATION

LONG RANGE PROGRAM PLAN

FISCAL YEAR 2015 - 2016 THROUGH FISCAL YEAR 2019 - 2020

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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 40 percent of all facility license renewal applications electronically via the Internet by Fiscal Year 2019-2020.

Objective 1.B: To reduce by 50 percent the number of Division of Health Quality Assurance (HQA) public record requests manually processed by Fiscal Year 2019-2020.

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 2019-2020.

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

Executive Direction and Support Services (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 2019-2020.

Objective 2.B: To increase the amount of overpayments prevented as a result of prevention activities conducted by the Bureau of Medicaid Program Integrity (MPI) at a rate of five percent through Fiscal Year 2019-2020.

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

Health Care Services (Division of Medicaid)

Objective 3.A: To transition between two percent (in Fiscal Year 2014-2015 and Fiscal Year 2015-2016) and three percent (Fiscal Year 2016-17 and beyond) per year of statewide long-term care recipients receiving care in nursing facilities to community based care until no more than 35 percent of all Medicaid long-term care recipients receive care in nursing facilities.

Objective 3.B: To improve the percentage of Adult and Child Core Sets within Healthcare Effectiveness Data and Information Set (HEDIS) measures for Managed Medical Assistance (MMA) plans (weighted average for all plans by measure) that meet or exceed the National Medicaid 75th percentile to 75 percent by Fiscal Year 2019-2020. That is, if the MMA plans report on 20 HEDIS measures that are in the Adult and Child Core Sets, the Agency's goal is for the MMA plans to meet or exceed the National Medicaid 75th percentile rate for 15 of the 20 measures (75 percent) by Fiscal Year 2019-2020.

Objective 3.C: To transition and maintain 85 percent or more of Medicaid recipients (in terms of total member months per year) into the Statewide Medicaid Managed Care (SMMC) Program.

Objective 3.D: To limit the annual growth in per member per month (PMPM) costs for recipients enrolled in SMMC to less than or equal to 5 percent as measured by 1115 Waiver Budget Neutrality.

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 renewal license applications received electronically via the Online Licensing Application.

Performance Projection Table 1.A:

Baseline Year FY 2013-2014	FY 2015-2016	FY 2016-2017	FY 2017-2018	FY 2018-2019	FY 2019-2020
8,717	2,615	3,147	3,199	3,269	3,487
Percent of renewal applications received via Internet	30.00%	36.10%	36.70%	37.50%	40.00%

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

Service Outcome Measure 1.B: The number of public record requests handled by the Agency's Division of HQA.

Performance Projection Table 1.B:

Baseline Year FY 2013-2014	FY 2015-2016	FY 2016-2017	FY 2017-2018	FY 2018-2019	FY 2019-2020
3,968	3,571	3,175	2,778	2,381	1,984
Percent of reduction in the annual number of public record requests processed by HQA	10.00%	20.00%	30.00%	40.00%	50.00%

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 2013-2014	FY 2015-2016	FY 2016-2017	FY 2017-2018	FY 2018-2019	FY 2019-2020
85.00%	90.00%	90.00%	90.00%	90.00%	90.00%

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.

Executive Direction and Support Services (Office of the Inspector General – Medicaid Program Integrity)

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

Performance Projection Table 2.A:

Baseline Year FY 2013-2014	FY 2015-2016	FY 2016-2017	FY 2017-2018	FY 2018-2019	FY 2019-2020
$35,700,000*	$47,858,082	$49,293,824	$53,730,268	$58,565,992	$63,836,931
Projected Increase in Percent	9.00%	9.00%	9.00%	9.00%	9.00%

**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 2013-2014	FY 2015-2016	FY 2016-2017	FY 2017-2018	FY 2018-2019	FY 2019-2020
$18,900,000	$25,327,808	$26,594,198	$27,923,908	$29,320,103	$30,786,108
Projected Increase in Percent	5.00%	5.00%	5.00%	5.00%	5.00%

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

Health Care Services (Division of Medicaid)

Service Outcome Measure 3.A: Transition between 2 percent (in Fiscal Year 2014-2015 and Fiscal Year 2015-2016) and 3 percent (Fiscal Year 2016-2017 and beyond) per year of statewide Long-term Care recipients receiving care in nursing homes to community based care until no more than 35 percent of all Medicaid Long-term Care recipients receive care in nursing homes.

Performance Projection Table 3.A:

Baseline Year FY 2013-2014	FY 2015-2016	FY 2016-2017	FY 2017-2018	FY 2018-2019	FY 2019-2020
83,446 Number of Long Term Care Recipients*	83,446	83,446	83,446	83,446	83,446
45,728 Number of Recipients in Nursing Homes	43,918	42,600	41,322	40,082	38,880
54.80% Percentage in Nursing Homes	52.63%	51.05%	49.52%	48.03%	46.59%
Target Percentage Transitioned	2.00%	3.00%	3.00%	3.00%	3.00%

*Number of Long-term Care recipients is based on enrollment counts as of June 30, 2014. Projections for number of recipients in future years were not available at the time of this report.

Service Outcome Measure 3.B: To improve the percentage for HEDIS measures for MMA plans that meet or exceed the National Medicaid 75th percentile to 75 percent by Fiscal Year 2019-2020.

Service Outcome Measure Projection Table 3.B:

Baseline Year FY 2013-2014	FY 2015-2016	FY 2016-2017	FY 2017-2018	FY 2018-2019	FY 2019-2020
32.00% Percentage of Core HEDIS measures for MMA plans >/= 75th National Medicaid Percentile	41.00%	49.00%	58.00%	66.00%	75.00%

Service Outcome Measure 3.C: To transition and maintain 85 percent of Medicaid recipients (in terms of total member months per year) into the SMMC Program.

Performance Projection Table 3.C:

Baseline Year FY 2013-2014	FY 2015-2016	FY 2016-2017	FY 2017-2018	FY 2018-2019	FY 2019-2020
85.00% Target Percentage of Medicaid Recipient Member Months SMMC	85.00%	85.00%	85.00%	85.00%	85.00%

Service Outcome Measure 3.D: To limit the annual growth in PMPM costs for recipients enrolled in SMMC to less than or equal to 5 percent as measured by budget neutrality.

Performance Projection Table 3.D:

Baseline Year FY 2013-2014	FY 2015-2016	FY 2016-2017	FY 2017-2018	FY 2018-2019	FY 2019-2020
Target growth Percentage	5.00%	5.00%	5.00%	5.00%	5.00%

Linkage to Governor's Priorities

Number	Governor's Priorities	Agency Goals
1	**Maintaining Affordable Cost of Living in Florida** 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	**Maintaining Affordable Cost of Living in Florida** 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	**Economic Development and Job Creation** Regulatory Reform	Goal 1: To operate an efficient and effective government. Goal 3: To assure access to quality and reasonably priced health services.
4	**Economic Development and Job Creation** Focus on Job Growth and Retention	Goal 1: To operate an efficient and effective government.

Trends and Conditions Statements

The Agency for Health Care Administration (Agency) was statutorily created by chapter 20, F.S., as the chief health policy and planning entity for the state. The mission for the Agency is "Better Health Care for All Floridians." As champions of that mission, we are responsible for the administration of the Florida Medicaid program, licensure and regulation of Florida's health facilities, and for providing information to Floridians about the quality of care they receive. We continually look for ways to improve health care in Florida by building strong partnerships with other agencies, developing relationships with stakeholders at all levels in communities around the state, enhancing our ability to target fraudulent providers, reducing unnecessary regulation, and reducing administrative costs in order to ensure that dollars go to serve patients and more.

Health Quality Assurance

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 HQA licenses, investigates, reviews, evaluates, monitors, and surveys facilities as well as approves facilities' construction plans as authorized by chapters 381, 383, 390, 394, 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. 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.

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 Facility (ALF) Enforcement Unit

In the past ten years, ALFs have become a more cost effective and less restrictive residential alternative to skilled nursing facilities for individuals not requiring full-time skilled nursing care. However, a continued increase of issues identified in ALFs led to the creation of the ALF Enforcement Unit in 2011. The Agency established a unit of ten ALF surveyors to function as a team responsible for statewide oversight of ALF inspection enforcement and to serve as liaisons with local law enforcement and other partners such as the Long-Term Care Ombudsman, Department of Health (DOH) and Department of Children and Families (DCF). The ALF Enforcement team's primary functions include:

- Assisting with the completion of high priority complaints;
- Collaborating with other agencies and law enforcement;
- Participating in unlicensed activity investigations;
- Participating in off hours or weekend inspections; and
- Conducting quality assurance reviews.

The Division's Bureau of Field Operations, Survey and Certification Support Branch enhanced training and focus for surveyors on core areas of compliance such as resident rights, nutrition and food service, medication management, staff training and physical environment in addition to proper licensure with the State. Every surveyor must take this enhanced ALF Surveyor Core Training course prior to being able to survey ALFs independently.

In addition to focused initiatives conducted in conjunction with the Agency's Bureau of Medicaid Program Integrity (MPI), the ALF Enforcement Team also conducted numerous investigations of unlicensed ALFs in Fiscal Year 2013-2014. The Division's Complaint Administration Unit received 163 complaints of unlicensed ALF activity. Of those complaints, 114 were investigated and 41 were substantiated, requiring additional action and follow-up visits. The majority of the investigations were conducted by the ALF Enforcement Team and in conjunction with the DCF and local law enforcement.

The goal is to ensure that all ALF residents receive appropriate healthcare. Facilities that provide substandard care as well as facilities providing care that exceeds the scope of the staff or the facility's licensure increase the cost of healthcare for Medicaid recipients. In an effort to bring about ALF reform, the Agency continues to pursue legislation that would increase fines and sanctions on non-compliant providers.

Cross-Divisional Enforcement Efforts

In addition to collaborative investigation activities, the Agency continues to align legal actions and sanctions between HQA and Medicaid. Licensure actions, including facility closures, denials, revocations, and license surrenders are communicated to Medicaid and managed care plans to ensure no additional claims are paid and no residents or patients are referred to the facility if licensure is a requirement of enrollment or registration in the Medicaid program. Additionally, providers terminated for cause from the Medicaid program are communicated to HQA and appropriate action is taken if the provider is a licensed facility. The Agency also publishes a monthly press release identifying 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. The press releases serve to

augment monthly reports submitted to the Senate Committee on Health Regulation documenting the effectiveness of Senate Bill 1986 (2009).

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, not only in Miami-Dade County but throughout the state. 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 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.

In addition to publishing an annual report detailing the implementation of the provisions of Senate Bill 1986, the Agency also submits monthly reports to the Senate Committee on Health Regulation. The Agency has expanded the monthly 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.

Optimizing Resources in Challenging Economic Times

The Agency continues to focus efforts on accomplishing more with the same or reduced resources. Over the past six 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 2013-2014, HQA's number of licensed, registered, certified, and regulated service providers and facilities continued to increase from 37,755 to 46,756 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 a 24 percent increase in regulated providers.

Table 1-1:

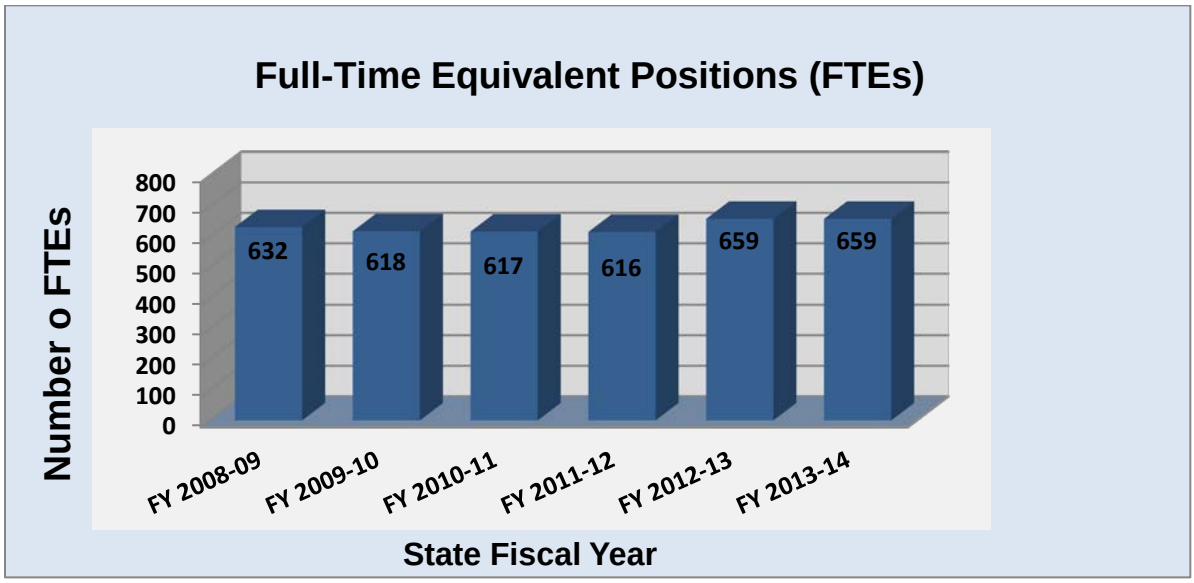
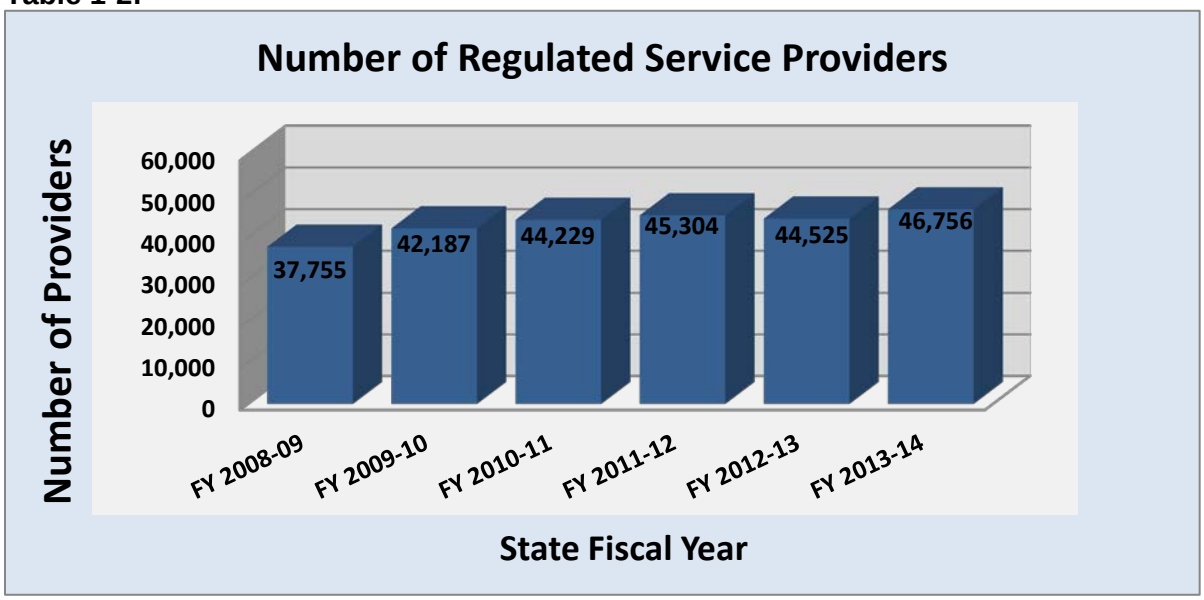


Table 1-2:



Streamlining through Regulatory Reduction

The Agency strives to be proactive in focusing on mission critical functions while reducing regulatory burdens. Legislation passed in 2014 made several changes to lessen regulatory burden, including the following:

SB 674 – Chapter 2014-84, Laws of Florida:

- Expanded disqualifying background screening offenses to include theft and fraud-related crimes;

- Eliminated the three year waiting period for individuals that have completed all monetary sanctions for a felony disqualifying offense;
- Authorizes the Agency and the Department of Highway Safety and Motor Vehicles (DHSMV) to share driver's license photos;
- Requires the registration and initiation of all criminal history background checks be made through the Care Provider Background Screening Clearinghouse for individuals required to be screened; and
- Eliminated notarization requirement for licensure applications, allowing for online submission.

