RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

LONG RANGE PROGRAM PLAN

Agency for Health Care Administration
Tallahassee, Florida 32308

September 30, 2015

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Senate Budget Committee
201 Capitol
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Dear Directors:

Pursuant to chapter 216, F.S., our Long Range Program Plan (LRPP) for the Agency for Health Care Administration is submitted in the format prescribed in the budget instructions. The information provided electronically and contained herein is a true and accurate presentation of our mission, goals, objectives, and measures for the Fiscal Year 2016-17 through Fiscal Year 2020-2021. 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

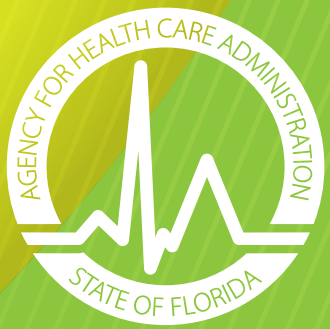
Tonya Kidd
Deputy Secretary for Operations

Florida Agency for Health Care Administration

Long Range Program Plan

Fiscal Year 2016-2017
through
Fiscal Year 2020-2021

Rick Scott
Governor



Elizabeth Dudek
Secretary

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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 100 percent of all facility license renewal applications electronically via the Internet by Fiscal Year 2020-2021.

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 2020-2021.

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 identification of overpayments by five percent originating from detection methods and subsequent Medicaid Program Integrity (MPI) staff audits through Fiscal Year 2020-2021.

Objective 2.B: To increase identification of the amount of overpayments prevented as a result of prevention activities conducted by MPI staff by 10 percent through Fiscal Year 2020-2021.

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

Health Care Services (Division of Medicaid)

Objective 3.A: Transition between two percent (in Fiscal Year 2014-2015 and Fiscal Year 2015-2016) and three 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 (LTC) recipients receive care in nursing homes.

Objective 3.B: For the Healthcare Effectiveness Data and Information Set (HEDIS) measures that are in the Adult and Child Core Sets, improve the percentage of 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.

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: Limit the annual growth in per member per month (PMPM) costs for recipients enrolled in SMMC to less than or equal to five 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 2014-2015	FY 2016-2017	FY 2017-2018	FY 2018-2019	FY 2019-2020	FY 2020-2021
7,311	4,387	5,118	5,849	6,580	7,311
Percent of renewal applications received via Internet	60.00%	70.00%	80.00%	90.00%	100.00%

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 2014-2015	FY 2016-2017	FY 2017-2018	FY 2018-2019	FY 2019-2020	FY 2020-2021
3,886	3,497	3,109	2,720	2,332	1,943
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 2016-2017	FY 2017-2018	FY 2018-2019	FY 2019-2020	FY 2020-2021
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 of overpayments to Medicaid providers in millions directly identified by MPI Staff.

Performance Projection Table 2.A:

Baseline Year FY 2013-2014	FY 2016-2017	FY 2017-2018	FY 2018-2019	FY 2019-2020	FY 2020-2021
$27,450,000*	$28,822,500	$30,323,625	$31,839,806	$33,431,796	$35,103,386
Projected Increase in Percent	5.00%	5.00%	5.00%	5.00%	5.00%

*Report Average: The State's Efforts to Control Medicaid Fraud and Abuse Fiscal Year 2013-2014. Projected identified overpayments in the latter years may include overpayments for providers enrolled in fee-for-serve (FFS) or managed care plans.

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

Performance Projection Table 2.B:

Baseline Year FY 2013-2014	FY 2016-2017	FY 2017-2018	FY 2018-2019	FY 2019-2020	FY 2020-2021
$25,320,000*	$27,852,000	$30,637,200	$33,700,920	$37,071,012	$40,778,113
Projected Increase in Percent	10.00%	10.00%	10.00%	10.00%	10.00%

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 two percent (in Fiscal Year 2014-2015 and Fiscal Year 2015-2016) and three 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 LTC recipients receive care in nursing homes.

Performance Projection Table 3.A:

Baseline Year FY 2013-2014	FY 2016-2017	FY 2017-2018	FY 2018-2019	FY 2019-2020	FY 2020-2021
83,446 Number of Long-Term Care Recipients*	92,392	92,392	92,392	92,392	92,392
45,728 Number of Recipients in Nursing Homes	46,566	45,169	43,814	42,500	41,225
54.80% Percentage in Nursing Homes	54.80%	50.40%	48.89%	47.42%	46.00%
Target Percentage Transitioned	1.00%	2.00%	3.00%	3.00%	3.00%

*Number of LTC recipients is based on enrollment as of July 31, 2015 and projections for Fiscal Year 2016-2017 as of August 2015. Actual future caseloads will change.

Service Outcome Measure 3.B: For the HEDIS measures that are in the Adult and Child Core Sets, improve the percentage of measures for 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.

Service Outcome Measure Projection Table 3.B:

Baseline Year FY 2012-2013	FY 2016-2017	FY 2017-2018	FY 2018-2019	FY 2019-2020	FY 2020-2021
32.00% Percentage of Core HEDIS measures for MMA plans >/= 75th National Medicaid Percentile	49.00%	58.00%	66.00%	75.00%	75.00%

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

Performance Projection Table 3.C:

Baseline Year FY 2014-2015	FY 2016-2017	FY 2017-2018	FY 2018-2019	FY 2019-2020	FY 2020-2021
41,504,316 Total Medicaid Member Months	50,765,612	52,292,000	53,818,964	59,471,251	59,471,251
35,278,669 Target Recipient Member Months in SMMC	43,150,770	44,448,200	45,746,119	50,550,563	50,550,563
31,199,904 Projected Recipient Member Months in SMMC	38,762,820	41,712,516	42,984,000	44,255,964	44,255,964
85.00% Target Percentage of Medicaid Recipient Member Months SMMC	85.00%	85.00%	85.00%	85.00%	85.00%

*Caseload estimates do not extend beyond Fiscal Year 2019-2020

Service Outcome Measure 3.D: Limit the annual growth in per member per month (PMPM) costs for recipients enrolled in SMMC to less than or equal to five percent as measured by 1115 Waiver Budget Neutrality.

Performance Projection Table 3.D:

Baseline Year FY 2014-2015	FY 2016-2017	FY 2017-2018	FY 2018-2019	FY 2019-2020	FY 2020-2021
$318.69 Projected PMPM Costs for SMMC Enrollees	$324.13	$339.04	$354.64	$372.37	$390.99
Target Growth Percentage from Previous Year	4.60%	4.60%	4.60%	5.00%	5.00%

*Budget Neutrality projections only extend through Fiscal Year 2018-2019. Projected Costs for Fiscal Year 2019-2020 and Fiscal Year 2020-2021 are what costs would be if they grew at the maximum rate of five percent per year. Actual PMPM in future years should be lower. PMPM reported reflects the Temporary Assistance to Needy Families (TANF) eligibility group.

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 60 and over were in Florida. Of the 5.2 million forecasted population growth by 2030, Florida's elderly population will account for 57.8 percent of the gain. 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.

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). The provisions in Senate Bill 1986 has enabled the Agency to be more aggressive in enforcing actions taken against non-compliant providers across the state. It also strengthened the Agency's authority to withhold Medicaid payments under certain circumstances. The monthly report submitted to the Senate Committee on Health Regulation includes data on all licensed facilities for provisions that apply to all licensure programs. The report outlines final orders and fines assessed against providers by HQA and Medicaid and provides 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.

Optimizing Resources in Challenging Economic Times

The Agency continues to focus efforts on accomplishing more with the same or reduced resources. HQA's full-time equivalent (FTE) positions (Table 1-1) have remained relatively stable with the exception of those positions that were transferred in Fiscal Year 2012-2013 associated with the realignment of Florida Center from the Admininstratiion and Support budget entity. However, from Fiscal Year 2009-2010 to Fiscal Year 2014-2015, HQA's number of licensed, registered, certified, and regulated service providers and facilities continued to increase from 42,187 to 48,043 in Fiscal Year 2014-2015 (Table 1-2). Overall, this represents a 13.9 percent increase in regulated providers.