HB 287 –Chapter 2014-110, Laws of Florida:

- Repealed the moratorium on community nursing home beds under the Certificate of Need (CON) process and increased flexibility in the CON approval process.

HB 1179 – Chapter 2014-142, Laws of Florida:

- Clarified the relationship between a nurse registry and the persons referred for contract by the registry and provides an exemption from accreditation for certain home health agencies.

The Agency plans to request additional legislative changes during the 2015 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 consumers, the Agency utilizes information technology to enhance streamlining efforts within the Agency. HQA continues to focus on the implementation of an Online Licensing system and the Care Provider Background Screening Clearinghouse. These major projects will allow the Agency to maximize its resources as well as enhance the application process for providers.

Online Licensing

The Agency continues to move toward the ultimate goal of a comprehensive, integrated, online licensure system. 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. It is being developed with the ability to interact with other internal and external agency databases for verification of Medicaid enrollment and appropriate business registration as well as identification of outstanding monetary obligations to facilitate the Agency's collections before licenses are issued or renewed.

This online licensing 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 percent of annual license renewal applications received electronically via the Internet.

The online licensing system currently interacts with the Agency's licensure database, Versa Regulation (VERSA), and allows for online payment as well as electronic submission of required supporting documentation. The system prepopulates 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 or federal employment identification number (FEIN), and utilizing corresponding information previously recorded in VERSA, thus reducing the chance for data entry errors. Responsibility for correct data entry remains 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. Approximately 65 percent of the license applications currently received have incorrect or missing information so this and other upcoming features should significantly reduce the submission of incomplete license applications. Additionally, the electronic document submission feature is integrated with the Agency's document management system, reducing Agency resources needed for manual document scanning.

Currently, the following providers may submit licensure renewal applications through the online licensing portal:

- Nursing Homes;
- Transitional Living Facilities;
- Prescribed Pediatric Extended Care Centers;
- Intermediate Care Facilities for the Developmentally Disabled;
- Abortion Clinics;
- Birth Centers;
- Multiphasic Health Testing Center;
- Crisis Stabilization Units;
- Homemaker and Companion Service Providers;
- Hospitals; and
- Clinical Laboratories;

Renewal applications for the remaining licensure types are scheduled to be available for online applications by June 2015. Although submission of online renewal applications will be voluntary, we anticipate significant adoption as there will be additional features to encourage use.

Electronic Background Screening

The Agency continues to move forward in the development of the Care Provider Background Screening Clearinghouse (Clearinghouse). The Clearinghouse is a secure, web-based database to house and manage screening results of multiple state agencies allowing the following agencies to share those results: The Agency, the Agency for Persons with Disabilities (APD), the Department of Elder Affairs (DOEA), the DCF, the DOH, the Department of Juvenile

Justice (DJJ), and Vocational Rehabilitation (VR) at the Department of Education (DOE). For the selected 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 currently the Agency, DOH, VR at DOE, and managed care health plans are participating with the remaining agencies expected to be brought on in 2015. Approximately 800 individuals a month applying for licensure or their licensure renewals with DOH are able to use a Clearinghouse screening reducing duplicative screening and costs. The Agency providers benefit by being able to use more than 400 screenings per month from the Clearinghouse. During Fiscal Year 2013-2014, more than 14,000 background screening results were shared among participating agencies and managed care health plans resulting in an overall cost savings of $1,395,700 to Agency providers, the DOH licensees and managed care health plans. The Clearinghouse also includes a RapBack requirement, 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 immediately notifies the provider so appropriate action can be taken.

The passage of SB 674, chapter 2014-84, Laws of Florida, during the 2014 Legislative Session made some substantial changes regarding the Clearinghouse. The bill authorizes the DHSMV to share driver's license photos with the Agency allowing for additional identity verification of individuals being screened. The bill also requires the registration and initiation of all criminal history background checks be made through the Clearinghouse for individuals required to be screened, providing reduced costs from duplicative screening, enhanced tracking of the screening, and a copy of the Florida public criminal history report of the applicant for providers.

Increasing Public Information and Transparency

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 such efforts as the regularly updated AHCA Docs and Florida Health Finder websites. This information is for the general public to use in making and/or determining important health care decisions. Because of the importance of this information, the Agency continues to maximize the use of all available technological resources in order to provide the most relevant health data and information from a single access point used to benefit all Florida stakeholders, including: consumers, providers, and researchers looking for accurate data.

During Fiscal Year 2013-2014, the Agency experienced a 13 percent 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 which cannot be posted online. With a continued effort to promote transparency through the expansion of information made available to the public on Florida Health Finder and AHCA Docs, the percent of public record requests processed manually by HQA is expected to decrease by more than half within the next five years.

The Agency also saw the implementation of some large initiatives, including the roll-out of the Statewide Medicaid Managed Care (SMMC) program. With this implementation, Florida

HealthFinder became a pertinent Agency tool to communicate with consumers via a single source and provide links to all Medicaid websites. The Health Plan landing/portal page that provides consumers with information needed to choose the right health plan was updated to include tools to help purchasers compare health plans and determine the relative value of care offered by managed care health plans. The measures presented on the Health Plan landing/portal page allow the public to understand how well health plans achieve results that matter, their effectiveness and the accessibility of delivered care. The Health Plan landing/portal page is comprehensive and covers not only Medicaid, but Medicare Health Management Organization (HMO), Healthy Kids HMO, and Commercial HMO, and Preferred Provider Organizations (PPO) plans. Data from member satisfaction surveys, quality of care, and performance data for each health plan are also available. The Agency expects to continue the use of FloridaHealthFinder to provide data on the utilization of SMMC plans.

Additionally, the Agency took great effort in improving the capabilities of online tools and interactive links accessible through FloridaHealthFinder. The release of an enhanced patient data query tool for hospitals, ambulatory surgery centers, and emergency departments will benefit researchers and professionals. The patient data query tool covers three years of trending data and allows for information drill-downs that express utilization rates, commonly used diagnoses, and the most cited reasons for emergency department visits. The patient data query tool also added additional data fields and provides for sortable reports in minimal clicks. To increase transparency, the FloridaHealthFinder Facility/Provider Locator tool was also modified, and now allows for a search of closed health providers.

The popularity of the FloridaHealthFinder website continues to grow as a result of its outreach, which includes Spanish tutorials, webinars, and a live virtual tour. Visits to the website have seen a steady increase since its inception, overcoming the 2014 goal of 2.5 million visitors. With the update of its tools and capabilities, the increased use of FloridaHealthFinder to improve access to consolidated information and communicate on Agency-wide health initiatives, FloridaHealthFinder saw Fiscal Year 2013-2014 visits totaling 2,934,075 visits, a 31.16 percent increase over the previous fiscal year (Table 1-3). It is anticipated that FloridaHealthFinder's Fiscal Year 2014-2015 will see more than 3 million visits (Table 1-4).

Table 1-3:

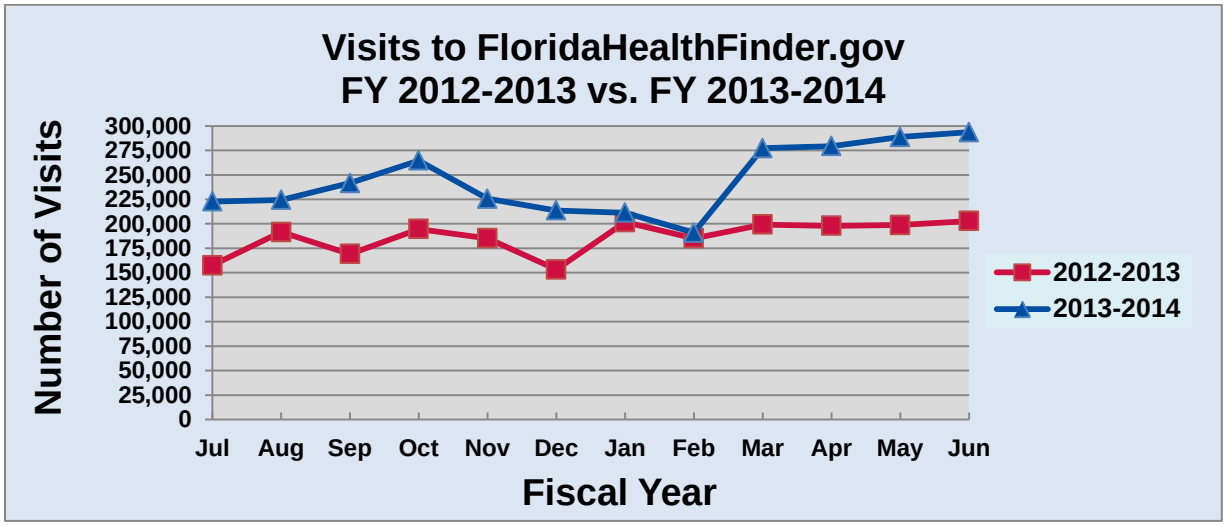
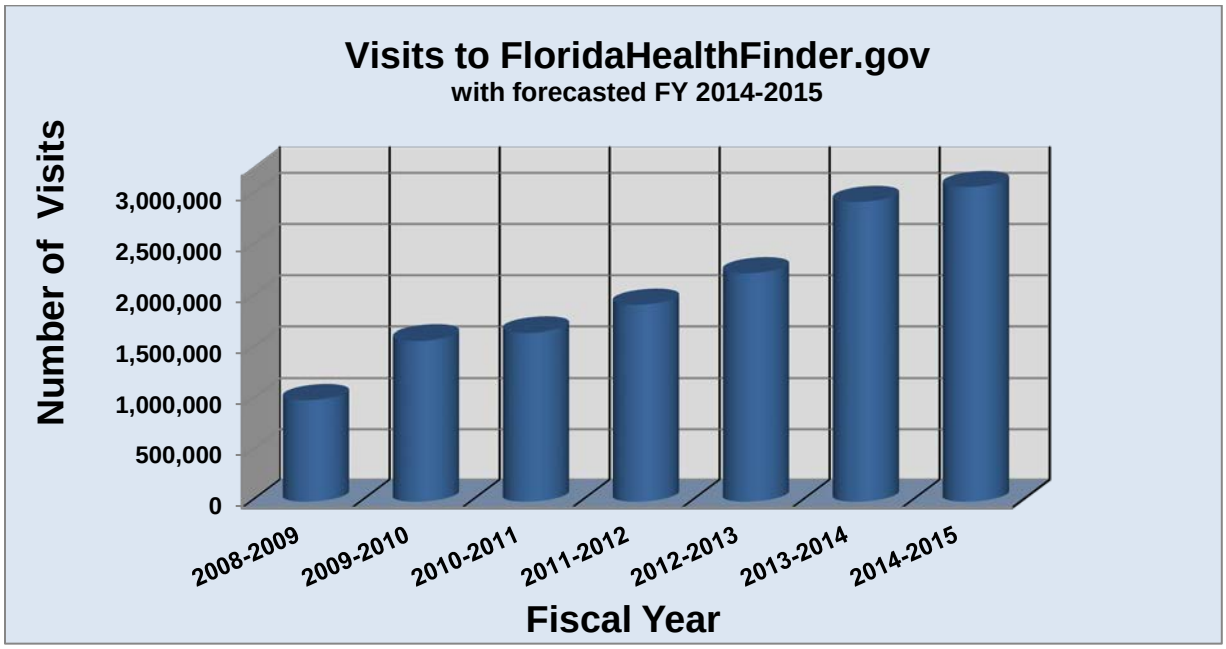


Table 1-4:



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 American Recovery and Reinvestment Act (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 6,254 Medicaid professional providers and 174 hospitals are participating.

The Agency implemented the statewide health information exchange infrastructure, known as the Florida Health Information Exchange (Florida HIE), and has now joined the eHealth Exchange, enabling health care providers participating in the Florida HIE to exchange health information with participating agencies with proper authorization. The eHealth Exchange is a group of federal agencies and non-federal organizations with a common mission to improve patient care, streamline disability benefit claims processing, and improve public health reporting through the secure and trusted exchange of health information.

This partnership expands the benefits of electronic health records enabling more efficient sharing of information and preventive care to avoid patient decline and adverse care outcomes. 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 HIE adoption statistics are reported on the Florida Health Information Network website at www.fhin.net.

The Shift towards Managed Health Care

Chapter 641, F.S., gives the Agency joint responsibility with the Department of Financial Services (DFS), Office of Insurance Regulation (OIR), to regulate managed care organizations (MCO). 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 (HMOs) and eight PSNs are contracted with Medicaid to provide services statewide in all 67 counties. Overall, Medicaid managed care enrollment is up from 1.51 million in July, 2013 to 2.3 million in July, 2014. See Table 1-5 for the type of product provided by MCOs.

Table 1-5:

Type of Managed Care Organization	Products and Services Provided*		
	Commercial Managed Care	Medicare Products	Medicaid Plans
Health Maintenance Organization (HMO)	39	28	13
Exclusive Provider Organization (EPO)	8	0	0
Prepaid Health Clinic (PHC)	5	0	0
Provider Services Network (PSN)	0	0	7

More than one product or service may be provided by a single HMO or EPO. 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 the SMMC program. 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 implementation of the SMMC program resulted in the disbandment of the Bureau of Managed Health Care (BMHC) under HQA and reorganization of the business programs, functions and staff that comprised the BMHC. Commercial Health Maintenance Organizations, Exclusive Provider Organizations, Prepaid Health Clinics, Worker's Compensation Managed Care Arrangements, Health Flex Plan, Subscriber Assistance and Beneficiary Assistance Programs were transferred to the Bureau of Health Facility Regulation as well as seven staff to

administer these programs. Four program staff responsible for collecting and tracking plan liquidated damages and sanctions as well as administering the Florida Health Care Responsibility Act (HCRA) program were transferred to the Bureau of Central Services. Health Care Services and Behavioral Health Services programs were transferred to the Division of Medicaid.

The Managed Medical Assistance (MMA) program provides acute care services to Medicaid recipients. The managed care plans were selected through a competitive bid process and are currently participating in the MMA program. The Agency began notifying and transitioning eligible Medicaid recipients into the program on May 1, 2014. As of August 1, 2014, the MMA program is currently operational in all areas.

Automation of manual processes and review can provide efficiencies similar to the benefits of the Online Licensing Project in managed care oversight. The BMHC worked collaboratively with Medicaid to expand the current Choice Counseling software to include a Provider Network Verification (PNV) module that enables contracted Medicaid managed care plans to submit weekly files of their provider networks for verification of network adequacy. 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 helped to create important infrastructure for data connectivity across multiple health provider systems. The system also assisted 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.

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.

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 mission of "Better Health Care for all Floridians". 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, cost benefit, 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.

The Florida Agency for State Technology

The Agency will collaborate and transition to the new Florida Agency for State Technology (AST) oversight created by SB 1762, chapter 2013-40, Laws of Florida. The State Chief Information Officer and AST Chief Operating Officer will be collaborated with on new IT standards and strategies.

Strategic Planning, Vision, and 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 ability 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 need for transparency and self-service aggregate analysis along with the importance of securing data from threats and inappropriate 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:

- Continued 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 10 to 12 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), who is 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 - To achieve a staff retention rate of 90 percent through use of improved training opportunities, better work environment, and total compensation by Fiscal Year 2019-2020, 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 all IT 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, and recent efforts for better interoperability with the re-procurement of the Medicaid Management Information System and Decision Support System. It is important that all the Agency's systems are considered in the new model, which will allow for modularity as well as co-allocated funding (known barriers to previous interoperability efforts). 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 return on

investment (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.

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 Medicaid Program Integrity (MPI) unit. In this program, the key indicator of fraud and abuse is overpayments. The Florida Medicaid program is a $24 billion program with an estimated total of 116,000 enrolled providers as of July 2014. The program is made up of 20 HMOs and eight PSNs that provided Medicaid services to recipients/enrollees during Fiscal Year 2013-2014.

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 and prosecutorial agencies in order to stop criminals, reduce fraud, and protect the integrity of the Florida Medicaid program.

The Agency was appropriated $5 million to procure enhanced data analytical subscription services in order to better identify fraud, waste, and abuse within the Florida Medicaid program. In August 2014, the Agency signed a contract with an independent contractor to provide these services. A request for continued funding will be submitted in the Agency's Legislative Budget Request (LBR) for Fiscal Year 2015-2016 requesting to augment MPI staff accordingly as identification and recoveries are projected to substantially increase.

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 and plans to implement the resources of a Recovery Audit Contractor (RAC), as required by 42 C.F.R., Part 455 [Sec. 1902 U.S.C. 1396a], through a procurement process in Fiscal Year 2014-2015. 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 2013-2014, MPI prevention efforts resulted in cost savings of $21.9 million. Actual overpayments recovered through the efforts of MPI totaled $31.4 million for the same fiscal year. Overall, in Fiscal Year 2013-2014, audit recoveries and cost avoidance amounts yielded a ROI of 5.8:1.

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, 58.79 percent of the expenditures for most Medicaid services were reimbursed with federal funds in Fiscal Year 2013-14. According to the CMS, federal share of expenditures for Fiscal Year 2014-2015 will be 59.72 percent. 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.

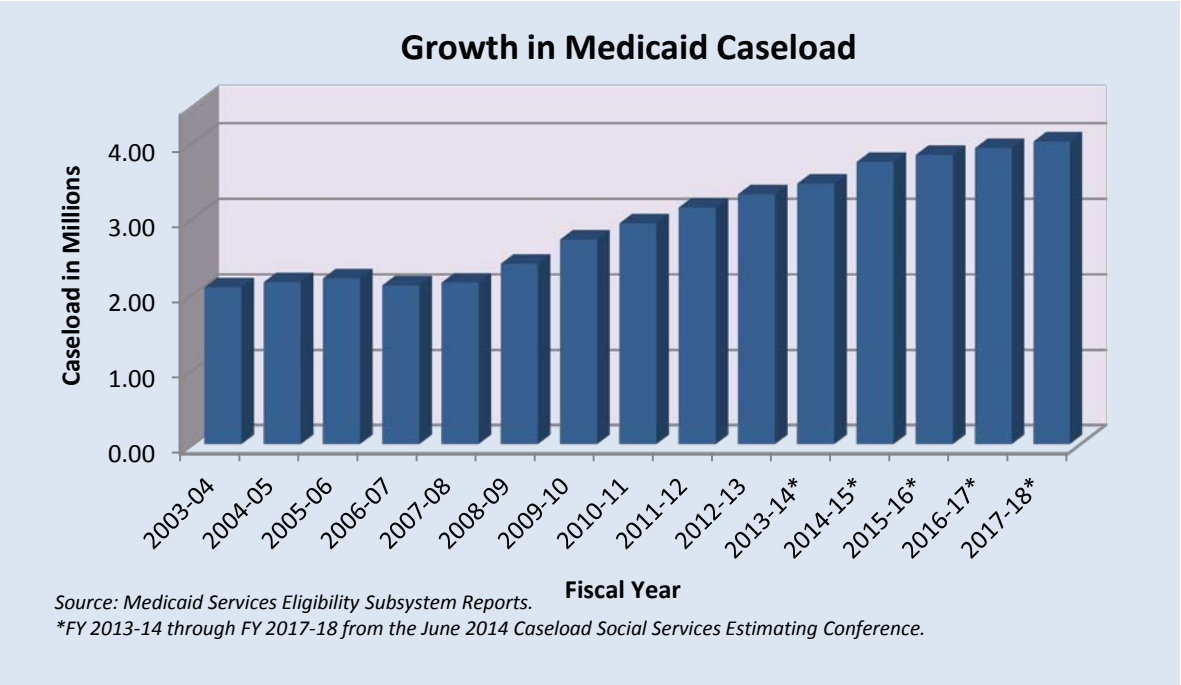
The need for Medicaid funded health care services is affected by population growth, the demographic profile of the population, and economic conditions that impact employment and income. Based on U.S. Census Bureau estimates, the population of Florida was estimated to be more than 19.3 million in 2013, 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 began implementation of the Long-term Care component of the SMMC program in 2013 completing rollout of the program on March 1, 2014.

In Fiscal Year 2013-2014, it is estimated that Medicaid will have served more than 3.4 million beneficiaries and paid claims to more than 81,000 enrolled providers. With expenditures of $22.2 billion in Fiscal Year 2013-2014, Medicaid is the largest single program in the state, accounting for roughly 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 2013-2014 were more than 65 percent higher than a decade ago (Figure 3-1). The caseload increased by 4.2 percent in Fiscal Year 2013-2014 over the prior fiscal year and is projected to increase in Fiscal Year 2014-2015 by more than 8 percent compared to Fiscal Year 2013-2014.

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. According to the Florida Department of Economic Opportunity (DEO), as of June 2014, the statewide unemployment rate had improved to 6.1 percent. While the economy has improved over the last few years, other external factors such as the launch of the federal insurance mandates have continued to drive Medicaid caseloads upward. The federal insurance mandate, coupled with health care exchanges that automatically refer eligible persons to Medicaid have contributed to the caseload increase.

Figure 3-1



Source: Medicaid Services Eligibility Subsystem Reports.
**FY 2013-14 through FY 2017-18 from the June 2014 Caseload Social Services Estimating Conference.*

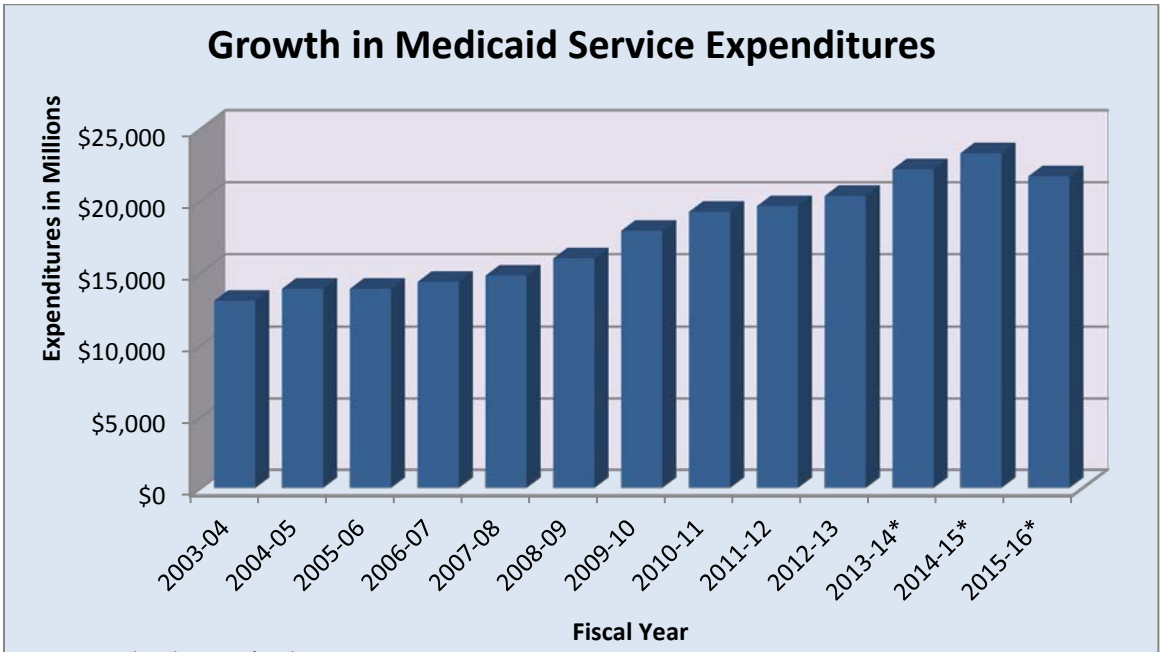
In the last ten years, expenditures in the Medicaid program grew from almost $13.1 billion in Fiscal Year 2003-2004 to $22.2 billion in Fiscal Year 2013-2014, growing nearly 70 percent in that time period (Figure 3-2). The primary factors contributing to expenditure growth have been the cost of prescription 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 ($4.3 billion);
- Hospital Inpatient Services ($3.3 billion);
- Nursing Facility Care ($2.9 billion);
- Prescription Services ($1.9 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).

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 federal insurance mandates at 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 but not previously enrolled 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 HB 7109, 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 Long-term Care (LTC) component of SMMC was implemented between August 2013 and March 2014, and the MMA component of SMMC was implemented between May 2014 and August 2014.

Figure 3-2



Source: Medicaid Services' Budget Forecasting System Reports.
**FY 2013-2014 through FY 2015-2016; August 2014 Social Services Estimating Conference.*

The Evolution of Florida Medicaid

Medicaid was implemented as a Fee-for-Service (FFS) program more than four decades ago and since the beginning, had been primarily a FFS based program. Over the years, enrollment grew rapidly and costs soared until Medicaid expenditures were more than one-fourth of the state budget. The rapid growth in enrollment and costs made it increasingly important to find ways to manage the diverse needs of the Medicaid population while also being able to better predict and plan for cost increases.

Medicaid's roles and responsibilities have been evolving since it moved away from a completely FFS program and the first Medicaid managed care plan was established in 1984. Eventually this led to a program that was a mix of special programs, waiver programs, a FFS population, a FFS primary care case management population (known as MediPass), and a population in prepaid health plans. Florida implemented a managed care pilot program (known as Medicaid Reform or simply Reform) in Broward and Duval counties in 2006 which was expanded to Baker, Clay and Nassau counties in 2007. By July 1, 2013 there were 1.54 million Medicaid recipients enrolled in managed care (including more than 1.2 million in HMOs), almost 1.16 million enrolled in FFS, and 587,339 enrolled in MediPass. This translates to 47 percent, 35 percent, and 18 percent of

the total Medicaid population respectively. Medicaid Reform initially ran from July 1, 2006 through June 30, 2011 and was extended to June 30, 2014.

Recent Changes to Medicaid – Statewide Medicaid Managed Care (SMMC)

Florida Medicaid has recently implemented significant program changes that have resulted in improved efficiency, cost predictability and accountability for the program and enhanced service provision for program recipients. The most significant change, perhaps the single greatest change in Medicaid since the program was adopted, is the implementation of the SMMC. The Agency, along with sister agencies, has worked diligently for more than three years to successfully implement the SMMC program.

HB 7107, chapter 2011-134, Laws of Florida, directs the Agency to implement the SMMC program as a statewide, integrated managed care program for all Medicaid covered medical assistance services and long-term care services. Now that the transition of Florida Medicaid to SMMC is complete, many of the previous FFS functions supported by Agency staff will be significantly diminished as managed care roles and responsibilities increase to support the need for procurement and contract compliance and monitoring functions.

The SMMC program has two components: the Long-term Care (LTC) Program and the Managed Medical Assistance program (MMA). As of August 1, 2014, implementation of both components of the SMMC program was complete. Both programs were implemented on a regional roll-out schedule. The LTC program was in operation statewide as of March 2014, and the MMA program was in operation statewide as of August 2014.

SMMC Long-Term Care

The LTC portion of the SMMC program is designed to provide streamlined options for care and care coordination for Medicaid LTC recipients who in the past have received services through a variety of waivers and programs. Long term care under the Florida Medicaid program includes institutional care, assistive care services, and home based services. Institutional care includes care in nursing facilities and Intermediate Care Facilities for the Developmentally Disabled (ICF/DD). Home based care is provided in ALFs, adult family care homes, and in individuals own homes or family homes.

SMMC LTC encompasses the following populations:

- Individuals who are 65 years of age or older and need nursing facility level of care; and
- Individuals who are 18 years of age or older, are eligible for Medicaid by reason of disability, and who need nursing facility level of care.

It also includes individuals who were enrolled in the following waiver programs:

- Aged and Disabled Adult (A/DA) Waiver;
- Consumer-Directed Care Plus (for individuals in the A/DA waiver);
- Assisted Living Waiver;
- Nursing Facility Diversion Waiver;
- Frail Elder Option; and

- Channeling Services Waiver.

SMMC LTC is available to individuals in the following programs as well, though their participation is not mandatory:

- Developmental Disabilities Individual Budgeting (iBudget) Waiver program;
- Traumatic Brain & Spinal Cord Injury (TBI) Waiver;
- Project AIDS Care (PAC) Waiver;
- Adult Cystic Fibrosis Waiver;
- Program of All-Inclusive Care for the Elderly (PACE);
- Familial Dysautonomia Waiver; and
- Model Waiver.

Over the past two years, Florida has allocated additional funding for home and community based services, which has allowed the state to move approximately 1,200 people off of the developmental disabilities waiver waitlist this year alone, and to provide services to approximately 5,500 additional people under the LTC component of the SMMC program since program inception in August of 2013. There is an increased emphasis on community based care and the Agency has implemented financial incentives to encourage the transition of care out of nursing facilities and into community settings. The goal is to eventually have no more than 35 percent of LTC services provided in a nursing facility or institutional setting.

As of June 30, 2014, SMMC LTC had seven health plans statewide providing care and services to 45,681 nursing facility residents and 37,710 waiver recipients for a total enrollment of 83,391 individuals.

SMMC Managed Medical Assistance

The MMA component of the SMMC program operates under an 1115 Demonstration waiver and is designed to implement a new statewide managed care delivery system without increasing overall program costs. The MMA program provides primary and acute medical care for certain populations through high quality, competitively selected managed care plans.

The objectives for SMMC MMA include:

- Improving outcomes through care coordination, patient engagement in their own health care and maintaining fiscal responsibility;
- Improving program performance by increasing patient satisfaction;
- Improving access to coordinated care by enrolling all non-exempt, eligible Medicaid participants in managed care; and
- Enhancing fiscal predictability and financial management by converting the purchase of Medicaid services to capitated, risk-adjusted payment systems, with strict financial oversight requirements for managed care plans to improve fiscal integrity.

Implementation of SMMC MMA began in May 2014 and was complete in all regions of the state by August 1, 2014. As of August 1, there were a total of 2,540,863 individuals enrolled in MMA in 20 managed care plans.

The MMA component of the SMMC program provides medical, dental, and behavioral health care services to recipients eligible for enrollment. Managed care plans are responsible for providing a comprehensive array of Medicaid services, including some services that had previously been covered primarily under a fee-for-service arrangement. Some of those services now included in MMA that were previously covered only in FFS or by a few managed care plans include:

- Assistive Care Services;
- Child Welfare Behavioral Health Overlay Service;
- Community Substance Abuse Services;
- Comprehensive Behavioral Health Assessment;
- Hospice Services;
- Non-Emergency Medical Transportation;
- Specialized Therapeutic Foster Care Services;
- Statewide Inpatient Psychiatric Program, and
- Therapeutic Group Care Services.

In addition to the comprehensive array of services offered by MMA plans, the Agency negotiated added value/benefits with managed care plans. Areas where added value/benefits were achieved include:

- Expanded benefits;
- Enhanced network adequacy standards;
- Establishing minimum thresholds for electronic health records (meaningful use) adoption; and
- Enhanced standards related to claims processing, prior authorization, and enrollee/provider help line (call center operations).