Table 1-1:

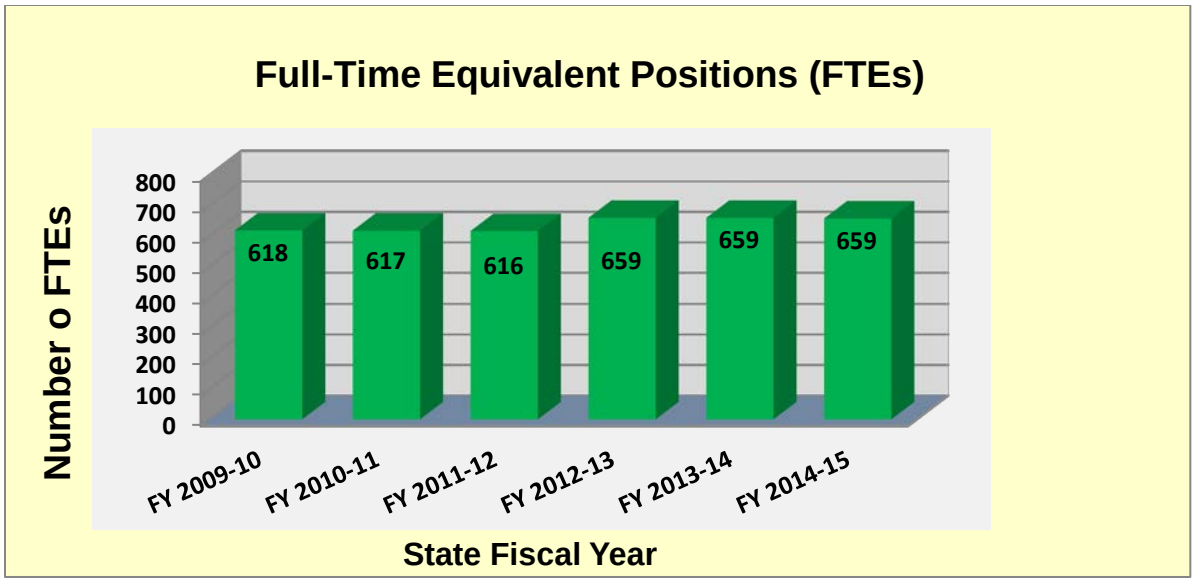
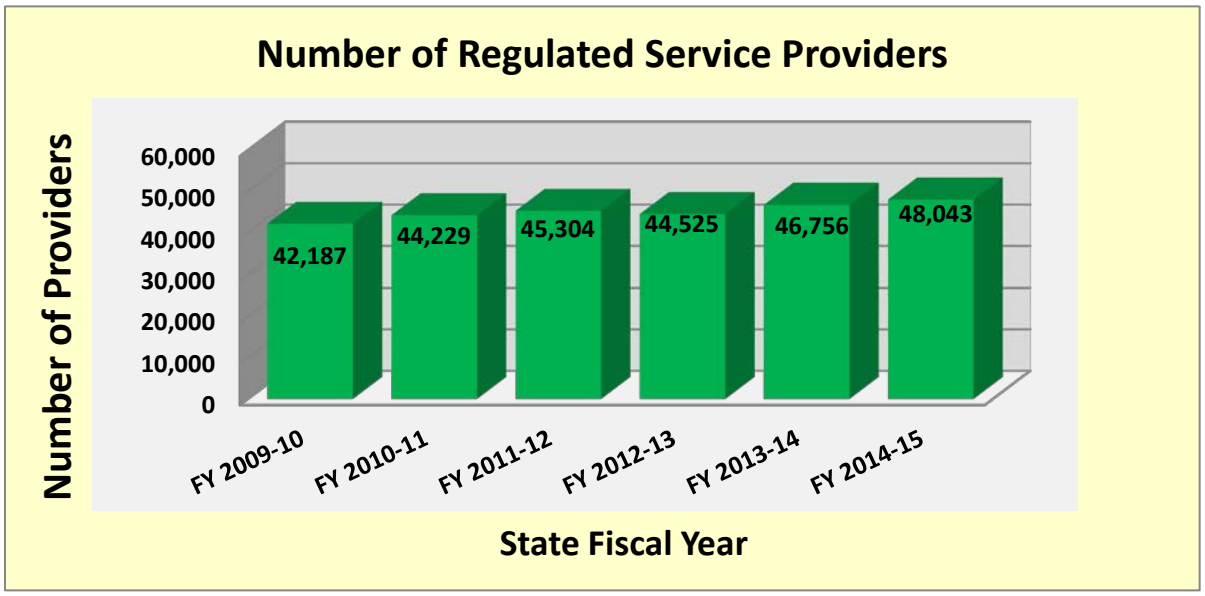


Table 1-2:



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 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. The fully developed system will have 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 and taxpayers 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 paper license applications currently received has incorrect or missing information. Therefore, 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, online licensing is available for renewal of all licensure types. From July 2014 through May 2015 the percentage of renewal applications submitted online has gone from 1.1 percent to 37.4 percent as the Agency rolled out new provider types. Future enhancements will include allowing for changes/updates to submitted applications, initial applications, and change of ownership applications in addition to creating more automated and electronic interaction with the applicant.

Although submission of online renewal applications is currently voluntary, the Agency anticipates wide use and will pursue statutory and rule changes to require online renewal.

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 Department of Children and Families (DCF), the Department of Health (DOH), the Department of Juvenile Justice 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 LTC 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, the DOH, the VR at DOE, managed care health plans, Medicaid Providers, the DCF, and the APD are participating with the remaining agencies expected to be brought on in 2015. Approximately 1,200 individuals a month applying for licensure or their licensure renewals with the DOH are able to use a Clearinghouse screening to reduce duplicative screening and costs. The Agency providers benefit by being able to use more than 1,000 screenings per month from the Clearinghouse. During Fiscal Year 2014-2015, more than 50,000 background screening results were shared among participating agencies and managed care health plans resulting in an overall cost savings of over $4,000,000 to Agency providers, the DOH licensees and managed care health plans, Medicaid providers, and the DCF and the APD providers. The Clearinghouse also includes a Rap Back requirement, known as "retained prints", which enables notification to the Agency of a Florida 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.

Once all specified agencies have integrated on the Clearinghouse, the next step is to implement the Federal Rap Back process. The implementation of the Federal Rap Back (tentatively set for late September 2016) would allow for the Clearinghouse to be notified of all arrests from all states, not just Florida. This process cannot be put into place until the Federal Bureau of Investigation (FBI) has implemented the process with the Florida Department of Law Enforcement (FDLE).

As the Clearinghouse continues to grow, additional system functionalities are needed to maintain an effective background screening system. Some of those further system enhancements include:

1. Updating of the Clearinghouse registration process to create internal user account registration and maintenance features that are federally Criminal Justice Information System (CJIS) security compliant.
2. Add functionality to identify Livescan vendors by location (state) to enable out-of-state vendors' access to improve use by out-of-state applicants who must be screened through the Clearinghouse.
3. Add functionality for criminal registration to improve tracking registered sex offenders, career offenders, and sexual predators in the Clearinghouse.
4. Add additional quality assurance workflow process for criminal history review and exemptions.
5. Develop reporting capabilities for each agency.
6. Connect to Comprehensive Case Information System (CCIS) to receive criminal offense information from county records that are not yet available through FDLE or the FBI.
7. Add functionality to give individual applicants access to initiate their own screenings, providing additional avenues for DOH licensees and others to request Clearinghouse screenings.
8. Add functionality to give third party employment contractors access to initiate screenings and maintain employee rosters on behalf of state agency providers.
9. Connect to the Department of Highway Safety and Motor Vehicles system to enable agency staff to compare driver's license photos to Clearinghouse photos to confirm identity of individual being screened when identify concerns arise.

10. Enhance Livescan vendor and location management within the application.

The Agency will evaluate the structure and resources necessary to efficiently manage the Clearinghouse across multiply Agencies over the next year and decide whether additional or a reallocation of resources and functions will be necessary to meet the administrative needs of the Clearinghouse.

Centralize Enforcement and Tracking

With the Agency's move to a managed care reimbursement system for Medicaid, the Division of HQA repurposed positions in the former Bureau of Managed Care. Part of this repurposing was the creation of the Enforcement Team. The goal for the Enforcement Team is to expand its current role of tracking the status of issues and liquidated damages for Medicaid Managed Care to all final orders and money owed in the Division. The team currently is involved with entering details into our final order case tracking system and processing payments through that system. In the upcoming year, this group will be responsible for ensuring that employees found to be ineligible to work at or own a regulated facility are being referred to licensure for follow-up and enforcement.

By centralizing these functions to a group with expertise in tracking and collection for managed care, the Agency can realize greater efficiencies by:

- Increase timely collection rates and reduce sending receivables to collections;
- Ensure providers are not licensed until all money owed to the Agency is received;
- Ensuring appropriate action is taken to ensure providers employ eligible employees;
- Reduce staff time researching money owed – leading to faster application turnaround times; and
- Accurately and timely report on the enforcement actions of the Agency across the Division.

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 AHCA Docs and FloridaHealthFinder.gov websites. This information is for the general public to use in making important health care decisions. The Agency also continues to maximize the use of available technological resources to provide the health data and information from a single access point, benefiting all stakeholders: consumers, providers, and policy-makers.

Updating and developing technological resources has helped the Agency increase its ability to respond timely and comprehensively to requests for provider information. The AHCA Docs website provides a means for the public to search for documents on health care providers in a single location. Through AHCA Docs, consumers can review inspection reports, legal orders, and Statements of Deficiencies for specific health care providers.

As the Agency has improved the capabilities of its websites and increased online access to consolidated health care data, the popularity of FloridaHealthFinder.gov, a website that provides easy access to health care information on Ambulatory Surgery Centers, Emergency Departments and Hospitals, has grown as well. The website began in 2000 and has gained national recognition as a leader in health care transparency.

In February 2015, the Agency added a Medicaid Consumer Report Card to the FloridaHealthFinder.gov Health Plan landing page. The Medicaid Consumer Report card presents an easily understandable summary of quality, access, and timeliness of performance for MMA health plans in Florida. The report card is also a valuable comparison tool that helps consumers determine the relative value of care offered by managed care health plans and choose the plan that's right for them. The Report Card currently shows the 2013 Healthcare Effectiveness Data and Information Set (HEDIS) for Reform and Non-Reform plans.

The online tools and interactive links accessible through FloridaHealthFinder.gov have also been updated. The Facility/Provider Locator, a tool that allows consumers to search for health care facilities and providers in specified areas and the most popular section of FloridaHealthFinder.gov, was modified to allow for a search of licensed Community Residential Homes (CRH) with less than 15 licensed beds. CRHs include adult family care homes, ALFs, intermediate care facilities for the developmentally disabled, residential treatment centers for adolescents and children, and residential treatment facilities. A search option for off-site out-patient hospital locations has also been added.

Overall, visits to the website for Fiscal Year 2014-2015 increased by 21.54 percent, totaling 3,566,188 visits (Table 1-3). Site visits to FloridaHealthFinder.gov have increased substantially each year since the website was created (Table 1-4); and as the Agency continues to promote transparency and the dissemination of information that informs decision-making, it is expected that this trend will continue.

Table 1-3:

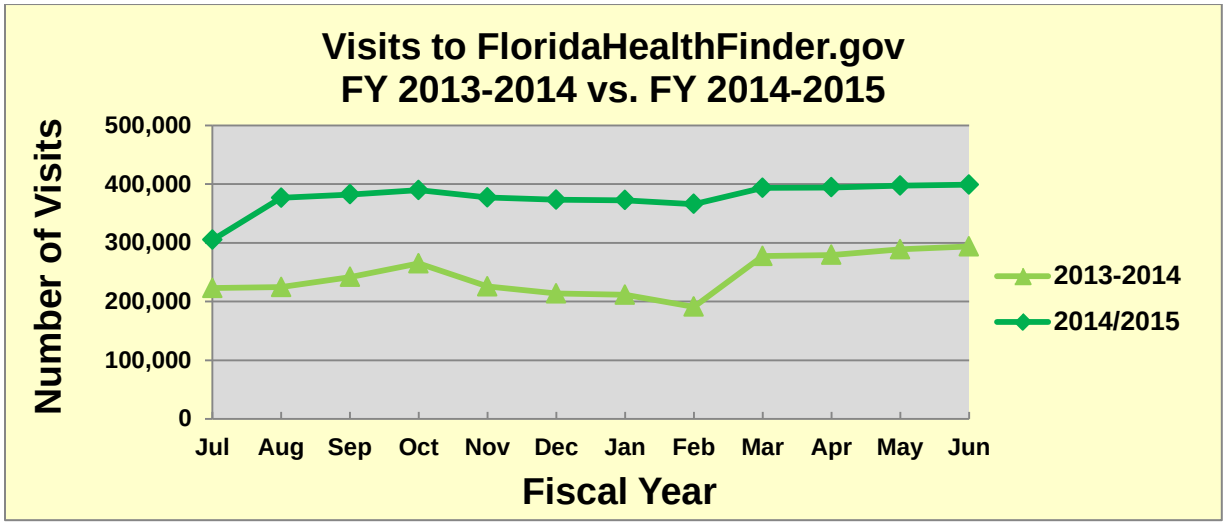
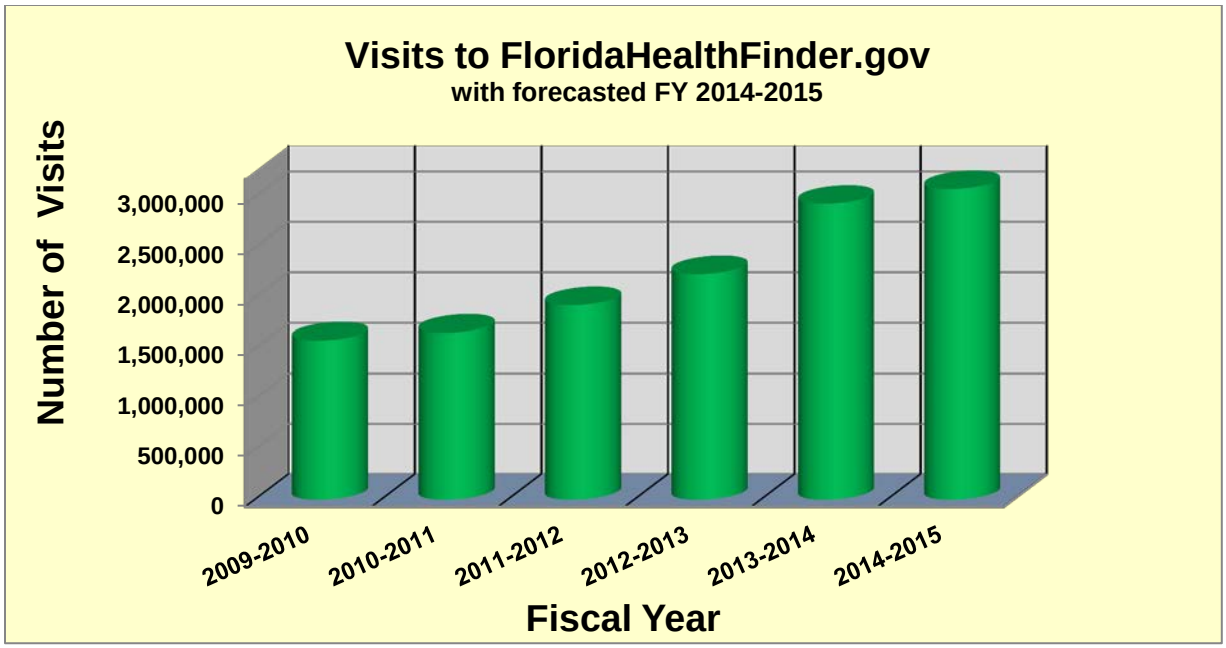


Table 1-4:



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.

Business Intelligence Competency Center (BICC)

The BICC was created to integrate silos of information and data that the Agency collects and maintains. A business intelligence (BI) environment allows us to understand and improve the quality of our delivery system, understand and improve internal performance, and eliminate redundant systems and processes resulting in cost savings, and leverage opportunities for drawing federal match for systems enhancements.

The BICC will:

- Be aware of and review procurements with a technology component;
- Participate in project teams for development and design of proposed technology projects to assure that enterprise needs are considered;
- Develop and maintain a survey of existing BI infrastructure and identify additional needs or potential efficiencies;
- Establish a sole source of truth among data resources and work to assure their integration at the enterprise level; and
- Recommend industry best practices in data governance and data access policies.

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 within the IT, each with clear and distinct responsibilities. Those bureaus 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 (AST)

The AST was established in 2014 by the Florida Legislature, HB 7073 (Chapter No. 2014-221, Laws of Florida), to oversee the state's essential technology projects and house Florida's Chief Information Officer. The agencies will collaborate with AST on new IT architectural standards and strategies and AST will perform project oversight on all state agency IT projects with total costs of $10 million or more as outlined in s. 282.0051(4), F.S.

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 s. 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. 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 s. 282.3055, F.S., to coordinate and facilitate the management and planning of the Agency's IT 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. 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.

In Fiscal Year 2013-2014, at the direction of the Florida Legislature, the Agency began the monumental task of shifting Medicaid recipient from services provided by providers on a FFS basis to services provided by a managed care plan. Currently, approximately 85 percent of the Florida enrolled Medicaid recipients are enrolled in managed care plans.

Fiscal Year 2014-2015 was a year of major adaptation for MPI. MPI performed a functional assessment and adjusted to the changing times by completing a modified reorganization and by shifting resources. The adaptation was completed to ensure that additional oversight is conducted on managed care plans while continuing to ensure that the appropriate oversight is performed on the FFS program providers. Small but necessary changes will continue as needed.

MPI now performs four major functions:

- Prevention & Program Oversight;
- Detection;
- Managed Care Oversight & Compliance; and
- Overpayment Recoupment.

The creation of these focal points are based on historical knowledge of program experience and best practices developed over the years as MPI combated fraud, abuse, and waste in the Florida Medicaid program. This foundation of knowledge and experience will continue to develop to ensure only the best oversight is pursued with the managed care plans and the remaining FFS providers.

Prevention & Program Oversight - The Prevention & Program Oversight Unit was established to enhance the effectiveness of MPI operations. The unit conducts research supplemented by field reviews to identify programmatic issues, to deter fraud and abuse issues, and to develop prevention analysis and strategic planning. The unit recommends collaborative initiatives to facilitate the best use of resources for combating non-compliance in the Medicaid program. The unit serves as the liaison with and makes referrals to the MFCU. In Fiscal Year 2014-2015, referrals to MFCU increased exponentially and this pattern is expected to continue.