Measuring Program Performance

With the implementation of SMMC, Florida's Medicaid program has adopted many private market principles to achieve higher quality care for those most in need at a lower cost to the taxpayer. In addition, the SMMC contract includes provisions for incentivizing quality. SMMC plans that exceed Agency-defined quality measure targets are eligible for a one-percent incentive add-on called an Achieved Savings Rebate. Plans that do not achieve defined targets for quality measures may be subject to liquidated damages and/or sanctions.

The increased emphasis on quality and accountability does not stop with the managed care plans. The Agency has added new tracking and monitoring components as well as additional reporting above and beyond what was required in the past. The increased visibility of overall program performance, with shifting staff roles and Agency priorities, has led to a re-evaluation of the way Medicaid tracks and reports performance in the Long Range Program Plan (LRPP). Assessment of the key elements necessary for measuring program performance led to the identification of three primary populations of focus, with four types of measures for each area.

After implementation of SMMC, the Florida Medicaid program will consist of three primary populations. These include the SMMC LTC population, the SMMC MMA population, and those recipients who remain in a FFS environment. Each of these populations can be analyzed based

on up to four program components. These components include the size and scope of the program, the cost of the program, access to services and care in the program, and health care outcomes in each program. Florida Medicaid will also continue to monitor certain aspects of the Florida KidCare program in its LRPP but the areas of analysis will be limited to the program size and scope, and a limited set of outcome/quality measures. Figure 3-3 shows a matrix of the different populations and program areas along which each population can be analyzed.

Figure 3-3

Analysis Component/Population	FFS	MMA	LTC	KidCare
Program Size/Scope	X	X	X	X
Program Costs	X	X	X	
Access/Utilization of Services	X	X	X	
Program Quality/ Outcomes	X	X	X	X

*For KidCare, the Agency can track overall costs and costs/utilization for certain components of the program such as MediKids. However, detailed utilization information is not collected by the Agency for the entire KidCare population.

Program size and scope measures will be used to measure the size of the different populations within Medicaid relative to budget projections and appropriations as well as relative to each other. The goal of the SMMC program is to enroll and maintain at least 85 percent of the population in managed care. While program size is not a performance measure per se, it is nonetheless important to track as a general guide for expected resource needs for future planning and to help to track how the program is doing relative to its long term goals of enrolling the majority of the population in managed care. It will also be a useful tool for tracking the voluntary population (i.e., those that have the option but are not required to enroll in managed care) over time to see if the pattern for opting in or out changes over time.

Program costs are also not necessarily performance measures since they are largely influenced by outside factors such as the overall economy, federal and state legislation, and environmental factors. However, one of the goals of SMMC is to have greater predictability for future program costs. Tracking cost measures will allow Medicaid to track expenditures over time, compare costs against estimates, identify and plan for areas of change in cost patterns and gauge the effectiveness of cost containment strategies.

Utilization measures and outcome/quality measures go hand-in-hand and are key to understanding the overall performance of the Medicaid program. Access and utilization measures will show how effectively recipients are using services within the program. Access and utilization are affected by many things such as the adequacy of the provider network, availability of transportation, and even the recipients understanding of their own health care needs. Access to timely primary care and having a medical home are key to ensuring long term health and help prevent minor medical problems from becoming expensive, hard to treat problems. Access includes measures like getting adequate prenatal care, being able to schedule appointments when necessary, or preventing unnecessary hospitalizations with adequate primary care. Program quality measures will help identify and track how well plans and providers are doing at ensuring the care provided is meeting established guidelines. Measures here can include plan performance against national benchmarks on Healthcare Effectiveness Data and Information Set (HEDIS) measures or recipient's satisfaction with the care they receive.

Florida Medicaid will continue to explore options for new LRPP measures. Emphasis will be placed on establishing measures that are meaningful as well as being useful for tracking

program performance. Discussions regarding program goals and measures, and best way to implement new measures to achieve the desired product are ongoing.

Medicaid Over the Next Five Years/Legislative Budget Requests

Over the next five years Florida Medicaid will continue its evolution to a managed care based program. While SMMC plan rollout was completed statewide in August 2014, Agency realignment to meet the new demands of the program's change in focus is ongoing. Medicaid anticipates submitting LBRs to accomplish staff and administrative realignment as well as seeking funding when necessary to improve the overall administration of the SMMC program and Medicaid as a whole. Medicaid will evaluate program and plan performance and will continue to evaluate ways to measure and track performance as well as seeking to improve patient care and outcomes on an ongoing basis.

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	Background Screening Clearinghouse	This issue requests recurring funding for staff augmentation dedicated to maintaining the Care Provider Background Screening Clearinghouse System (Clearinghouse), which includes bug-fixes, system enhancements requested by specified agencies, and inclusion of Federal RapBacks. In addition, this issue requests funding for storage, hardware, and band-width to accommodate the increased data with bringing on the specified agencies.	If this issue is not approved, the Agency will not have the recurring appropriation needed to maintain and continue to host the Clearinghouse.
Division of Information Technology			
2	None		
Office of the Inspector General			
3	Advanced Data Analytics and Detection Services	This issue requests funding to modernize detection abilities by using advanced statistical methods and graph pattern analysis	If the issue is not funded, the Agency will not have adequate budget authority to continue this project. Additionally, the

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
		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. The Legislature appropriated the Agency $3 million in Fiscal Year 2013-2014 and $5 in Fiscal Year 2014-2015 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.	Agency will lose an opportunity for a 90/10 federal match.
Division of Medicaid			
4	ICD-10 Conversion	This issue requests funding to complete the conversion from ICD-9 to ICD-10. 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, 2015.
5	Consulting Services for the Development of an	This issue requests funding to contract with an independent entity to develop a plan to convert the current outpatient cost	If funding is not approved, rates would continue to be set based upon cost based reimbursement instead of payment

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
	Outpatient Prospective Payment	based reimbursement payment processes to an outpatient prospective payment process that utilizes Ambulatory Patient Groups (APGs).	processes tied more to the condition of the patient and less to the expenses reported. APGs align better with SMMC.
6	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 and $1 million in Fiscal Year 2014-2015 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.
7	Consulting Services for the Development of an Nursing Home Prospective Payment	This issue requests funding to contract with an independent entity to develop a plan to convert the current nursing facility cost based per diem reimbursement payment process to a nursing facility prospective payment process.	If funding is not approved, nursing facility rates would continue to be set based upon a cost based per diem reimbursement process. A prospective payment process aligns better with SMMC.
8	Achieved Savings Rebate	This issue requests budget authority to comply with the requirements of s. 409.967(3), F.S., which requires the financial	If this issue is not approved, the Agency will not be able to comply with a state mandate.

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
		statements of prepaid health plans participating in the SMMC program to be audited.	

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(b)(2), F.S.	Florida Health Reinsurance Program	Ongoing responsibilities
7.	section 624.91, F.S.	Florida Healthy Kids Corporations Board of Directors	Ongoing responsibilities

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
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.	section 409.1451 (7), F.S.	Independent Living Advisory Council	Ongoing responsibilities
11.	section 427.013, F.S.	Commission for the Transportation Disadvantaged	Ongoing responsibilities
12.	section 14.2019, F.S.	Florida Suicide Prevention Coordinating Council	Ongoing responsibilities
13.	section 624.351, F.S.	Medicaid and Public Assistance Fraud Strike Force	Ongoing responsibilities
14.	chapter 2012-120, Laws of Florida	Statewide Task Force on Prescription Drug Abuse and Newborns	Final Report/January 15, 2015
15.	section 893.055, F.S.	Prescription Drug Monitoring Program	Ongoing responsibilities

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
16.	Executive Order No. 07-148	Commission on Disabilities	Ongoing responsibilities
17.	section 893.0551, F.S.	Program Implementation and Oversight Taskforce on Prescription Drug Monitoring	Ongoing responsibilities
18.	Supreme Court of Florida No. AOSC13-8	Taskforce on Substance Abuse and Mental Health Issues in the Court	Ongoing responsibilities
19.	Chapter 2014-161, Laws of Florida	Statewide Council on Human Trafficking	Ongoing responsibilities
Health Quality Assurance			
20.	section 408.909(9), F.S.	Annual report on Health Flex to be submitted jointly with the Office of Insurance Regulation	Annually/January 1
21.	section 408.7057(2)(g)2., F.S.	Annual Report on the Cases of the Statewide Managed Care Dispute Resolution Program	Annually/February 1
22.	section 400.191, F.S.(2)	Nursing Home Guide Quarterly Report	Ongoing responsibilities
23.	section 395.10972, F.S.	Risk Managers Advisory Group – This is a standing advisory group that has not met in several years.	Ongoing responsibilities
24.	section 483.26, F.S.	Clinical Laboratory Technical Advisory Panel	Ongoing responsibilities

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
25.	section 627.4236, F.S.	Bone Marrow Transplant Advisory Panel	Ongoing responsibilities
26.	section 409.912, F.S.	Drug Utilization Review Board	Ongoing responsibilities
27.	section 288.0656, F.S.	Rural Economic Development Initiative	Ongoing responsibilities
28.	section 408.05, F.S.(8)	Health Information Exchange Coordinating Committee	Ongoing responsibilities
29.	section 402.281, F.S.	Governor's Panel on Excellence in Long-Term Care (Gold Seal Program)	Ongoing responsibilities
30.	section 408.7056 and section 408.7057, F.S.	Statewide Provider and Subscriber Assistance Panel	Ongoing responsibilities
31.	section 409.913, F.S.	Joint report for the Agency and Medicaid Fraud Control Unit (MFCU) documenting effectiveness of efforts to control fraud	Annually/January 1
32.	section 20.055(5)(i), F.S.	Annual long-term and audit plans – Inspector General audit plans submitted to the Chief Auditor General	Annually/September 30
33.	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
34.	section 429.19, F.S.	Assisted Living Facilities Annual Report on Fines	Annually/July 30

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
35.	section 408.05(8), F.S.	State Consumer Health Information and Policy Advisory Council	Ongoing responsibilities
36.	section 627.6699, F.S.	Florida Health Insurance Advisory Board (FHIAB)	Ongoing responsibilities
Division of Information Technology			
37.	None		
Division of Medicaid			
38.	section 409.913, F.S.	Annual Medicaid Fraud and Abuse Report	Ongoing responsibilities
39.	section 409.91211, F.S.	Enhanced Benefits Panel	Ongoing responsibilities
40.	section 409.818, F.S.	Florida KidCare Grievance Committee	Ongoing responsibilities
41.	section 409.91213, F.S.	Low Income Pool (LIP)	Quarterly progress reports and annual reports for 1115 waivers
42.	section 409.911, F.S.	LIP Council	Ongoing responsibilities

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
43.	section 409.91211, F.S.	Medicaid Reform Technical Advisory Panel	Ongoing responsibilities
44.	section 381.0602, F.S.	Organ Transplant Advisory Council	Ongoing responsibilities
45.	section 400.235, F.S.	Pharmaceutical and Therapeutics Committee	Ongoing responsibilities
46.	section 16.615, F.S.	Council on the Social Status of Black Men and Boys	Ongoing responsibilities
47.	section 409.818(2)(c), F.S.	Kid Care Coordinating Council (Membership Only)	Ongoing responsibilities
48.	section 409.8177(2), F.S.	Florida KidCare Enrollment Report on enrollment for each component of Florida KidCare Program	Ongoing responsibilities
49.	section 409.908(2)(b)5, F.S.	Nursing Care Cost Report: Annual Report on direct and indirect care costs	Ongoing responsibilities
50.	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
51.	section 409.91213, F.S.	Medicaid Reform Quarterly Report: Agency analysis and the status of various operational areas	Ongoing responsibilities

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
52.	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
53.	section 409.912 (44), F.S.	HSD annual report of audit results to ensure cost effectiveness relating to Medicaid Managed Care	Ongoing responsibilities
54.	section 409.8177(1), F.S.	Florida KidCare Evaluation Annual Report: the Agency, in consultation with the DOH, the DCF & Florida Healthy Kids contract for evaluation and report on KidCare program	Ongoing responsibilities
55.	section 409.912(15)(e), F.S.	CARES Program Operation Annual Report: the Agency and the DOEA submit annual report on operation of CARES	Ongoing responsibilities
56.	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
57.	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 2014-2015 (Words)		Approved Prior Year Standards FY 2013-2014 (Numbers)	Prior Year Actual FY 2013-2014 (Numbers)	Approved Standards for FY 2014-2015 (Numbers)	Requested FY 2015-2016 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%	10.96%	11.45%	11.45%
Program: Health Care Services			**Code: 68500000**		
Service/Budget Entity: Children's Special Health Care			**Code: 68500100**		
3	Percent of hospitalizations for conditions preventable by good ambulatory care	7.70%	See New Measure 3A Below	7.70%	DELETE[4]
3A	New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): CMSN enrollees (Title XIX and Title XXI)	N/A	19.31%	20.00%	20.00%[4]
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	71.80%	90.00%	75.00%[4]
5	Percent of children enrolled with up-to-date immunizations	85.00%	N/A	85.00%	DELETE[4]

	Approved Performance Measures for FY 2014-2015 (Words)	Approved Prior Year Standards FY 2013-2014 (Numbers)	Prior Year Actual FY 2013-2014 (Numbers)	Approved Standards for FY 2014-2015 (Numbers)	Requested FY 2015-2016 Standard (Numbers)
6	Percent of compliance with the standards established in the Guidelines for Health Supervision of Children and Youth as developed by the American Academy of Pediatrics for children eligible under the program	97.00%	N/A	97.00%	DELETE[4]
7	Percent of families satisfied with the care provided under the program	95.00%	92.81%	95.00%	90.00%[4]
8	Total number of Title XXI-eligible children enrolled in Kidcare	228,159	238,448	228,159	Per Estimates[1]
9	Number of Title XXI-eligible children enrolled in Florida Healthy Kids	195,867	192,458	195,867	Per Estimates[1]
10	Number of Title XXI-eligible children enrolled in MediKids	2,100	27,441	21,000	Per Estimates[1]
11	Number of Title XXI-eligible children enrolled in Children's Medical Services Network	111,292	18,549	10,053	Per Estimates[1]
Program: Health Care Services			**Code: 68500000**		
Service/Budget Entity: Executive Direction and Support Services			**Code: 68500200**		
12	Program administrative costs as a percent of total program costs	1.44%	1.74%	1.44%	2.00%[4]
13	Average number of days between receipt of clean Medicaid claim and payment	15	8.2	15	15
14	Number of Medicaid claims received	145,101,035	172,062,023	145,101,035	Per Estimates[1]
Program: Health Care Services			**Code: 68500000**		
Service/Budget Entity: Medicaid Services - Individuals			**Code: 68501400**		

Approved Performance Measures for FY 2014-2015 (Words)		Approved Prior Year Standards FY 2013-2014 (Numbers)	Prior Year Actual FY 2013-2014 (Numbers)	Approved Standards for FY 2014-2015 (Numbers)	Requested FY 2015-2016 Standard (Numbers)
15	Percent of hospitalizations that are preventable by good ambulatory care	11.00%	See New Measured 15A and 15B Below	11.00%	DELETE[4]
15A	New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Ages 1 to 20 enrolled in Fee-for-Service, MediPass, and Provider Service Networks	N/A	30.11%	25.00%	25.00%[4]
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	23.06%	20.00%	20.00%[4]
16	Percent of women receiving adequate prenatal care	86.00%	83.90%	86.00%	86.00%
17	Neonatal mortality rate per 1000	4.70%	4.90%	4.70%	5.00%[4]
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 18 months.	N/A	74.00%	50.00%	75.00%[4]
19	Percent of eligible children who received all required components of EPSDT screening	64.00%	46.00%	64.00%	64.00%
20	Number of children ages 1-20 enrolled in Medicaid	1,249,276	2,188,843	1,249,276	Per Estimates[1]
21	Number of children receiving EPSDT services	407,052	971,064	407,052	Per Estimates[1]
22	Number of hospital inpatient services provided to children	92,960	308,667	92,960	Per Estimates[1]