Detection - The Detection Unit serves as the point of entry for receipt of and the initial assessment and triage of complaints related to Medicaid fraud and abuse. The triage efforts produce referrals to units within MPI to complete actions such as pre-payment reviews, audits, and managed care oversight. Additionally, the triage efforts result in outside referrals to licensure departments, Medicaid, Medicare, other state and federal agencies, and managed care plans. Provider program suspensions and terminations will continue as a result of the triage activities. The unit's data analytics section will continue to conduct data assessments and validation to develop leads and supports data driven information to support all office functions.

In August 2014, the Agency entered into a contract with SAS Institute, Inc. (SAS), to provide advanced analytic services to supplement the existing MPI detection processes. Likewise, the advanced analytic services will be applied to encounter data for enhanced oversight of the managed care plans.

Managed Care Oversight & Compliance – The Managed Care Oversight & Compliance Unit performs oversight on reporting requirements such as the Anti-Fraud and Compliance Plans, fraud and abuse investigative requirements, and allegations filed against the plan involving

fraud and abuse activities. This newly created unit will evaluate reports and ensure the plans and their special investigative units (SIUs) are adequately addressing fraud, abuse, and waste issues.

Overpayment Recoupment – The Overpayment Recoupment Unit will continue to investigate and perform recovery efforts. These efforts include comprehensive audits involving reviews of medical 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 on specific issues; and the imposition of fines and costs.

MPI will address the increased workload created by the advance analytic services by continuing to use staff in the most effective and efficient manner, by employing such options as procuring an audit vendor(s) to be paid via a contingency basis or other fee arrangements that ensure a high return on investment, and by continuing to work collaboratively with CMS and the Medicaid Integrity Contractor(s) to perform audit services.

Combating fraud, abuse, and waste in the Medicaid program is a comprehensive endeavor requiring effective and efficient use of staff, investigations, assessments, collaboration, prevention measures, recoupment measures, and adaptation. MPI's skilled staff will continue to adjust and improve oversight duties in both the managed care program and the FFS program.

Health Care Services (Division of Medicaid)

Authority for the Medicaid program is established in chapter 409, F.S., (Social and Economic Assistance) and Rule 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, 59.72 percent of the expenditures for most Medicaid services were reimbursed with federal funds in Fiscal Year 2014-15. According to the CMS, federal share of expenditures for Fiscal Year 2015-16 will be 60.67 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 19.6 million in 2014, making it the third most populous state in the nation. Florida's growth rate has been among the fastest in the nation for decades.

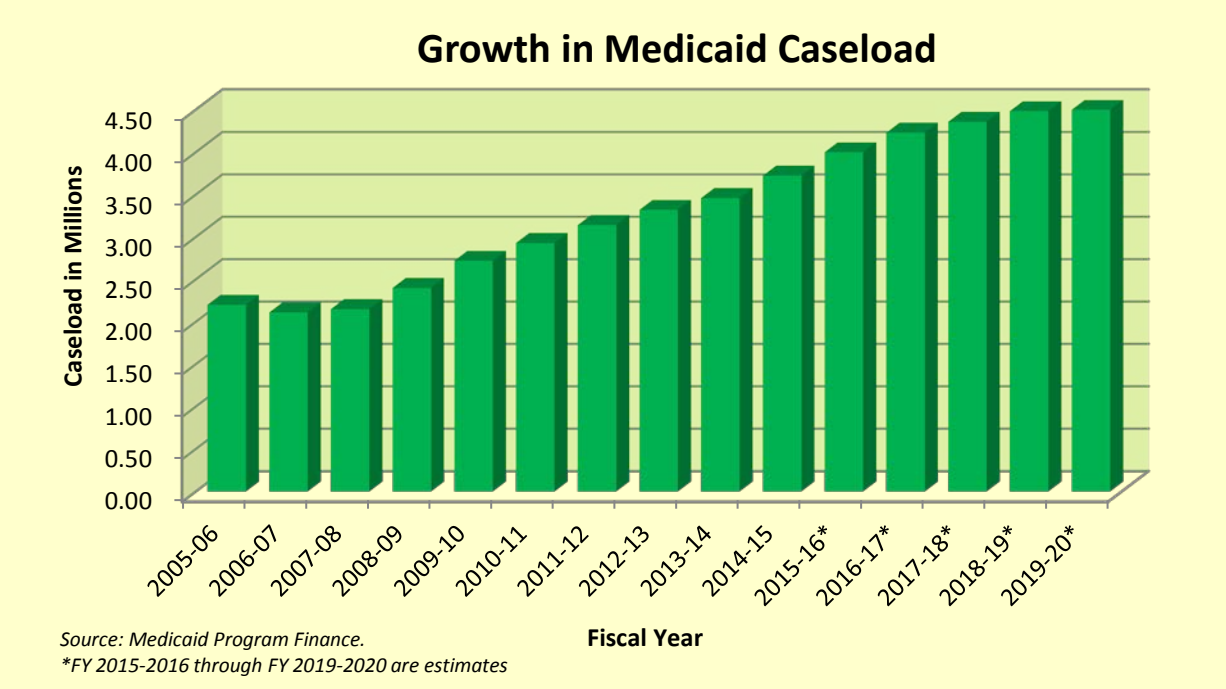
At the time of the 2010 U.S. Census, Florida had the highest percentage (17.3 percent) of elderly residents in the nation. As the baby–boom generation (those born between 1946 and 1964 per U.S. Census Bureau) begins reaching retirement age in the next few years and substantial numbers of retirees relocate 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 Medicaid services and to provide greater predictability of cost increases, Florida implemented the SMMC program. The SMMC program has two key program components: the LTC program and the MMA program. The Agency phased in the SMMC program on a regional basis during 2013 and 2014. The SMMC program was fully implemented on August 1, 2014.

Medicaid Caseload

In Fiscal Year 2014-2015, Medicaid had almost 116,000 fully enrolled providers (providing services to both FFS and managed care recipients) and almost 28,000 registered providers (providing services in health plan provider networks) serving an estimated 3.7 million recipients. With expenditures of $23.5 billion in Fiscal Year 2014-2015, 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 2014-2015 were more than 73 percent higher than a decade ago (Figure 3-1). Total caseload increased by 7.6 percent in Fiscal Year 2014-2015 over the prior fiscal year and is projected to continue increasing in Fiscal Year 2015-2016 by more than 7 percent.

Figure 3-1



Source: Medicaid Program Finance.
**FY 2015-2016 through FY 2019-2020 are estimates*

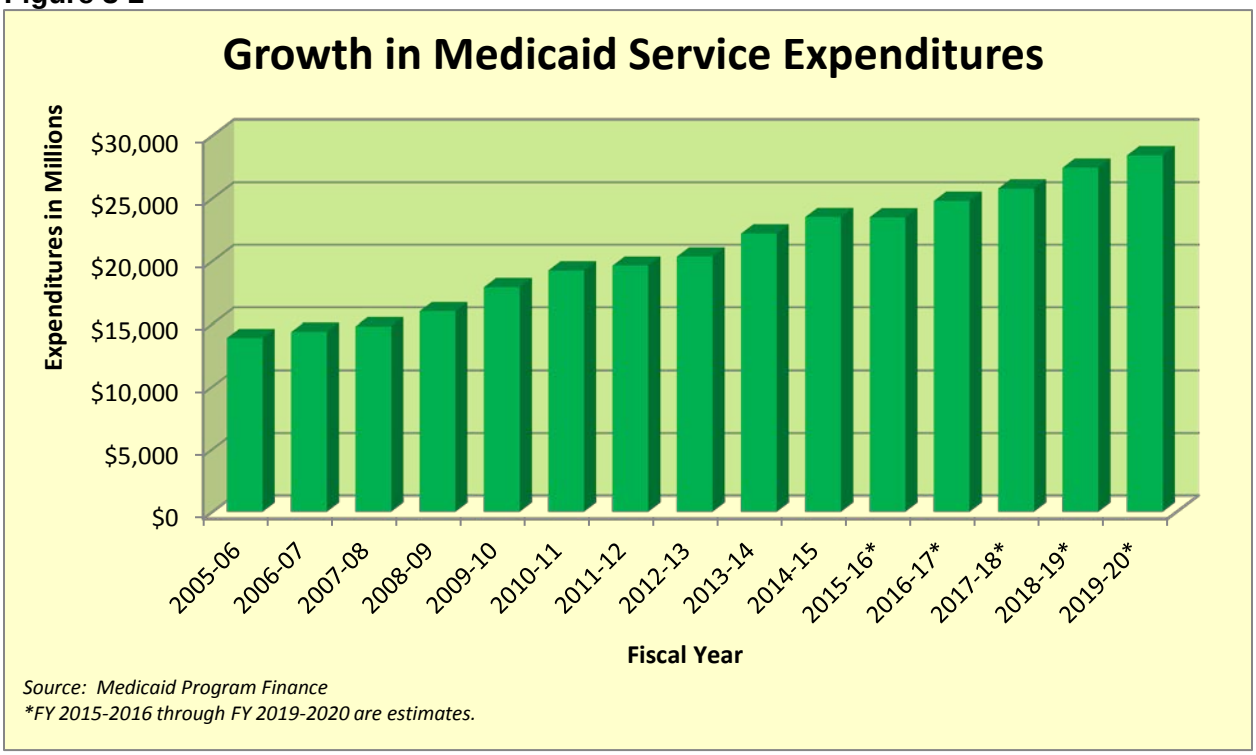
The caseload increases in recent years reflect external factors not within the Medicaid program's control, especially the rapid downturn in the economy in Fiscal Year 2007-2008 through Fiscal Year 2008-2009, with sustained stifled growth and the resulting statewide unemployment rate of 10.6 percent as of June 2011. According to the Florida Department of Economic Opportunity (DEO), as of June 2015, the statewide unemployment rate improved to 5.5 percent. While the economy has improved over the last few years, other external factors such as the launch of the Affordable Care Act (ACA) have continued to drive Medicaid caseloads upward. The federal insurance mandate, coupled with health care exchanges that automatically refer eligible persons to Medicaid, have also contributed to the caseload increase.

Medicaid Expenditures

In the last 10 years, expenditures in the Medicaid program grew 69.3 percent, from almost $13.9 billion in Fiscal Year 2005-2006 to $23.5 billion in Fiscal Year 2014-15 (Figure 3-2). The primary factors contributing to expenditure growth have been an increase in the total caseload and an increase in the costs of providing medical services and long-term care. The largest expenditure categories for Fiscal Year 2014-2015 and expected total expenditures are:

- Prepaid Health Plans ($10.5 billion);
- Prepaid Health Plan/LTC ($3.5 billion);
- Low Income Pool (LIP) ($2.2 billion)
- Supplemental Medical Insurance ($1.3 billion);
- Hospital Inpatient Services ($1.1 billion);

Figure 3-2



Source: Medicaid Program Finance
**FY 2015-2016 through FY 2019-2020 are estimates.*

Health care cost inflation has surpassed cost increases in other economic sectors for years and that continues to be the case today. In order to address these rising costs and minimize the long-term impact on the budget, the 2011 Legislature passed 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 program provides greater cost predictability while ensuring Medicaid recipients continue to have access to quality health care services. The LTC component of SMMC program was implemented between August 2013 and March 2014, and the MMA component of the SMMC program was implemented between May 2014 and August 2014.

The Evolution of Florida Medicaid

Medicaid was implemented as a 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 health care plan was established in 1984. Eventually this led to a program that was a mix of programs including, waiver programs, a FFS population, a FFS primary care case management population (known as MediPass), and a population in prepaid health plans including prepaid dental and mental health programs. Recipients could potentially be enrolled in more than one of these programs and sometimes up to three. For example, a recipient could be enrolled in MediPass for their primary care, a prepaid dental plan for their dental services, and a prepaid mental health plan for their mental health services.

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 health maintenance organizations), 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.

Following Medicaid Reform, the Agency completed implementation of the SMMC program in 2014. The SMMC transitioned a majority of Medicaid recipients into managed health care plans. These health plans are paid a capitation rate to provide all Medicaid covered services to their enrollees.

Statewide Medicaid Managed Care

The Agency implemented significant program changes in the Medicaid program that have resulted in improved efficiency, cost predictability and accountability for the program, and enhanced service provision for program recipients. The most significant change in Medicaid since the program was adopted is the implementation of the SMMC program.

Chapter 2011-134, Laws of Florida, directed 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 to SMMC is complete, many of the previous FFS functions supported by Agency staff have been significantly diminished. With an emphasis on health plan accountability and the oversight of managed care services, there has been a Division-wide shift in the roles and responsibilities to support the need for procurement and contract compliance and monitoring functions.

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

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. LTC under the Medicaid program includes nursing facilities, assistive care services, and home based services. Home based care is provided in ALFs, adult family care homes, and in individual's 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, which ended with the implementation of the LTC program:

- 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.

As of June 30, 2015, SMMC LTC health plans were providing care and services to 45,669 nursing facility residents and 41,261 waiver recipients for a total enrollment of 86,930 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 health 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 health plans to improve fiscal integrity.

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

As of June 30, 2015 there were a total of 3,005,986 individuals enrolled in the MMA program.

Accountability to Florida's Medicaid Recipients

Now that the implementation of SMMC is complete, there is an ongoing emphasis on program accountability. The Agency has incorporated many private market principles to the Medicaid program to achieve higher quality care for those most in need at a lower cost to the taxpayer. The Agency uses a three-pronged approach to ensure quality and accountability in the Medicaid program. The three areas of emphasis include extensive plan reporting requirements; tracking plan performance through comprehensive financial data collection and analysis, and detailed plan monitoring activities carried out by the Agency; and liquidated damages and sanctions against under-performing health plans.

The increased emphasis on quality and accountability does not stop with the health plans. The Agency has added new tracking and monitoring components to the FFS population as well as additional reporting above and beyond what was required in the past.

A Framework for Ensuring Accountability and Measuring Program Performance

The Medicaid program consists of three primary populations. These include the SMMC LTC population, the SMMC MMA population, and those recipients who remain in a FFS delivery system. Each of these populations is monitored 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. Medicaid will also continue to monitor certain aspects of the Florida KidCare program in its Long Range Program Plan, 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 that 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 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 a majority 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 goal 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 make more accurate expenditure predictions 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 a key component 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 factors such as the adequacy of a health plan's 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, complex problems. Access includes measures like accessing adequate prenatal care, scheduling appointments when necessary, preventing unnecessary hospitalizations, and focusing on care management to ensure adequate primary care. Program quality measures will help identify and track how well plans and providers are performing to ensure 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.

Medicaid will continue to explore options for increased accountability to Medicaid recipients.

Medicaid Over the Next Five Years/Legislative Budget Requests

Over the next five years, Medicaid will continue its evolution as a managed care based program. The Agency has completed the staffing realignment for the Division of Medicaid (Division) to meet the new demands of the program's change in focus. Even though the realignment is complete, the evaluation of staffing needs to meet any future shifts in the Division's roles and responsibilities and to ensure program accountability will be an ongoing process.

The planning, preparation, and transition of the Florida Medicaid Management Information System (FMMIS) contract is currently underway. The current contract with the fiscal agent expires on June 30, 2018. The composition of service delivery under the SMMC program and the need for data analytics features of a system will overtake the need for traditional claims processing. A greater range of analytical possibilities beyond the static reporting of aggregated data is needed. The Agency is in Year 2 of 5 for this complex project. The Agency hired a project manager to provide comprehensive project management services through the close of the project. In addition, the Agency has hired an independent validation and verification vendor to provide independent project oversight through the close of the project. The Agency, in conjunction with an independent research and planning vendor, has determined that the most beneficial and cost effective solution for the competitive solicitation is to take over the current system with make enhancements and deliver a new Decision Support System (DSS).

In an effort to make program costs more predictable, the Agency has identified an opportunity to utilize the services of an independent consultant to develop a plan to convert the current nursing facility cost-based per diem reimbursement payment process to a nursing facility prospective payment process. The prospective payment process uses a case mix reimbursement methodology to determine resident care needs as well as geographic variations in wages and would incorporate the costs of nursing facility services such as routine, ancillary, and capital related costs. Implementing this prospective payment process would remove the need for post-payment cost settlement and aligns better with SMMC.

The Agency is in the process of implementing Express Enrollment which will ensure new recipients get into a health plan and start receiving care and accessing the benefits of managed care more quickly. This in turn means recipients will gain access to all the benefits of managed care including having a dedicated primary care provider to coordinate their health services, access to a dedicated health plan provider network that meets rigorous Agency standards for service availability and quality, and immediate access to expanded benefits offered by the plans. The Agency is always looking for ways to enhance the delivery of health care and is exploring ways to build more robust provider networks, increase available services, and provide avenues for more people to take advantage of those services. In addition, the Agency will continue to explore new ways of ensuring accountability; investigate ways to make provider credentialing stronger; improve the accuracy and completeness of encounter data; evaluate program and plan performance; and 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	None		
Division of Information Technology			
2	Budget Authority for Agency Telecommunications Services	This issue requests an increase in funding in the Expenses category to replace the eliminated budget authority in the Data Processing Service TRC – DMS (210010) category previously used to transfer funds to the Department of Management Services (DMS) for the cost of telecommunications services.	If the issue is not funded, the Agency will be required to pay for telecommunication services provided through DMS from existing expenses budget which could limit the Agency's ability to cover other needed IT expenditures.
Office of the Inspector General			
3	Advanced Data Analytics and Detection Services	This issue requests non-recurring funding to continue the advanced data analytics and detection services contract, which started on August 15, 2014. These services modernize detection abilities by using advanced statistical methods and graph pattern analysis methods to identify aberrant billing patterns	If the issue is not funded, the Agency will not have adequate budget authority to continue this service contract. Additionally, the Agency will lose an opportunity for a 90/10 federal match.