	Approved Performance Measures for FY 2014-2015 (Words)	Approved Prior Year Standards FY 2013-2014 (Numbers)	Prior Year Actual FY 2013-2014 (Numbers)	Approved Standards for FY 2014-2015 (Numbers)	Requested FY 2015-2016 Standard (Numbers)
23	Number of physician services provided to children	6,457,900	10,907,151	6,457,900	Per Estimates[1]
24	Number of prescribed drugs provided to children	4,444,636	6,926,439	4,444,636	Per Estimates[1]
25	Number of hospital inpatient services provided to elders	100,808	105,692	100,808	Per Estimates[1]
26	Number of physician services provided to elders	1,436,160	1,734,014	1,436,160	Per Estimates[1]
27	Number of prescribed drugs provided to elders	15,214,293	1,053,200	15,214,293	Per Estimates[1]
28	Number of uninsured children enrolled in the Medicaid Expansion	1,227	0	1,227	DELETE[4]
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	13.28%	20.00%	20.00%[4]
30	Number of case months (home and community-based services)	550,436	613,671	550,436	Per Estimates[1]
31	Number of case months services purchased (Nursing Home)	619,387	531,468	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 2014-2015 (Words)		Approved Prior Year Standards FY 2013-2014 (Numbers)	Prior Year Actual FY 2013-2014 (Numbers)	Approved Standards for FY 2014-2015 (Numbers)	Requested FY 2015-2016 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	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	20.37%	25.00%	25.00%[4]
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	16.25%	20.00%	20.00%[4]
34	Number of case months services purchased (elderly and disabled)	1,877,040	284,904	1,877,040	DELETE[4]
35	Number of case months services purchased (families)	9,850,224	8,932,404	9,850,224	DELETE[4]
Program: Program: Health Care Regulation			**Code: 68700700**		
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]

Approved Performance Measures for FY 2014-2015 (Words)		Approved Prior Year Standards FY 2013-2014 (Numbers)	Prior Year Actual FY 2013-2014 (Numbers)	Approved Standards for FY 2014-2015 (Numbers)	Requested FY 2015-2016 Standard (Numbers)
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]
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 2014-2015 (Words)	Approved Prior Year Standards FY 2013-2014 (Numbers)	Prior Year Actual FY 2013-2014 (Numbers)	Approved Standards for FY 2014-2015 (Numbers)	Requested FY 2015-2016 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.	100.00%	100.00%	100.00%	100.00%[4]
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 Subscriber Assistance Program cases	53	See New Measure 52A Below	53	REVISE[4]
52A	New Measure - Average processing time (in days) for Subscriber Assistance Program and Beneficiary Assistance Program cases	N/A	N/A	N/A	53[4]
53	Number of construction reviews performed (plans and construction)	4,500	5,007	4,500	4,500

	Approved Performance Measures for FY 2014-2015 (Words)	Approved Prior Year Standards FY 2013-2014 (Numbers)	Prior Year Actual FY 2013-2014 (Numbers)	Approved Standards for FY 2014-2015 (Numbers)	Requested FY 2015-2016 Standard (Numbers)
54	Number of new enrollees provided with choice counseling	520,000	359,000	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
55	New Measure - Percent of renewal applications received electronically via the Online Licensing Application	N/A	N/A	N/A	30.00%[4]
56	New Measure - Average processing time (in days) for financial reviews	N/A	N/A	N/A	3.00[4]

[1] These estimates are established by Estimating Conference and represent anticipated counts and are not performance measures.
[2] There have been no complaints of HMO patient dumping received by this agency for several years. If any such complaints were to be received, they would be investigated.
[3] The Department of Health now takes its own practitioner calls. These are no longer done by 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 2014

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 2014

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%	71.80%	18.20%	20.20%

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 standard of 90 percent reflected the target goal of having children re-enroll in KidCare or find another form of insurance. Through further study, it has been determined that it is impossible to accurately capture the insurance status of children who choose, for whatever reason, not to re-enroll in KidCare. In addition, with the launch of the ACA insurance plans, children may have moved to other plans at a greater rate than normal in the past year.

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.

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

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

☐ Training
☐ Technology
☐ Personnel
☒ Other (Identify)

Recommendations: The measure should be changed to reflect re-enrollment in KidCare only. The standard should be revised to 75.00 percent to reflect this change. Enrollment and re-enrollment and the impact of the ACA on insurance status of Title XXI children should be monitored closely.

Office of Policy and Budget – July 2014

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
85.00%	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: 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 ☒ 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: Inconsistent data is collected.

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

Office of Policy and Budget – July 2014

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 2014

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%	92.81%	2.19%	3.40%

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: The approved standard should be 90.00 percent which reflects a performance goal in line with national averages. The program had an approval rating higher than the national average.

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 approved standard is too high and does not provide an accurate target goal for the program. 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 above 90.00 percent levels of satisfaction demonstrate a very high level of approval with the program and reflects a performance level above the national average.

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. Standard should be revised to 90.00 percent to reflect the national standard.

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Children's Special Health Care/68500100
Measure #8: Total Number of Title XXI-eligible Children Enrolled in Kidcare

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
228,159	238,448	10,289	4.51%

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 launch of the ACA and health care exchanges has identified an increasing number of children eligible for Title XXI programs. Standards and expectation will need to reflect the additional outreach (and subsequently larger numbers of identified eligible children) that the publicity for the ACA provides.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: It is recommended that the standard for this measure be changed to 237,377 to reflect the actual enrollment expectations based upon the Social Services Estimating Conference (SSEC).

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Children's Special Health Care/68500100
Measure #9: Number of Title XXI-eligible Children Enrolled in Florida Healthy Kids

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
195,867	192,458	3,409	1.70%

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 launch of the Affordable Care Act (ACA) and health care exchanges has identified an increasing number of children eligible for Title XXI programs. This includes a higher percentage than previously identified that are eligible for different components of KidCare other than Healthy Kids. This is evident in the lower than expected number of children enrolling in Healthy Kids (i.e., this measure) and the much higher number of children enrolling in MediKids.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☐ Other (Identify)
Recommendations: It is recommended that the standard for this measure be changed to 191,200 to reflect the actual enrollment expectations based upon the SSEC.

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Children's Special Health Care/68500100
Measure #10: Number of Title XXI-eligible Children Enrolled in MediKids

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
2,100	27,441	25,341	1206.70%

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 approved standard does not reflect recent trends for the population in this program. 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 the standard for this measure be changed to 30,173 to reflect the actual enrollment expectations based upon the SSEC.

Office of Policy and Budget – July 2014

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 ☒ 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
111,292	18,549	92,743	80.00%

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 the actual enrollment numbers.

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 approved standard does not reflect recent trends for the population in this program. 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 ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: It is recommended that the standard for this measure be changed to 14,836 to reflect the actual enrollment expectations based upon the SSEC.

Office of Policy and Budget – July 2014

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.

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #15A: Percent of 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:
☒ Performance Assessment of Outcome Measure ☒ Revision of Measure
☐ Performance Assessment of Output Measure ☐ Deletion of Measure
☐ Adjustment of GAA Performance Standards

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
25.00%	30.11%	5.11%	20.40%

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: Data collection did not capture all the elements to completely replicate the methods used by the national research agency to calculate this measure since some exclusionary criteria could not be applied. This has led to a higher than expected percentage since the numerator is artificially high. The collection of DRG information which started in 2014 should alleviate this problem in the future.

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 launch of the ACA and health care exchanges has identified an increasing number of children eligible for the Medicaid program. Many of these children likely had not health insurance prior to their enrollment in Medicaid and the large influx of new, previously uninsured recipients may have caused a temporary spike in this measure. Those children that were not in MediPass or a PSN often do not have a single provider, or "medical home" to monitor and coordinate their care.

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

Measure #15A: Percent of 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

Recommendations: With the launch of statewide Medicaid managed care, there will be far fewer children in FFS. Those that remain in FFS will mostly be those in special programs and should have better care regardless. The performance for this measure should improve significantly.

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #15B: Percent of 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:
☒ Performance Assessment of Outcome Measure
☐ Performance Assessment of Output Measure
☐ Adjustment of GAA Performance Standards
☐ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
20.00%	23.06%	3.06%	15.30%

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: Data collection did not capture all the elements to completely replicate the methods used by the national research agency to calculate this measure since some exclusionary criteria could not be applied. This has led to a higher than expected percentage since the numerator is artificially high. The collection of DRG information which started in 2014 should alleviate this problem in the future

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 launch of the ACA and health care exchanges has identified an increasing number of people eligible for the Medicaid program. Many of these new enrollees likely had no health insurance prior to their enrollment in Medicaid and the large influx of new, previously uninsured recipients may have caused a temporary spike in this measure. Those people that were not in MediPass or a PSN often do not have a single provider, or "medical home" to monitor and coordinate their care.

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

Measure #15B: Percent of 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

Recommendations: With the launch of statewide Medicaid managed care, there will be far fewer enrollees in FFS. Those that remain in FFS will mostly be those in special programs and should have better care regardless. The performance for this measure should improve significantly.

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #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%	83.90%	2.10%	2.40%

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: 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.

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #17: Neonatal Mortality Rate per 1000

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
4.70%	4.90%	0.20%	4.10%

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: 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. While the performance did not meet the approved standard for this measure, it does reflect a performance that is better than the national average. The target standard should be set to 5.0 percent to align with national standards.

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

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #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%	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: 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
☐ Technology
☐ Personnel
☒ 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.

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #18A: Percentage of Women with an Interpregnancy Interval (IPI) Greater than or Equal to 18 Months

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%	74.00%	24.00%	N/A

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

External Factors (check all that apply):
☐ Resources Unavailable ☐ Technological Problems
☐ Legal/Legislative Change ☐ Natural Disaster
☒ Target Population Change ☒ Other (Identify)
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission
Explanation: The approved standard of 50 percent was for women who had an IPI greater than 24 to 28 months. As the IPI shortens, even fewer women should fall into the category of failing to have a given IPI between births. Researchers who collect the information for the Agency changed the data reporting method so the percentage of women with an IPI of at least 28 months cannot be identified. The standard should be changed to 75.00 percent to reflect recent trends given the new data reporting.

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

Recommendations: The target IPI should be at least 18 months and the approved standard should be set to 75.00 percent to reflect current trends and the new data reporting.

Office of Policy and Budget – July 2014

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%	46.00%	18.00%	28.10%

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.

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #27: Number of Prescribed Drugs Provided to Elders

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
15,214,293	1,053,200	14,161,093	91.63%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect ☒ Other (Identify)
Explanation: 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 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 ☐ Technology
☐ Personnel ☒ 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 2014

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	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: 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 2014

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
12.60%	N/A	N/A	N/A

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

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

M**anagement Efforts to Address Differences/Problems** (check all that apply):
☐ Training ☒ Technology
☐ Personnel ☐ Other (Identify)
Recommendations: While ambulatory sensitive hospitalizations remain an accepted national standard as part of an overall evaluation of access and preventive care services, the population group previously defined in the 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.

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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 #30: Number of Case Months (Home and Community-based Services)

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
550,436	613,671	63,235	11.50%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect ☒ Other (Identify)
Explanation: 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 Long Term Care (LTC) component of the Statewide Medicaid managed care (SMMC) program completed rollout during FY 2013-2014. Part of the emphasis for LTC under SMMC is the transition of care in institutional settings to community based settings. The standard should therefore reflect a growing emphasis on community based care in the future.

M**anagement Efforts to Address Differences/Problems** (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: Standards should reflect programmatic changes and should be based on estimates for this population established by the Social Services Estimating Conference.

Office of Policy and Budget – July 2014

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
619,387	531,468	87,819	14.20%

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: 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 Long Term Care (LTC) component of the Statewide Medicaid managed care (SMMC) program completed rollout during FY 2013-2014. Part of the emphasis for LTC under SMMC is the transition of care in institutional settings to community based settings. The standard should therefore reflect a growing emphasis on community based care in the future.

M**anagement Efforts to Address Differences/Problems** (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: Standards should reflect programmatic changes and should be based on estimates for this population established by the Social Services Estimating Conference.

Office of Policy and Budget – July 2014

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 2014

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 2014

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
1,877,040	284,904	1,592,136	86.27%

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: 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 ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: The target population and activity group have changed. The measure should be deleted.

Office of Policy and Budget – July 2014

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	8,932,404	917,820	13.92%

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 2014

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%	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: 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 2014

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%	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: 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 2014

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 2014

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 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 2014

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%	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 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
☒ 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 2014

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0.00%	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: 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 ☐ Technological Problems
☐ Legal/Legislative Change ☐ Natural Disaster
☐ Target Population Change ☐ Other (Identify)
☒ This Program/Service Cannot Fix the Problem
☐ Current Laws Are Working Against the Agency Mission
Explanation: The Agency has no control over whether there will be serious deficiencies 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 ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: The Agency is requesting that this measure be deleted.

Office of Policy and Budget – July 2014

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%	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: 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 2014

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%	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: 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 2014

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%	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: 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 2014

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0.00%	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: 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 ☐ Technological Problems
☐ Legal/Legislative Change ☐ Natural Disaster
☐ Target Population Change ☐ Other (Identify)
☒ This Program/Service Cannot Fix the Problem
☐ Current Laws Are Working Against the Agency Mission
Explanation: The Agency has no control over whether there will be serious deficiencies. We can only site and require correction of these deficiencies.

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

Office of Policy and Budget – July 2014

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
6.00%	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'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 ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: The Agency hires staff who are knowledgeable of hospital risk management issues and are available to provide consultation to hospitals (when requested) related to the reporting of "serious incidents". The Agency is requesting that this measure be deleted.

Office of Policy and Budget – July 2014

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

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

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix the Problem
☐ Current Laws Are Working Against the Agency Mission
☒ Technological Problems
☐ Natural Disaster
☐ Other (Identify)
Explanation: Information is no longer collected.

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

Office of Policy and Budget – July 2014

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%	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: 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 2014

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 2014

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
7,550	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 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 ☐ Technological Problems
☐ Legal/Legislative Change ☐ Natural Disaster
☐ Target Population Change ☒ Other (Identify)
☐ This Program/Service Cannot Fix the Problem
☐ Current Laws Are Working Against the Agency Mission
Explanation: The number of surveys fluctuates with the number of facilities that are licensed.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: The Agency is requesting that this measure be deleted because it measures workload not performance.

Office of Policy and Budget – July 2014

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Bureau of Managed Health Care
Program: Subscriber Assistance Program
Service/Budget Entity: Health Care Regulation/68700700
Measure #52: Average Processing Time (in Days) for Subscriber Assistance Program Cases.

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
53	11	42 (Under)	79%

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

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

Recommendations: The Agency requests the approved standard to be updated to 18 days.

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #53: Number of Construction Reviews Performed (Plans and Construction)

Action:

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
4,500	5,007	507 (Over)	11%

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 number of plan reviews fluctuates with the number of reviews requested.

External Factors (check all that apply):

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

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

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

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

Recommendations:

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	359,000	161,000	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 2014

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

Action (check one):

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

Proposed Change to Measure:
N/A

Data Sources and Methodology:
N/A

Proposed Standard/Target:
N/A

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

Office of Policy and Budget – July 2014

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): Children's Medical Service Network 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 or ICD-10 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 2013 for the LRPP published in 2014).

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 and ICD-10 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, 2014

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

Action (check one):

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

Proposed Change to Measure:
N/A

Data Sources and Methodology:
N/A

Proposed Standard/Target:
N/A

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

Office of Policy and Budget – July 2014

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 renew KidCare coverage

Also, the Agency recommends changing the proposed standard from 100.00 percent to 75.00 percent and modifying the data source.

Data Sources and Methodology:
Data is provided to the Florida Institute for Child Health Policy (ICHP) by Florida Healthy Kids 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).

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

Proposed Standard/Target:
75.00 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.

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

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

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 through KidCare 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 and a standard of 75.00 percent would reflect an historically high, but desirable outcome

Office of Policy and Budget – July 2014

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

Action (check one):

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

Proposed Change to Measure:
N/A

Data Sources and Methodology:
N/A

Proposed Standard/Target:
N/A

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

Office of Policy and Budget – July 2014

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 #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 (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:
N/A

Data Sources and Methodology:
N/A

Proposed Standard/Target:
N/A

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

Office of Policy and Budget – July 2014

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 #8: Total Number of Title XXI-eligible Children Enrolled in Kidcare

Action (check one):

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

Proposed Change to Measure:
The target standard should be the estimates established by the SSEC.

Data Sources and Methodology:
FY 2014-2015 SSEC

Proposed Standard/Target:
237,377 (for FY 2015-2016)

Validity:
N/A

Reliability:
N/A

Discussion:
State budget appropriations are based on estimates established by the SSEC. The target standard, and number of children actually enrolling in the program should be measured against that standard.

Office of Policy and Budget – July 2014

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 #9: Number of Title XXI-eligible Children Enrolled in Florida Healthy Kids

Action (check one):

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

Proposed Change to Measure:
The target standard should be the estimates established by the SSEC.

Data Sources and Methodology:
FY 2014-2015 SSEC

Proposed Standard/Target:
191,200 (for FY 2015-2016)

Validity:
N/A

Reliability:
N/A

Discussion:
State budget appropriations are based on estimates established by the SSEC. The target standard, and number of children actually enrolling in the program should be measured against that standard.

Office of Policy and Budget – July 2014

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 #10: Number of Title XXI-eligible Children Enrolled in MediKids

Action (check one):

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

Proposed Change to Measure:
The target standard should be the estimates established by the SSEC.

Data Sources and Methodology:
FY 2014-2015 SSEC

Proposed Standard/Target:
30,173 (for FY 2015-2016)

Validity:
N/A

Reliability:
N/A

Discussion:
State budget appropriations are based on estimates established by the SSEC. The target standard, and number of children actually enrolling in the program should be measured against that standard.

Office of Policy and Budget – July 2014

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:
The target standard should be the estimates established by the SSEC.

Data Sources and Methodology:
FY 2014-2015 SSEC

Proposed Standard/Target:
14,836 (for FY 2015-2016)

Validity:
N/A

Reliability:
N/A

Discussion:
State budget appropriations are based on estimates established by the SSEC. The target standard, and number of children actually enrolling in the program should be measured against that standard. .

Office of Policy and Budget – July 2014

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Executive Direction and Support Services/68500200
Measure #12: Program Administrative Costs as a Percent of Total Program Costs

Action (check one):

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

Proposed Change to Measure:
N/A

Data Sources and Methodology:
N/A

Proposed Standard/Target:
N/A

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

Office of Policy and Budget – July 2014

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 #13: Average Number of Days between Receipt of Clean Medicaid Claim and Payment

Action (check one):

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

Proposed Change to Measure:
N/A

Data Sources and Methodology:
N/A

Proposed Standard/Target:
N/A

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

Office of Policy and Budget – July 2014

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 #14: Number of Medicaid Claims Received

Action (check one):

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

Proposed Change to Measure:
N/A

Data Sources and Methodology:
N/A

Proposed Standard/Target:
N/A

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

Office of Policy and Budget – July 2014

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

Action (check one):

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

Proposed Change to Measure:
N/A

Data Sources and Methodology:
N/A

Proposed Standard/Target:
N/A

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

Office of Policy and Budget – July 2014

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

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 and/or ICD-10 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 1 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. Women eligible for Medicaid through the Family Planning Waiver;
c. 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);
d. Medicaid recipients whose eligibility was determined through the medically needy program;
e. 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 – Page 2

f. Special Low-Income Medicare Beneficiaries (SLMBs) or Qualified Individuals at Level 1 (QI-1s);
g. Title XXI-funded children with chronic conditions who are enrolled in CMSN;
h. Women eligible for Medicaid due to breast and/or cervical cancer;
i. Individuals eligible under a hospice-related eligibility group; and
j. Individuals enrolled in a managed care plan.

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 Diagnoses Related Group (DRG) grouping is used for hospital billing and payment. The ICD-9 and/or ICD-10 codes are used for 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

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 and/or ICD-10 diagnosis codes and Diagnosis Related Groups (DRGs), 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 2013 for the LRPP published in 2014).

Enrollees/beneficiaries are divided into “ages 1 to 20” and “over 21” age groups because the Medicaid benefit package varies for adults and children. Children under 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. SOBRA for pregnant women;
b. Women eligible for Medicaid through the Family Planning Waiver;
c. 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 ICF/DD;
d. Medicaid recipients whose eligibility was determined through the medically needy program;
e. QMBs;

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 – Page 2

f. SLMBs or QI-1s;
g. Title XXI-funded children with chronic conditions who are enrolled in CMSN;
h. Women eligible for Medicaid due to breast and/or cervical cancer;
i. Individuals eligible under a hospice-related eligibility group; and
j. Individuals enrolled in a managed care plan.

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 Diagnoses Related Group (DRG) grouping is used for hospital billing and payment. The ICD-9 and/or ICD-10 codes are used for 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 #16: Percent of all Medicaid women receiving adequate prenatal care

Action (check one):

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

Proposed Change to Measure:
N/A

Data Sources and Methodology:
N/A

Proposed Standard/Target:
N/A

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

Office of Policy and Budget – July 2014

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 #17: Neonatal Mortality Rate per 1000

Action (check one):

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

Proposed Change to Measure:
Establish an appropriate rate that reflects state and/or national trends while controlling for factors unique to the Medicaid population.

Data Sources and Methodology:
The neonatal mortality rate is defined as the number of deaths of infants less than 28 days old per 1,000 deliveries. To obtain information about the Medicaid population, death certificate information is merged with Medicaid eligibility files. The number of deaths of infants to women who were Medicaid eligible during their pregnancy is then divided by the total number of women who were eligible for Medicaid during their pregnancy.

The data source is the Medicaid Maternal and Child Health Status Indicators Report produced under contract annually for the Agency. The data and report are researched and compiled through a partnership with the Maternal Child Health and Education Research and Data Center (MCHERDC) at the University of Florida, and The Lawton and Rhea Chiles Center for Health Mothers and Babies (Chiles Center) at the University of South Florida.

Proposed Standard/Target:
5.0 per 1,000

Validity:
The validity is high. Neonatal mortality is a reflection of problems in the newborn that are linked to the pregnancy and delivery services. The Medicaid program wants to ensure that the quality of care provided to beneficiaries is such as to minimize the incidence of adverse outcomes.

The data, definitions, and calculation procedures are reviewed annually by a data committee that includes representatives of the Agency for Health Care Administration, Department of Health, Centers for Disease Control and Prevention, and other experts.

Reliability:
The measure is very reliable. The Department of Health is responsible for maintaining the death certificate file. Eligibility files are the responsibility of the Department of Children and Families. The system is considered accurate. It forms the basis on which claims for Medicaid services are paid.

Measure #17: Neonatal Mortality Rate per 1000 – Page 2

Discussion:
The non-Medicaid statewide and national neonatal mortality rate has traditionally been between 4 and 6 per 1,000 live births, with Medicaid rates about 2 per 1,000 live births higher than the statewide and national averages. The target measure should reflect the statewide and national average when controlling for such factors as overall health status, socio-economic factors, and so on.

Office of Policy and Budget – July 2014

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 #18: Average Number of Months between Pregnancies for those Receiving Family Planning Services

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:
N/A

Data Sources and Methodology:
N/A

Proposed Standard/Target:
N/A

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

Office of Policy and Budget – July 2014

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 18 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. Healthy Start and the Family Planning Waiver program both advocate optimal spacing between pregnancies in order to ensure the best environment for children and mothers. An IPI of at least 18 months insures 24 or more months between children.

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 University of Florida, Family Data Center which contains Medicaid eligibility, birth certificate, death certificate, and Healthy Start data related to women giving birth in Florida for each year since 1991. Medicaid extracts claims each year which contains the social security number of the person. UF compares this information to the number of women giving birth in the following year and identifies those who had a birth. The IPI for the identified women is then calculated by summing the number of months between pregnancies (measured from the end of the first pregnancy to the beginning of the subsequent pregnancy for all women with a subsequent birth and dividing by the number of women with a subsequent birth. Those with an IPI of 18 months or more are then divided by the total number of women with a subsequent birth to arrive at a percentage.

Proposed Standard/Target:
75.00 percent

Validity:
This is a valid measure for the effectiveness of family planning services. Lengths between children's' births 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 Services to Individuals/68501400
Measure #19: Percent of Eligible Children who received all Required Components of EPSDT Screening

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:
N/A

Data Sources and Methodology:
N/A

Proposed Standard/Target:
N/A

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

Office of Policy and Budget – July 2014

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 #20: Number of children ages 1-20 enrolled in Medicaid

Action (check one):

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

Proposed Change to Measure:
N/A

Data Sources and Methodology:
N/A

Proposed Standard/Target:
N/A

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

Office of Policy and Budget – July 2014

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 #21: Number of children receiving EPSDT services

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:
N/A

Data Sources and Methodology:
N/A

Proposed Standard/Target:
N/A

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

Office of Policy and Budget – July 2014

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 #22: Number of hospital inpatient services provided to children

Action (check one):

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

Proposed Change to Measure:
N/A

Data Sources and Methodology:
N/A

Proposed Standard/Target:
N/A

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

Office of Policy and Budget – July 2014

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 #23: Number of physician services provided to children

Action (check one):

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

Proposed Change to Measure:
N/A

Data Sources and Methodology:
N/A

Proposed Standard/Target:
N/A

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

Office of Policy and Budget – July 2014

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 #24: Number of prescribed drugs provided to children

Action (check one):

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

Proposed Change to Measure:
N/A

Data Sources and Methodology:
N/A

Proposed Standard/Target:
N/A

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

Office of Policy and Budget – July 2014

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 #25: Number of hospital inpatient services provided to elders

Action (check one):

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

Proposed Change to Measure:
N/A

Data Sources and Methodology:
N/A

Proposed Standard/Target:
N/A

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

Office of Policy and Budget – July 2014

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 #26: Number of physician services provided to elders

Action (check one):

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

Proposed Change to Measure:
N/A

Data Sources and Methodology:
N/A

Proposed Standard/Target:
N/A

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

Office of Policy and Budget – July 2014

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 #26: Number of physician services provided to elders

Action (check one):

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

Proposed Change to Measure:
N/A

Data Sources and Methodology:
N/A

Proposed Standard/Target:
N/A

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

Office of Policy and Budget – July 2014

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 #27: Number of Prescribed Drugs Provided to Elders

Action (check one):

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

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

Data Sources and Methodology:
Number of prescribed drugs is based on submitted Medicaid claims and encounter data. Data from the FMMIS is queried by the Agency's Bureau of Medicaid Program Analysis to determine the number of prescribed drugs provided.

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

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

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

Discussion:
The current approved standard does not reflect actual expectations and has not accounted for changes in policy (particularly the implementation of Medicare Part D) that have impacted the number of prescribed drugs provided to elders. State budget appropriations are based on estimates established by the SSEC. The target standard, and number of children actually enrolling in the program should be measured against that standard

Office of Policy and Budget – July 2014

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

Action (check one):

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

Proposed Change to Measure:
N/A

Data Sources and Methodology:
N/A

Proposed Standard/Target:
N/A

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

Office of Policy and Budget – July 2014

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

Action (check one):

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

Proposed Change to Measure:
N/A

Data Sources and Methodology:
N/A

Proposed Standard/Target:
N/A

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

Office of Policy and Budget – July 2014

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 and/or ICD-10 diagnosis codes as well as DRGs, 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 2013 for the LRPP published in 2014).

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 DRG grouping is used for hospital billing and payment. The ICD-9 and/or ICD-10 codes are used for 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 Long-Term Care/68501500
Measure # 30: Number of Case Months (Home and Community-based Services)

Action (check one):

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

Proposed Change to Measure:
N/A

Data Sources and Methodology:
N/A

Proposed Standard/Target:
N/A

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

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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 Long-Term Care/68501500
Measure # 31: Number of Case Months Services Purchased (Nursing Home)

Action (check one):

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

Proposed Change to Measure:
N/A

Data Sources and Methodology:
N/A

Proposed Standard/Target:
N/A

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

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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 Prepaid Health Plans/68501600
Measure # 32: Percent of Hospitalizations for Conditions Preventable with Good Ambulatory Care

Action (check one):

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

Proposed Change to Measure:
N/A

Data Sources and Methodology:
N/A

Proposed Standard/Target:
N/A

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

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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 Prepaid Health Plans/68501600
Measure # 33: Percent of Women and Child Hospitalizations for Conditions Preventable with Good Ambulatory Care

Action (check one):

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

Proposed Change to Measure:
N/A

Data Sources and Methodology:
N/A

Proposed Standard/Target:
N/A

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

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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 Prepaid Health Plans/68501600
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 and/or ICD-10 diagnosis codes and DRGs, using the algorithm and methodology outlined by the federal HHS, AHRQ. The percentage of hospitalizations that occur for ASCs 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 2013 for the LRPP published in 2014).

Enrollees/beneficiaries are divided into “ages 1 to 20” and “over 21” age groups because the Medicaid benefit package varies for adults and children. Children under 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. SOBRA for pregnant women;
b. Women eligible for Medicaid through the Family Planning Waiver;
c. 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 ICF/DD;
d. Medicaid recipients whose eligibility was determined through the medically needy program;
e. 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

f. SLMBs or QI-1s;
g. Title XXI-funded children with chronic conditions who are enrolled in CMSN;
h. Women eligible for Medicaid due to breast and/or cervical cancer;
i. Individuals eligible under a hospice-related eligibility group; and,
j. Individuals enrolled in a managed care plan.

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 Diagnoses Related Group (DRG) grouping is used for hospital billing and payment. The ICD-9 and/or ICD-10 codes are used for 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 Prepaid Health Plans/68501600
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 and/or ICD-10 diagnosis codes and Diagnosis Related Groups (DRGs), 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 2013 for the LRPP published in 2014).

Enrollees/beneficiaries are divided into “ages 1 to 20” and “over 21” age groups because the Medicaid benefit package varies for adults and children. Children under 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 the measure relates to children. This proposed measure is for adults over age 21. The following groups would be excluded from this measure:

a. Sixth Omnibus Budget Reconciliation Act (SOBRA) for pregnant women;
b. Women eligible for Medicaid through the Family Planning Waiver;
c. 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);
d. Medicaid recipients whose eligibility was determined through the medically needy program;
e. 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

f. Special Low-Income Medicare Beneficiaries (SLMBs) or Qualified Individuals at Level 1 (QI-1s);
g. Title XXI-funded children with chronic conditions who are enrolled in CMSN;
h. Women eligible for Medicaid due to breast and/or cervical cancer;
i. Individuals eligible under a hospice-related eligibility group; and
j. Individuals enrolled in a managed care plan.

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 DRG grouping is used for hospital billing and payment. The ICD-9 and/or ICD-10 codes are used for 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 Prepaid Health Plans/68501600
Measure # 34: Number of Case Months Services Purchased (Elderly and Disabled)

Action (check one):

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

Proposed Change to Measure:
N/A

Data Sources and Methodology:
N/A

Proposed Standard/Target:
N/A

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

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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 Prepaid Health Plans/68501600
Measure # 35: Number of Case Months Services Purchased (Families)

Action (check one):

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

Proposed Change to Measure:
N/A

Data Sources and Methodology:
N/A

Proposed Standard/Target:
N/A

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

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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 #36: Percent of Nursing Home Facilities with Deficiencies that Pose a Serious Threat to the Health, Safety, or Welfare of the Public.