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
		due to fraud or errors for the Agency.	
Division of Medicaid			
4	FMMIS	This issue requests funding for the planning, preparation, and transition of the FMMIS and DSS contract. This project covers a five-year period starting in Fiscal Year 2014-2015 and spanning through Fiscal Year 2018-2019. The Agency requires funding in the amount of $17,433,393 to continue activities related to the FMMIS, DSS, and fiscal agent services for Year 3 of the project.	If the issue is not funded, the Agency will not have adequate budget authority to continue this project and transition to a new fiscal agent and DSS vendor at the expiration of the current contract in June 2018.
5	Nursing Home Prospective Payment Process	This issue requests funding to contract with an independent consultant 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.

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	Ongoing responsibilities
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

LRPP Exhibit II: Performance Measures and Standards

Approved Performance Measures for FY 2014-2015 (Words)		Approved Prior Year Standards FY 2014-2015 (Numbers)	Prior Year Actual FY 2014-2015 (Numbers)	Approved Standards for FY 2015-2016 (Numbers)	Requested FY 2016-2017 Standard (Numbers)
Program: Administration and Support			**Code: 68200000**		
1	Administrative costs as a percent of total agency costs	0.11%	0.07%	0.11%	0.11%
2	Administrative positions as a percent of total agency positions	11.45%	10.88%	11.45%	11.45%
Program: Health Care Services			**Code: 68500000**		
Service/Budget Entity: Children's Special Health Care			**Code: 68500100**		
3	Percent of hospitalizations for conditions preventable by good ambulatory care	7.70%	See New Measure 3A Below	7.70%	DELETE[4]
3A	New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): CMSN enrollees (Title XIX and Title XXI)	N/A	22.67%	25.00%	25.00%[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	79.10%	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 2014-2015 (Numbers)	Prior Year Actual FY 2014-2015 (Numbers)	Approved Standards for FY 2015-2016 (Numbers)	Requested FY 2016-2017 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%	92.20%	95.00%	90.00%[4]
8	Total number of Title XXI-eligible children enrolled in Kidcare	228,159	220,442	228,159	Per Estimates[1]
9	Number of Title XXI-eligible children enrolled in Florida Healthy Kids	195,867	183,502	195,867	Per Estimates[1]
10	Number of Title XXI-eligible children enrolled in MediKids	2,100	23,810	21,000	Per Estimates[1]
11	Number of Title XXI-eligible children enrolled in Children's Medical Services Network	111,292	13,110	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%	1.37%	1.44%	2.00%[4]
13	Average number of days between receipt of clean Medicaid claim and payment	15	9.10	15	15
14	Number of Medicaid claims received	145,101,035	97,129,539	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 2014-2015 (Numbers)	Prior Year Actual FY 2014-2015 (Numbers)	Approved Standards for FY 2015-2016 (Numbers)	Requested FY 2016-2017 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	14.91%	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	20.29%	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%	4.20%	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	76.10%	50.00%	75.00%[4]
19	Percent of eligible children who received all required components of EPSDT screening	64.00%	43.00%	64.00%	64.00%
20	Number of children ages 1-20 enrolled in Medicaid	1,249,276	2,254,045	1,249,276	Per Estimates[1]
21	Number of children receiving EPSDT services	407,052	964,266	407,052	Per Estimates[1]
22	Number of hospital inpatient services provided to children	92,960	145,034	92,960	Per Estimates[1]

	Approved Performance Measures for FY 2014-2015 (Words)	Approved Prior Year Standards FY 2014-2015 (Numbers)	Prior Year Actual FY 2014-2015 (Numbers)	Approved Standards for FY 2015-2016 (Numbers)	Requested FY 2016-2017 Standard (Numbers)
23	Number of physician services provided to children	6,457,900	8,111,283	6,457,900	Per Estimates[1]
24	Number of prescribed drugs provided to children	4,444,636	4,008,959	4,444,636	Per Estimates[1]
25	Number of hospital inpatient services provided to elders	100,808	170,588	100,808	Per Estimates[1]
26	Number of physician services provided to elders	1,436,160	10,043,962	1,436,160	Per Estimates[1]
27	Number of prescribed drugs provided to elders	15,214,293	6,338,227	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	39,629	550,436	Per Estimates[1]
31	Number of case months services purchased (Nursing Home)	619,387	80,967	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 2014-2015 (Numbers)	Prior Year Actual FY 2014-2015 (Numbers)	Approved Standards for FY 2015-2016 (Numbers)	Requested FY 2016-2017 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	22.02%	25.00%	25.00%[4,5] (Budget Entity 68501600 no longer exists, standard should be in Medicaid Services - Individuals Budget Entity 68501400)
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	20.14%	20.00%	20.00%[4,5] (Budget Entity 68501600 no longer exists, standard should be in Medicaid Services - Individuals Budget Entity

	Approved Performance Measures for FY 2014-2015 (Words)	Approved Prior Year Standards FY 2014-2015 (Numbers)	Prior Year Actual FY 2014-2015 (Numbers)	Approved Standards for FY 2015-2016 (Numbers)	Requested FY 2016-2017 Standard (Numbers)
					68501400)
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]
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	99.66%	100.00%	100.00%
39	Percent of accredited hospitals and ambulatory surgical centers cited for not complying with life safety, licensure, or emergency access standards	25.00%	23.80%	25.00%	DELETE[4]
40	Percent of validation surveys that are consistent with findings noted during the accreditation survey	98.00%	100.00%	98.00%	DELETE[4]

	Approved Performance Measures for FY 2014-2015 (Words)	Approved Prior Year Standards FY 2014-2015 (Numbers)	Prior Year Actual FY 2014-2015 (Numbers)	Approved Standards for FY 2015-2016 (Numbers)	Requested FY 2016-2017 Standard (Numbers)
41	Percent of assisted living facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0.00%	1.30%	0.00%	DELETE[4]
42	Percent of home health facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0.00%	0.04%	0.00%	DELETE[4]
43	Percent of clinical laboratories with deficiencies that pose a serious threat for not complying with life safety, licensure or emergency access standards	0.00%	0.03%	0.00%	DELETE[4]
44	Percent of ambulatory surgical centers with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0.00%	0.00%	0.00%	DELETE[4]
45	Percent of hospitals with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0.00%	2.00%	0.00%	DELETE[4]
46	Percent of hospitals that fail to report serious incidents (agency identified)	6.00%	1.70%	6.00%	DELETE[4]
47	Percent of new Medicaid recipients voluntarily selecting managed care plan	50.00%	56.00%	50.00%	TRANSFER[4,5] (This is a Medicaid program – should be in Executive Direction and Support Services Budget Entity 68500200)
48	Percent of complaints of HMO patient dumping received that are investigated[2]	100.00%	See New Measure 48A Below	100.00%	REVISE[4]
48A	New Measure - Percent of complaints of HMO access to care received that are investigated.	N/A	100.00%	100.00%	100.00%[4]

	Approved Performance Measures for FY 2014-2015 (Words)	Approved Prior Year Standards FY 2014-2015 (Numbers)	Prior Year Actual FY 2014-2015 (Numbers)	Approved Standards for FY 2015-2016 (Numbers)	Requested FY 2016-2017 Standard (Numbers)
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	13	53	53[4]
53	Number of construction reviews performed (plans and construction)	4,500	4,599	4,500	4,500
54	Number of new enrollees provided with choice counseling	520,000	1,285,508	520,000	TRANSFER[4,5] Per Estimates[1] (This is a Medicaid program and should be moved to Executive Direction and Support Services Budget Entity 68500200)
55	New Measure - Percent of renewal applications received electronically via the Online Licensing Application	N/A	29.90%	30.00%	30.00%[4]
56	New Measure - Average processing time (in days) for financial reviews	N/A	1.30	3.00	3.00[4]

Approved Performance Measures for FY 2014-2015 (Words)	Approved Prior Year Standards FY 2014-2015 (Numbers)	Prior Year Actual FY 2014-2015 (Numbers)	Approved Standards for FY 2015-2016 (Numbers)	Requested FY 2016-2017 Standard (Numbers)
[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 the 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.				

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 2015

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 2015

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%	79.10%	10.90%	12.11%

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 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 2015

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Children's Special Health Care/68500100
Measure #5: Percent of Children Enrolled with Up-to-Date Immunizations

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
85.00%	N/A	N/A	N/A

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☐ Staff Capacity
☐ Level of Training
☒ Other (Identify)
Explanation: Information previously reported has been based on a composite measure developed from the Annual KidCare Evaluation Report and does not accurately reflect immunization levels. Immunization information is not collected every year and was not collected for the current reporting period. Due to the inconsistency of getting data for this measure, it should be deleted.

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

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

Office of Policy and Budget – July 2015

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 2015

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%	92.20%	2.90%	3.10%

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: 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	220,422	(7,737)	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: 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 who would have previously been eligible for Title XXI (CHIP) programs but who are now Medicaid eligible. This means the number of Title XXI children will be smaller than previous estimates. 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 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	183,508	(12,365)	6.30%

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 and Medicaid. 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 and Title XIX Medicaid.

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 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 ☒ 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
2,100	23,810	21,710	10.34%

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 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 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 #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	13,110	98,182	88.22%

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 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: Medicaid Services to Individuals/68501400
Measure #15: Percent of Hospitalizations that are Preventable by Good Ambulatory Care

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
11.00%	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: 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 ☒ 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: 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
☐ 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%	14.91%	10.09%	40.36%

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: During the transition to SMMC, the Agency implemented several measures to ensure there was no interruption of service and that everyone received appropriate care.

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 and a significant number of people have been transitioned into managed health plans. With the launch of SMMC, there will be far fewer enrollees in FFS. Those that remain in FFS will mostly be those in special programs which could impact the future performance of this measure.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☒ Other (Identify)
Recommendations: None. The Standard appears accurate and the performance is within expected limits.

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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%	20.29%	0.29%	1.40%

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: Actual performance is very close to the stated objective and observed percentages are within the margin of error for 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 launch of the ACA and health care exchanges has identified an increasing number of people eligible for the Medicaid program and a significant number of people have been transitioned into managed health plans. With the launch of SMMC, there will be far fewer enrollees in FFS. Those that remain in FFS will mostly be those in special programs which could impact the future performance of this measure.

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

Recommendations: None. The Standard appears accurate and the performance is within expected limits.

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: Actual performance is very close to the stated objective and observed percentages are within the margin of error for 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%	4.20%	(0.50%)	10.60%

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

External Factors (check all that apply):
☐ Resources Unavailable ☐ Technological Problems
☐ Legal/Legislative Change ☐ Natural Disaster
☐ Target Population Change ☒ Other (Identify)
☐ This Program/Service Cannot Fix the Problem
☐ Current Laws Are Working Against the Agency Mission
Explanation: 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 years' worth of follow up data available to determine whether they had a subsequent birth. This further means by default that any woman who gave birth four years ago and who subsequently had a second birth (to be included in the denominator) had 24 months or less between pregnancies. Those that have not given birth in those 24 months are excluded from the calculation because no data are available, even if they had a second pregnancy anywhere from 25 to 48 months after their first pregnancy. This artificially truncates the available period at a point below the target standard for this measure. While an alternative could theoretically be to only consider women who had been in the program at least 36 months after their first pregnancy and were therefore even technically able to achieve the standard, that bases the performance measure on something that could have happened five years in the past. A better measure (proposed 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 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%	76.10%	26.10%	52.20%

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 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.

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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 #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%	43.00%	21.00%	32.80%

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	6,338,227	8,876,066	58.34%

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.

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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 #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.

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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 #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.

Office of Policy and Budget – July 2015

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	39,629	(510,807)	92.80%

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 LTC component of the SMMC program completed rollout during Fiscal Year 2013-2014 and the remainder of the SMMC program completed rollout during Fiscal Year 2014-2015. The majority of LTC services are now covered through a managed health plan.

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 SSEC.

Office of Policy and Budget – July 2015

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	80,967	(538,420)	86.90%

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

External Factors (check all that apply):
☐ Resources Unavailable ☐ Technological Problems
☒ Legal/Legislative Change ☐ Natural Disaster
☐ Target Population Change ☐ Other (Identify)
☐ This Program/Service Cannot Fix the Problem
☐ Current Laws Are Working Against the Agency Mission
Explanation: The LTC component of the SMMC program completed rollout during Fiscal Year 2013-2014 and the remainder of the SMMC program completed rollout during Fiscal Year 2014-2015. The majority of LTC services are now covered through a managed health plan.

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 SSEC.

Office of Policy and Budget – July 2015

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 2015

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 2015

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 #33B: Percent of 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:
☒ 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%	20.14%	0.14%	0.7%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☐ Staff Capacity
☐ Level of Training
☒ Other (Identify)
Explanation: Actual performance is very close to the stated objective and observed percentages are within the margin of error for 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 launch of the ACA and health care exchanges has identified an increasing number of people eligible for the Medicaid program and a significant number of people have been transitioned into managed health plans.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☒ Other (Identify)
Recommendations: None. The Standard appears accurate and the performance is within expected limits.

Office of Policy and Budget – July 2015

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 2015

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 2015

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 ☐ 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: 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 ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: The Agency is requesting that this measure be deleted.

Office of Policy and Budget – July 2015

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 2015

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.

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 2015

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
N/A	99.66%	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.

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 provides substantial training/preceptor mentoring for the surveyors. The Field office has instituted corrective action measures to prevent this happening in the future in that office. Other offices will be instructed on this corrective action to facilitate compliance statewide.

Office of Policy and Budget – July 2015

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 2015

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.

Office of Policy and Budget – July 2015

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 2015

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 ☐ 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 2015

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 2015

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 ☐ 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 2015

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 2015

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 2015

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 2015

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 2015

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 2015

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 2015

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

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

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

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

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

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

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

Recommendations: None. The Standard appears accurate and the performance is within expected limits.

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 2015

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 2015

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 2014 for the LRPP published in 2015).

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, 2015

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 2015

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 create the measure "Percentage of all Title XXI KidCare enrollees eligible for renewal who renew KidCare coverage." Measure was previously identified as "Percentage of all Title XXI KidCare Enrollees Eligible for Renewal Who Either Renew KidCare Coverage or Maintain Health Care Coverage from Another Source."

The Agency recommends the proposed standard be 75.00 percent based on program expectations and historical performance.

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

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

Proposed Standard/Target:
75.00 percent

Validity:
Keeping eligible children enrolled in FHK ensures adequate access to health care services. Re-enrolling children when they are eligible ensures continuity of coverage which helps ensure uninterrupted access to health care services leading to better health outcomes overall. This is a valid measure for continuity of access to health care services and the validity of the data is high. The enrollment data comes directly from FHK administrative data which are used for determining eligibility for services.

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.

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

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

While this measure should be as close to 100.00 percent as possible, there will always be some people who choose not to maintain insurance coverage 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 a historically high, but desirable outcome.

Office of Policy and Budget – July 2015

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 2015

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 2015

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 or caregivers 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. 90.00 percent is the national standard for the proposed change and the Agency is requesting that the standard reflect this change as well.

Data Sources and Methodology:
To assess KidCare program satisfaction, the University of Florida Institute for Child Health Policy (ICHP) conducts a telephone interview survey, as part of the annual KidCare Evaluation, with caregivers whose children have been receiving health care coverage through one of the KidCare program components for at least 12 consecutive months. The survey population includes children receiving the following coverage: Medicaid enrolled with an HMO, Medicaid enrolled with a MediPass provider, and the Title XXI programs (MediKids, Healthy Kids and Children's Medical Services Network). ICHP uses the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey instrument. CAHPS asks consumers and patients to report on and evaluate their experiences with health care. For this measure, it 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 Agency for Healthcare Research and Quality, 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.

Measure #7: Percent of Families Satisfied with the Care Provided Under the Program – Page 2

Discussion:
The ICHP includes this measurement in each annual evaluation.

Office of Policy and Budget – July 2015

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:

Proposed Standard/Target:
Based on SSEC appropriations estimates.

Validity:
This is a valid measure of the size and scope of the Title XXI program and is used to track changes in enrollment over time. This is not a valid measure of program performance as enrollment is determined by factors outside the Agency's control.

Reliability:
Data reflect enrollment data provided by Florida Healthy Kids. These data are a count of who is enrolled in the program and eligible to receive services. KidCare data is collected by FHK and is assumed to be reliable.

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 2015

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:

Proposed Standard/Target:
Based on SSEC appropriations estimates.

Validity:
This is a valid measure of the size and scope of the Florida Healthy Kids program and is used to track changes in enrollment over time. This is not a valid measure of program performance as enrollment is determined by factors outside the Agency's control.

Reliability:
Data reflect enrollment data provided by Florida Healthy Kids. These data are a count of who is enrolled in the program and eligible to receive services. KidCare data is collected by FHK and is assumed to be reliable.

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 2015

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:

Proposed Standard/Target:
Based on SSEC appropriations estimates.

Validity:
This is a valid measure of the size and scope of the Title XXI MediKids program and is used to track changes in enrollment over time. This is not a valid measure of program performance as enrollment is determined by factors outside the Agency's control.

Reliability:
Data reflect enrollment data provided by Florida Healthy Kids. These data are a count of who is enrolled in the program and eligible to receive services. KidCare data is collected by FHK and is assumed to be reliable.

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 2015

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:
This is an administrative change only.

Proposed Standard/Target:
Based on SSEC appropriations estimates.