Action (check one):

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

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

Survey deficiency data are maintained in the federal Automated Survey Processing Environment (ASPEN) and centrally collected. The number of facilities is obtained from the Agency's regulatory system, VERSA Regulation (VR).

Validity:
The Agency is committed to acting decisively and pursuing more aggressive penalties for poorly performing facilities. Data collected for this outcome enable the Agency to determine how well facilities are performing, but is not a realistic measure of how well the Agency is doing. The facilities have ultimate control over reducing the percentage of deficiencies that pose a serious threat to the health, safety, or welfare of the public.

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

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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 #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 (check one):

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

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

Each confirmed complaint of unlicensed activity, which would result in a cease and desist order, is maintained in the Agency's regulatory system (VR).

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

Each confirmed complaint of unlicensed activity, which would result in a cease and desist order, is maintained in VR.

Reliability:
Centralized collection of data combined with management review of supporting data should ensure accurate and consistent reporting, resulting in reliability for the measure. However, we believe that this condition is impossible to measure accurately. Cease and desist order are not issued by all units for unlicensed activity, nor are they issued for all types of facilities. Unlicensed facilities may emerge under different names and ownership and not be identifiable as repeated unlicensed activity. Also, there is no further action other than another cease and desist order that can be taken by the agency. Unlicensed activity is a crime and should be reported to law enforcement authorities.

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

Data Sources and Methodology:
The Florida Regulatory and Enforcement System/Versa (FRAES/VR) and the Centers for Medicare and Medicaid Services ASPEN Central Office (CMS/ACO) database are used to obtain this information, which comes from a count of all complaints in the system with priority code 1. These are considered the very serious complaints that the Call Center receives. FRAES/VR also identifies which complaints have been investigated and which have not as well as whether or not a complaint was confirmed or not confirmed. The percent of priority 1 consumer complaints that are investigated within two business days comes from a series of computations. First, compute the length of time the priority 1 complaint is received to when it is investigated. The length of time is calculated by subtracting the Received Date from the Survey Start Date. Second, from the listing of complaints, determine how many complaints have a length of time that is two or fewer business days. Third, the percent is comprised by dividing the total number of complaints with a length of time of two or fewer business days by the total number of priority 1 complaints.

Validity:
The measure is based upon complaints entered into the FRAES/VR database and surveys investigated by field operations survey staff that are in the CMS/ACO database. A complaint is a valid transaction that begins with either a call to the call center or correspondence to one of the facility units in the Agency. All such complaints are entered into FRAES/VR to be investigated. Complaints received by the call center are entered into FRAES/VR by the call center staff at the time of the call. Written complaints are tracked through CorrFlow, the Agency's correspondence tracking system. They are entered into the FRAES/VR database by facility unit staff before being sent to the survey staff for investigation and to be entered into the CMS/ACO database.

Reliability:
The measure is as reliable as the input of data into the FRAES/VR and CMS/ACO databases. To the extent that any complaint is "missed" for inputting, it will also be missed for tracking purposes. All reports on this data are pulled directly from FRAES/VR and CMS/ACO.

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Field Operations
Service/Budget Entity: Field Operations
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
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

Data Sources and Methodology:
The Florida Regulatory and Enforcement System/Versa (FRAES/VR) and the Centers for Medicare and Medicaid Services ASPEN Central Office (CMS/ACO) database are used to obtain this information, which comes from a count of all complaints in the system with priority code 1. These are considered the very serious complaints that the Call Center receives. FRAES/VR also identifies which complaints have been investigated and which have not as well as whether or not a complaint was confirmed or not confirmed. The percent of priority 1 consumer complaints that are investigated within two business days comes from a series of computations. First, compute the length of time the priority 1 complaint is received to when it is investigated. The length of time is calculated by subtracting the Received Date from the Survey Start Date. Second, from the listing of complaints, determine how many complaints have a length of time that is two or fewer business days. Third, the percent is comprised by dividing the total number of complaints with a length of time of two or fewer business days by the total number of priority 1 complaints.

Validity:
The measure is based upon complaints entered into the FRAES/VR database and surveys investigated by field operations survey staff that are in the CMS/ACO database. A complaint is a valid transaction that begins with either a call to the call center or correspondence to one of the facility units in the Agency. All such complaints are entered into FRAES/VR to be investigated. Complaints received by the call center are entered into FRAES/VR by the call center staff at the time of the call. Written complaints are tracked through CorrFlow, the Agency's correspondence tracking system. They are entered into the FRAES/VR database by facility unit staff before being sent to the survey staff for investigation and to be entered into the CMS/ACO database.

Reliability:
The measure is as reliable as the input of data into the FRAES/VR and CMS/ACO databases. To the extent that any complaint is "missed" for inputting, it will also be missed for tracking purposes. All reports on this data are pulled directly from FRAES/VR and CMS/ACO.

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Action (check one):

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

Data Sources and Methodology:
This measure is defined as the number of accredited hospitals and ambulatory surgical centers (ASCs) that have been cited for deficiencies during the period, divided by the total number of accredited hospitals and ASCs. Deficiencies that are cited are not tabulated individually (i.e. if five deficiencies are cited during a survey, it is reported as one deficiency in the numerator). In addition, deficiencies that are noted include any and all deficiencies from minor to severe. A national accrediting body confers accreditation. If a facility is accredited, a full licensure survey is not required to be performed biennially. A validation survey (same as a full licensure survey) is performed on a sample of facilities. Deficiencies may also be found during complaint investigations of accredited facilities. A life safety inspection is required annually for hospitals and ASCs. Life safety inspections evaluate the control and prevention of fire and other life-threatening conditions on the premises for the purpose of preserving human life. Emergency access standards require every hospital to treat and/or stabilize any patient admitted for an emergency medical condition.

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

Validity:
The Agency is committed to ensuring health care services' compliance with standards of safety, quality and accessibility established by state and federal regulations. This outcome measure will enable the Agency to monitor its goal of decreasing the percentage of accredited hospitals and ambulatory surgical centers cited for not complying with life safety, licensure or emergency access standards

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

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 #40: Percent of Validation Surveys that are Consistent with Findings Noted during the Accreditation Survey.

Action (check one):
☒ Requesting revision to approved performance measure – Delete measure.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☐ Backup for performance measure.

Data Sources and Methodology:
This measure is defined as the number of state accreditation validation surveys conducted for hospitals that are consistent with findings noted during the accreditation survey divided by the total number of validation surveys performed during the period. A state validation survey is performed, at minimum, on a 5% sample of accredited hospitals that have received their accreditation survey. This measure does not include federal accreditation validation surveys.
The Joint Commission (JC) provides to the Agency a monthly report that lists accreditation surveys scheduled for the next six weeks. This report is provided to the Manager of the Hospital Unit and the Chief of Field Operations on the last day of each month. Hospital Unit staff review the JC list within five days of receipt and pull a sample of 5-10% of facilities (or a minimum of one) to be surveyed for state licensure validation inspection to be completed within 60 days of the survey end date noted on the report. To insure statewide distribution of facilities selected for validation surveys, the facilities that have a significant volume of complaint allegations and Risk Management deviations during the previous or current year will be identified for validation survey. Additional validation inspections in excess of the mandatory 5% random sampling will be selected by the Hospital Unit under consultation with the Chief of Field Operations and Field Office Management.

Validity:
A validation survey assesses whether the review by the accrediting organization has adequately evaluated the facility according to minimum state standards (same as a full licensure survey). Validation survey data are maintained in the federal Automated Survey Processing Environment (ASPEN)

Reliability: Hospital Unit staff compares the Agency validation survey results with the JC survey utilizing a decision matrix developed by Health Standards and Quality/Field Operations staff and make the following notation in the Agency's regulatory system (VR) comment field: "consistent with accreditation findings" or "not consistent with accreditation findings". The review is completed within 30 days of receipt of both the state and JC reports. The data entry is completed within 10 days of the review.
Data maintained in ASPEN and VR are centrally collected. Centralized collection of data and management review of supporting data should ensure accurate and consistent reporting.

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 #41: Percent of Assisted Living Facilities with Deficiencies that Pose a Serious Threat to the Health, Safety, or Welfare of the Public.

Action (check one):

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

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

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

Validity:
The Agency is committed to acting decisively and pursuing more aggressive penalties for poorly performing facilities. Data collected for this outcome enable the Agency to determine how well facilities are performing, but is not a realistic measure of how well the Agency is doing. The facilities have ultimate control over reducing the percentage of deficiencies that pose a serious threat to the health, safety, or welfare of the public.

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

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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 #42: Percent of Home Health Agencies with Deficiencies that Pose a Serious Threat to the Health, Safety, or Welfare of the Public.

Action (check one):

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

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

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

Validity:
The Agency is committed to acting decisively and pursuing more aggressive penalties for poorly performing facilities. Data collected for this outcome enable the Agency to determine how well facilities are performing, but is not a realistic measure of how well the Agency is doing. The facilities have ultimate control over reducing the percentage of deficiencies that pose a serious threat to the health, safety, or welfare of the public.

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

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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 #43: Percent of Clinical Laboratories with Deficiencies that Pose a Serious Threat for Not Complying with Life Safety, Licensure or Emergency Access Standards.

Action (check one):

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

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

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

Validity:
The Agency is committed to acting decisively and pursuing more aggressive penalties for poorly performing facilities. Data collected for this outcome enable the Agency to determine how well facilities are performing, but is not a realistic measure of how well the Agency is doing. The facilities have ultimate control over reducing the percentage of deficiencies that pose a serious threat to the health, safety, or welfare of the public.

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

Office of Policy and Budget – July 2014

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 #44: Percent of Ambulatory Surgical Centers with Deficiencies that Pose a Serious Threat to the Health, Safety, or Welfare of the Public.

Action (check one):

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

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

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

Validity:
The Agency is committed to acting decisively and pursuing more aggressive penalties for poorly performing facilities. Data collected for this outcome enable the Agency to determine how well facilities are performing, but is not a realistic measure of how well the Agency is doing. The facilities have ultimate control over reducing the percentage of deficiencies that pose a serious threat to the health, safety, or welfare of the public.

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

Office of Policy and Budget – July 2014

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 #45: Percent of Hospitals with Deficiencies that Pose a Serious Threat to the Health, Safety, or Welfare of the Public.

Action (check one):

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

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

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

Validity:
The Agency is committed to acting decisively and pursuing more aggressive penalties for poorly performing facilities. Data collected for this outcome enable the Agency to determine how well facilities are performing, but is not a realistic measure of how well the Agency is doing. The facilities have ultimate control over reducing the percentage of deficiencies that pose a serious threat to the health, safety, or welfare of the public.

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

Office of Policy and Budget – July 2014

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Action (check one):

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

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

Methodology: The number of hospitals that were cited for failure to report an adverse incident divided by the total number of hospitals that were surveyed for risk management activities.

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

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

Office of Policy and Budget – July 2014

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

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 from Health Care Services Service/Budget Entity to Executive Direction and Support Services/68500200.

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

Proposed Standard/Target:
Per Estimating Conference

Validity:
N/A

Reliability:
N/A

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

Office of Policy and Budget – July 2014

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Bureau of Managed Health Care
Program: Managed Health Care
Service/Budget Entity: Health Care Regulation/68700700
Measure #48: Percent of Complaints of HMO Patient Dumping Received that are Investigated.

Action (check one):

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

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

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

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

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

Office of Policy and Budget – July 2014

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Bureau of Managed Health Care
Program: Managed Health Care
Service/Budget Entity: Health Care Regulation/68700700
Measure #48A: Percent of Complaints 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 CIRTS data base.

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

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

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

Office of Policy and Budget – July 2014

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation
Measure #49: Percent of Complaints of Facility Patient Dumping Received that are Investigated.

Action (check one):

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

Data Sources and Methodology:
The Florida Regulatory and Enforcement System/Versa (FRAES/VR) and the Centers for Medicare and Medicaid Services ASPEN Central Office (CMS/ACO) database database is used to obtain this information, which comes from a count of all complaints in the system with allegation code 48. These are Medicare and Medicaid Patient Dumping, respectively. FRAES/VR also identifies which complaints have been investigated and which have not as well as whether or not a complaint was confirmed or not confirmed. The standard is based on the total number of complaints of facility patient dumping.

Validity:
The measure is based upon complaints entered into the FRAES/VR database and surveys investigated by field operations survey staff that are in the CMS/ACO database. A complaint is a valid transaction that begins with either a call to the call center or correspondence to one of the facility units in the Agency. All such complaints are entered into FRAES/VR to be investigated. Complaints received by the call center are entered into FRAES/VR by the call center staff at the time of the call. Written complaints are tracked through CorrFlow, the Agency's correspondence tracking system. They are entered into the FRAES/VR database by facility unit staff before being sent to the survey staff for investigation and to be entered into the CMS/ACO database.

Reliability:
The measure is as reliable as the input of data into the FRAES/VR and CMS/ACO databases. To the extent that any complaint is "missed" for inputting, it will also be missed for tracking purposes. All reports on this data are pulled directly from FRAES/VR and CMS/ACO.

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

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:
Related to the Agency Complaint & Information Call Center Contract (current contract # HQA012, expiring 12/31/2013): Prior to July 1, 2009, a caller could choose a dedicated option for practitioner-related calls from the automated voice response system at the call center. The number of inquiries to the call center regarding practitioner licensure and disciplinary information was captured by data entry into the call center vendor's data base, as the call was taken. This number was provided to the Agency Contract Manager on a monthly basis as part of the reporting, required by the contract terms.

Validity:
We are unable to provide this data for the current reporting period because we discontinued handling practitioner-related calls effective July 1, 2009. The Department of Health (DOH) had already established an active toll-free number for these types of calls prior to July 2009. 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. Currently, if callers call the Agency Call Center requesting practitioner information, they are referred to DOH for assistance.

Reliability:

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 #51: Total Number of Full Facility Quality-of-Care Surveys Conducted.

Action (check one):

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

Data Sources and Methodology:
A full facility survey is defined as initial, validation, and renewal licensure and certification surveys. Plans and Construction surveys are not included. Licensure and certification surveys performed together, for the same facility, count as one survey. Full surveys do not include separate life safety surveys, risk management surveys, or complaint investigations. Survey data are maintained in the federal Automated Survey Processing Environment (ASPEN) and centrally collected. This allows a count of the actual number of surveys conducted during any given period. Centralized aggregation of this data will ensure consistency among several facility types.

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

Reliability:
Survey data are maintained in the federal Automated Survey Processing Environment (ASPEN) and centrally collected. Centralized collection of data and management review of supporting data should ensure accurate and consistent reporting, resulting in reliability of the measure.

Office of Policy and Budget – July 2014

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Bureau of Managed Health Care
Program: Subscriber Assistance Program
Service/Budget Entity: Health Care Regulation/68700700
Measure #52: Average Processing Time (in Days) for Subscriber Assistance Program Cases.

Action (check one):

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

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

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

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

Office of Policy and Budget – July 2014

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 #53: Number of Construction Reviews Performed (Plans and Construction).

Action (check one):

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

Data Sources and Methodology:
All plans and construction projects are tracked in the Office of Plans and Construction Tracking (OPCTrack) computer system. This is an electronic database that contains an accounting of all projects, facilities, submissions and time invoiced by all reviewers. Data in this system can be accessed for any timeframe for various facility types of reviews. The Agency produces monthly reports using this data source. A query is made in the system to generate the number of submissions (or reviews) to which time was billed during the period. A submission occurs when a project is logged into the system and each time a review of plans and construction sites occurs.

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

Reliability:
Project time sheets are reviewed and approved by the supervisors. One person enters the data from these sheets into the data system. There are various electronic flags in the system that will signal false data entry, i.e., incorrect date, incorrect log number, projects already closed, etc. External factors relating to available funding for health care construction have a direct impact on the number of projects submitted for review each year. Electronic data has been randomly checked against manual source material and been found to be substantially error free.

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 2014

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 #55: Percent of Renewal Applications Received Electronically via the Online Licensing Application

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 and is relevant to determine the success and adoption of the Agency's transition to submission and completion of online renewal applications.

Data Sources and Methodology: The data sources will be the data from Online Licensing and the Agency's licensure database VERSA. The methodology is straight forward and is simply the number of renewal applications submitted via Online Licensing divided by the total number of applications that were renewed during the specified time period = percent of renewal applications that were submitted online.

Proposed Standard/Target: 75%

Validity: The target is based on provider responses to the customer service survey regarding the preference of online application submission to paper application submission. The measure is a valid way to identify the level of adoption of the online licensing system and whether or not it has been successful based on our target. Because it is a percentage, fluctuations in provider types and amounts year-over-year will not distort the relevance of the measure.

Reliability: The measure will be highly reliable as all of the inputs in the calculation are system generated data.

Discussion: Based on survey data from our providers, the ultimate target is 75%; however, it is expected to take two years to reach this level after initial deployment of the first provider type.

Office of Policy and Budget – July 2014

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 #56: Average Processing Time (in Days) for Financial Reviews

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: Applicants for initial and change of ownership licenses are required to submit financial information as documentation of proof of financial ability to operate. This is a new measure of efficiency and timeliness for the processing and review of an applicant's financial information required to be submitted with initial and change of ownership licensure applications.

Data Sources and Methodology: Currently, processing times are tracked manually using a tracking log on a shared site which captures the dates the financial information is received by the Financial Analysis Unit and the review is completed. The methodology is the number of workdays from the date the application was received by the Financial Analysis Unit to the date that the approval, denial, or omission memo is sent to the Licensure Unit for the application in question. The number of workdays for each application are added together and divided by the total number of reviews to calculate the average workday for a specified period.

Proposed Standard/Target: 3 Business Days

Validity: This stat is reported monthly and reviewed by the supervisor.

Reliability: Because this is tracked manually in a log, data entry errors could exist. This is mitigated by the fact that this stat is reported monthly and reviewed by the supervisor for outliers and sampled for validity.

Discussion:

Office of Policy and Budget – July 2014

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 2014-2015 (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 2014-2015 (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 2014-2015 (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 2014-2015 (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 2014-2015 (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 2014-2015 (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 2014-2015 (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 2014-2015 (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 2014-2015 (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 2014-2015 (Words)	Associated Activities Title
30	Number of case months (home and community-based services)	Home and Community Based Services ACT5030 Capitates Nursing Home Diversion Waiver ACT5060
31	Number of case months services purchased (Nursing Home)	Nursing Home Care ACT5020 Other ACT5070
Medicaid Prepaid Health Plan		**Code: 68501600**
32	Percent of hospitalizations for conditions preventable by good ambulatory care	Prepaid Health Plans Elderly and Disabled ACT1620 Prepaid Health Plans - Family ACT1650
33	Percent of women and child hospitalizations for conditions preventable with good ambulatory care	Prepaid Health Plans - Family ACT1650

Approved Performance Measures for FY 2014-2015 (Words)		Associated Activities Title
33A	New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Ages 1-20 in full service capitated managed health care plans	Prepaid Health Plans - Family ACT1650
33B	New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Ages 21 and over in full service capitated managed health care plans	Prepaid Health Plans - Family ACT1650
34	Number of case months services purchased (elderly and disabled)	Prepaid Health Plans Elderly and Disabled ACT1620
35	Number of case months services purchased (families)	Prepaid Health Plans - Family ACT1650

Approved Performance Measures for FY 2014-2015 (Words)		Associated Activities Title
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
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

Approved Performance Measures for FY 2014-2015 (Words)		Associated Activities Title
39	Percent of accredited hospitals and ambulatory surgical centers cited for not complying with life safety, licensure or emergency access standards	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
40	Percent of validation surveys that are consistent with findings noted during the accreditation survey	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
41	Percent of assisted living facilities with deficiencies that pose a serious threat to the health, safety or welfare of the public	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
42	Percent of home health facilities with deficiencies that pose a serious threat to the health, safety or welfare of the public	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
43	Percent of clinical laboratories with deficiencies that pose a	Health Facility Regulation (Compliance, Complaints) - Field Offices

Approved Performance Measures for FY 2014-2015 (Words)		Associated Activities Title
	serious threat for not complying with life safety, licensure or emergency access standards	Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
44	Percent of ambulatory surgical centers with deficiencies that pose a serious threat to the health, safety or welfare of the public	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
45	Percent of hospitals with deficiencies that pose a serious threat to the health, safety or welfare of the public	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
46	Percent of hospitals that fail to report serious incidents (agency identified)	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
47	Percent of new Medicaid recipients voluntarily selecting managed care plan	Health Facilities and Practitioner Regulation - Medicaid Choice Counseling ACT7150

	Approved Performance Measures for FY 2014-2015 (Words)	Associated Activities Title
48	Percent of complaints of HMO patient dumping received that are investigated	Managed Health Care ACT7090
48A	New Measure - Percent of complaints of HMO access to care received that are investigated	Managed Health Care ACT7090
49	Percent of complaints of facility patient dumping received that are investigated	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
50	Number of inquiries to the call center regarding practitioner licensure and disciplinary information	Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020 This measure is no longer handled by the Agency. Was transferred to DOH in 2009 with renewal of call center contract.

Approved Performance Measures for FY 2014-2015 (Words)		Associated Activities Title
51	Total number of full facility quality-of-care surveys conducted	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
52	Average processing time (in days) for Statewide Provider and Subscriber Assistance Panel cases	Subscriber/Beneficiary Assistance Panel ACT7130
53	Number of construction reviews performed (plans and construction)	Plans & Construction ACT7080
54	Number of new enrollees provided 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 2013-14			
SECTION I: BUDGET	**OPERATING**			**FIXED CAPITAL**
TOTAL ALL FUNDS GENERAL APPROPRIATIONS ACT			**24,053,514,688**	**0**
ADJUSTMENTS TO GENERAL APPROPRIATIONS ACT (Supplementals, Vetoes, Budget			**-821,157,207**	**0**
FINAL BUDGET FOR AGENCY			**23,232,357,481**	**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 *	2,257,404	1,000.58	2,258,703,765	
Prepaid Health Plans - Families *	14,217,804	143.04	2,033,774,110	
Elderly And Disabled/Fee For Service/Medipass - Hospital Inpatient * Number of case months Medicaid program services	499,767	3,378.32	1,688,371,501	
Elderly And Disabled/Fee For Service/Medipass - Prescribed Medicines * Number of case months Medicaid program services	499,767	2,033.85	1,016,451,915	
Elderly And Disabled/Fee For Service/Medipass - Physician Services * Number of case months Medicaid program services	499,767	1,338.30	668,836,217	
Elderly And Disabled/Fee For Service/Medipass - Hospital Outpatient * Number of case months Medicaid program services	499,767	934.89	467,228,027	
Elderly And Disabled/Fee For Service/Medipass - Supplemental Medical Insurance * Number of case months Medicaid program	324,225	3,323.54	1,077,573,501	
Elderly And Disabled/Fee For Service/Medipass - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	93,952	285.16	26,791,402	
Elderly And Disabled/Fee For Service/Medipass - Patient Transportation * Number of case months Medicaid program services	499,767	135.14	67,536,127	
Elderly And Disabled/Fee For Service/Medipass - Case Management * Number of case months Medicaid program services	499,767	268.62	134,249,828	
Elderly And Disabled/Fee For Service/Medipass - Home Health Services * Number of case months Medicaid program services	499,767	126.12	63,030,517	
Elderly And Disabled/Fee For Service/Medipass - Therapeutic Services For Children * Number of case months Medicaid program	93,952	394.45	37,059,080	
Elderly And Disabled/Fee For Service/Medipass - Hospital Insurance Benefit * Number of case months Medicaid program	295,541	364.25	107,650,973	
Elderly And Disabled/Fee For Service/Medipass - Hospice * Number of case months Medicaid program services purchased	499,767	208.93	104,417,009	
Elderly And Disabled/Fee For Service/Medipass - Private Duty Nursing * Number of case months Medicaid program services	93,952	1,738.99	163,381,604	
Elderly And Disabled/Fee For Service/Medipass - Other * Number of case months Medicaid program services purchased	499,767	1,407.72	703,529,891	
Women And Children/Fee For Service/Medipass - Hospital Inpatient * Number of case months Medicaid program services	833,655	1,651.73	1,376,976,424	
Women And Children/Fee For Service/Medipass - Prescribed Medicines * Number of case months Medicaid program services	833,655	384.11	320,217,685	
Women And Children/Fee For Service / Medipass - Physician Services * Number of case months Medicaid program services	833,655	969.84	808,515,342	
Women And Children/Fee For Service / Medipass - Hospital Outpatient * Number of case months Medicaid program services	833,655	758.12	632,008,504	
Women And Children/Fee For Service / Medipass - Supplemental Medical Insurance * Number of case months Medicaid program	1,188	165,751.21	196,912,432	
Women And Children/Fee For Service / Medipass - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	840,489	382.05	321,112,586	
Women And Children/Fee For Service / Medipass - Patient Transportation * Number of case months Medicaid program	833,655	88.79	74,020,122	
Women And Children/Fee For Service / Medipass - Case Management * Number of case months Medicaid program services	833,655	19.60	16,339,466	
Women And Children/Fee For Service / Medipass - Home Health Services * Number of case months Medicaid program services	833,655	136.08	113,442,758	
Women And Children/Fee For Service / Medipass - Therapeutic Services For Children * Number of case months Medicaid	722,174	153.35	110,748,384	
Women And Children/Fee For Service / Medipass - Clinic Services * Number of case months and Medicaid program services	833,655	58.05	48,393,307	
Women And Children/Fee For Service / Medipass - Other * Number of case months Medicaid program services purchased	833,655	583.49	486,429,250	
Medically Needy - Hospital Inpatient * Number of case months Medicaid program services purchased	45,119	4,875.87	219,994,585	
Medically Needy - Prescribed Medicines * Number of case months Medicaid program services purchased	45,119	3,105.22	140,104,266	
Medically Needy - Physician Services * Number of case months Medicaid program services purchased	45,119	1,855.06	83,698,258	
Medically Needy - Hospital Outpatient * Number of case months Medicaid program services purchased	45,119	1,985.03	89,562,589	
Medically Needy - Supplemental Medical Insurance * Number of case months Medicaid program services purchased	5,163	1,290.33	6,661,969	
Medically Needy - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services	7,030	198.75	1,397,205	
Medically Needy - Patient Transportation * Number of case months Medicaid program services purchased	45,119	54.11	2,441,574	
Medically Needy - Case Management * Number of case months Medicaid program services purchased	45,119	53.24	2,401,963	
Medically Needy - Home Health Services * Number of case months Medicaid program services purchased	45,119	36.87	1,663,735	
Medically Needy - Therapeutic Services For Children * Number of case months Medicaid program services purchased	7,030	10.52	73,941	
Medically Needy - Other * Number of case months Medicaid program services purchased	45,119	23,491.12	1,059,895,890	
Refugees - Hospital Inpatient * Number of case months Medicaid program services purchased	5,476	577.46	3,162,168	
Refugees - Prescribed Medicines * Number of case months Medicaid program services purchased	5,476	86,028.24	471,090,631	
Refugees - Physician Services * Number of case months Medicaid program services purchased	5,476	571.12	3,127,447	
Refugees - Hospital Outpatient * Number of case months Medicaid program services purchased	5,476	390.60	2,138,913	
Refugees - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services	797	296.98	236,692	
Refugees - Patient Transportation * Number of case months Medicaid program services purchased	5,476	7.49	41,027	
Refugees - Case Management * Number of case months Medicaid program services purchased	5,476	10.46	57,297	
Refugees - Home Health Services * Number of case months Medicaid program services purchased	5,476	23.54	128,927	
Refugees - Therapeutic Services For Children * Number of case months Medicaid program services purchased	797	4.22	3,364	
Refugees - Other * Number of case months Medicaid program services purchased	5,476	301.71	1,652,140	
Nursing Home Care * Number of case months Medicaid program services purchased	45,729	63,597.63	2,908,256,053	
Home And Community Based Services * Number of case months Medicaid program services purchased	68,914	17,025.96	1,173,326,842	
Intermediate Care Facilities For The Developmentally Disabled - Sunland Centers * Number of case months Medicaid program	642	524,951.49	337,018,855	
Mental Health Disproportionate Share Program * Number of case months Medicaid program services purchased	720	100,706.52	72,508,697	
Capitated Nursing Home Diversion Waiver * Number of case months Medicaid program services purchased	19,623	19,504.34	382,733,619	
Purchase Medikids Program Services * Number of case months Medicaid Program services purchased	32,070	1,902.90	61,025,932	
Purchase Children's Medical Services Network Services * Number of case months	19,268	7,152.85	137,821,038	
Purchase Florida Healthy Kids Corporation Services * Number of case months	220,260	1,471.15	324,034,791	
Certificate Of Need/Financial Analysis * Number of certificate of need (CON) requests/financial reviews conducted	2,928	615.62	1,802,541	
Health Facility Regulation (compliance, Licensure, Complaints) - Tallahassee * Number of licensure/certification	45,496	329.90	15,009,277	
Facility Field Operations (compliance, Complaints) - Field Offices Survey Staff * Number of surveys and complaint	44,204	1,095.41	48,421,694	
Health Standards And Quality * Number of transactions	2,941,083	1.21	3,569,125	
Plans And Construction * Number of reviews performed	5,007	1,237.79	6,197,625	
Managed Health Care * Number of Health Maintenance Organization (HMO) and workers' compensation	136	22,047.28	2,998,430	
Background Screening * Number of requests for screenings	204,597	3.95	807,516	
Subscriber Assistance Panel * Number of cases	160	5,074.71	811,953	
TOTAL			**22,689,580,295**	
SECTION III: RECONCILIATION TO BUDGET				
PASS THROUGHS				
TRANSFER - STATE AGENCIES				
AID TO LOCAL GOVERNMENTS				
PAYMENT OF PENSIONS, BENEFITS AND CLAIMS				
OTHER			**503,423,074**	
REVERSIONS			**39,354,208**	
TOTAL BUDGET FOR AGENCY (Total Activities + Pass Throughs + Reversions) - Should equal Section I above. (4)			**23,232,357,577**	

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

(1) Some activity unit costs may be overstated due to the allocation of double budgeted items.
(2) Expenditures associated with Executive Direction, Administrative Support and Information Technology have been allocated based on FTE. Other allocation methodologies could result in significantly different unit
(3) Information for FCO depicts amounts for current year appropriations only. Additional information and systems are needed to develop meaningful FCO unit costs.
(4) Final Budget for Agency and Total Budget for Agency may not equal due to rounding.

Glossary of Terms and Acronyms

- **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.

- **ASC** - The term "ambulatory care sensitive conditions" is a category of physiological disorders of which severe conditions are considered preventable through medication, home care, and a healthy lifestyle. In this way, occurrences and recurrences of emergency hospitalizations and admissions can also be prevented. There are over 20 disorders that can be classified under ambulatory care sensitive conditions, some of which are cardiovascular diseases, diabetes, and hypertension. Other conditions are asthma, chronic urinary tract infections, and gastroenteritis.

- **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.