Validity:
This is a valid measure of the size and scope of the Title XXI MediKids program and is used to track changes in enrollment over time. This is not a valid measure of program performance as enrollment is determined by factors outside the Agency's control.

Reliability:
Data reflect enrollment data provided by Florida Healthy Kids. These data are a count of who is enrolled in the program and eligible to receive services. KidCare data is collected by FHK and is assumed to be reliable.

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 2015

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 2015

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 2015

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 2015

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 2015

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. 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 DOH and Human Services, Agency for Healthcare Research and Quality. The percentage of hospitalizations that occur for Ambulatory Sensitive Conditions within the measure target 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 2014 for the LRPP published in 2015).

Enrollees/beneficiaries are divided into “ages 1 through 20” and “21 and older” 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 through 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 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: 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. 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 the measure target 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 2014 for the LRPP published in 2015).

Enrollees/beneficiaries are divided into “ages 1 through 20” and “21 and older” 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 through 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.

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 #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 2015

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, DOH, Centers for Disease Control and Prevention, and other experts.

Reliability:
The measure is very reliable. The DOH is responsible for maintaining the death certificate file. Eligibility files are the responsibility of the DCF. 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 2015

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 2015

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 health and environment for children and mothers. An inter-pregnancy interval of at least 18 months ensures 24 or more months between births.

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 2015

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 2015

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 2015

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 2015

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 2015

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 2015

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 2015

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 2015

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 SSEC.

Data Sources and Methodology:
Number of prescribed drugs is based on submitted Medicaid claims and encounter data. Data from the FMMIS is queried by Medicaid staff to determine the number of prescribed drugs provided.

Proposed Standard/Target:
Proposed standard should reflect expectations based upon the SSEC.

Validity:
This is a valid measure of the size and scope of a service within the Medicaid program and is used to track changes over time. This is not a valid measure of program performance as the number of drugs provided to elders is a factor of enrollment and Medicaid policy which is determined by factors outside the Agency's control.

Reliability:
The service count for this measure is derived from Medicaid claims data. Claims data are tested by Agency staff for accuracy and completeness. Reliability is high.

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.

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 2015

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 2015

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 the 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, 2015

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

Office of Policy and Budget – July 2015

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

Office of Policy and Budget – July 2015

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

Office of Policy and Budget – July 2015

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

Office of Policy and Budget – July 2015

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 2014 for the LRPP published in 2015).

Enrollees/beneficiaries are divided into “ages 1 through 20” and “21 and older” 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 through 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;
f. SLMBs or QI-1s;
g. Title XXI-funded children with chronic conditions who are enrolled in CMSN;

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

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 the DCF 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: 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. 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 the measure target 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 2014 for the LRPP published in 2015).

Enrollees/beneficiaries are divided into “ages 1 through 20” and “21 and older” 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 through 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 the 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: 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

Office of Policy and Budget – July 2015

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

Office of Policy and Budget – July 2015

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.

Office of Policy and Budget – July 2015

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.

Office of Policy and Budget – July 2015

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 perent 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 perent 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.

Office of Policy and Budget – July 2015

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.

Office of Policy and Budget – July 2015

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 2015

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 2015

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 2015

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 2015

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 2015

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 2015

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 2015

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.

Office of Policy and Budget – July 2015

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:
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 AHCA 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 DOH (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 2015

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: Subscriber Assistance Program data is tracked in an Excel database updated daily by staff. All cases are tracked upon receipt and throughout the case preparation and hearing process until the outcome of the case has been determined. Formulas have been created to track the average time it takes staff to process a case from open to close. Case processing time is tracked on an individual, monthly and yearly basis.

Validity: Since the Subscriber Assistance Program is a consumer driven program, the number of requests for assistance received by the program varies from year to year. This in turn increases/decreases the staff's workload, therefore effecting the processing time of cases. By using an average of the three most recent fiscal years we are provided with a realistic annual target.

Reliability: Daily case tracking in Excel is maintained by one staff member. Formulas created provide an individual, monthly and yearly average processing time for cases received by the program.

Office of Policy and Budget – July 2015

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 2015

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: 75.00%

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. Management will utilize platforms like tableau to regularly review the data to identify any anomalies that might indicate an issue with the reports and system dates. In addition, IT has scripts in place and error logs to check for things erroneous system data. Issues related to data are relayed at regularly scheduled meetings.

Discussion: Based on survey data from our providers, the ultimate target is 75.00%; 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 2015

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 statistic is reported monthly and reviewed by the supervisor. This measure is a means to demonstrate that the financial reviews completed in the Unit meet the Bureau's goals of delivering a fast, reliable, and professional work product. Initial and Change of Ownership Licensure Applications cannot be processed unless the financial reviews are completed timely.

Reliability: Because this is tracked manually in a log, data entry errors could exist. This is mitigated by the fact that this statistic is reported monthly and reviewed by the supervisor for outliers and sampled for validity. Since the data fields are manually entered, the log is randomly checked to ensure staff is not manipulating dates to show faster turnaround times.

Office of Policy and Budget – July 2015

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

Approved Performance Measures for FY 2014-2015 (Words)		Associated Activities Title
43	Percent of clinical laboratories with deficiencies that pose a serious threat for not complying with life safety, licensure or emergency access standards	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
44	Percent of ambulatory surgical centers with deficiencies that pose a serious threat to the health, safety or welfare of the public	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
45	Percent of hospitals with deficiencies that pose a serious threat to the health, safety or welfare of the public	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
46	Percent of hospitals that fail to report serious incidents (agency identified)	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020

Approved Performance Measures for FY 2014-2015 (Words)		Associated Activities Title
47	Percent of new Medicaid recipients voluntarily selecting managed care plan	Health Facilities and Practitioner Regulation - Medicaid Choice Counseling ACT7150
48	Percent of complaints of HMO patient dumping received that are investigated	Managed Health Care ACT7090
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

Approved Performance Measures for FY 2014-2015 (Words)		Associated Activities Title
50	Number of inquiries to the call center regarding practitioner licensure and disciplinary information	Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020 This measure is no longer handled by the Agency. Was transferred to DOH in 2009 with renewal of call center contract.
51	Total number of full facility quality-of-care surveys conducted	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
52	Average processing time (in days) for Statewide Provider and Subscriber Assistance Panel cases	Subscriber/Beneficiary Assistance Panel ACT7130
52A	Average processing time (in days) for Subscriber Assistance Program and Beneficiary Assistance Program (SAP/BAP) cases	Subscriber/Beneficiary Assistance Panel ACT7130

	Approved Performance Measures for FY 2014-2015 (Words)	Associated Activities Title
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
55	Percent of Renewal Applications Received Electronically via the Online Licensing Application	Health Facility Regulation (Compliance, licensure, complaints) - Tallahassee ACT7020
56	Average processing time (in days) for review of Applicant Financial Information	CON / Financial Analysis ACT7010

LRPP Exhibit VI: Agency-Level Unit Cost Summary

AGENCY FOR HEALTH CARE ADMINISTRATION	FISCAL YEAR 2014-15			
SECTION I: BUDGET	OPERATING			FIXED CAPITAL OUTLAY
TOTAL ALL FUNDS GENERAL APPROPRIATIONS ACT			24,586,090,660	0
ADJUSTMENTS TO GENERAL APPROPRIATIONS ACT (Supplementals, Vetoes, Budget Amendments, etc.)			801,987,032	0
FINAL BUDGET FOR AGENCY			23,784,103,628	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 *	559,662	11,364.41	6,364,629,930	
Prepaid Health Plans - Families *	2,794,530	1,609.94	4,496,228,922	
Elderly And Disabled/Fee For Service/Medipass - Hospital Inpatient * Number of case months Medicaid program services purchased	64,612	4,907.77	317,100,789	
Elderly And Disabled/Fee For Service/Medipass - Prescribed Medicines * Number of case months Medicaid program services purchased	88,366	4,326.45	382,307,174	
Elderly And Disabled/Fee For Service/Medipass - Physician Services * Number of case months Medicaid program services purchased	151,484	1,779.35	269,542,737	
Elderly And Disabled/Fee For Service/Medipass - Hospital Outpatient * Number of case months Medicaid program services purchased	151,484	734.42	111,253,019	
Elderly And Disabled/Fee For Service/Medipass - Supplemental Medical Insurance * Number of case months Medicaid program services purchased	769,476	1,435.86	1,104,860,719	
Elderly And Disabled/Fee For Service/Medipass - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	28,166	536.10	15,099,734	
Elderly And Disabled/Fee For Service/Medipass - Patient Transportation * Number of case months Medicaid program services purchased	151,484	74.33	11,259,723	
Elderly And Disabled/Fee For Service/Medipass - Case Management * Number of case months Medicaid program services purchased	708,819	59.55	42,207,045	
Elderly And Disabled/Fee For Service/Medipass - Home Health Services * Number of case months Medicaid program services purchased	64,612	272.53	17,608,707	
Elderly And Disabled/Fee For Service/Medipass - Hospital Insurance Benefit * Number of case months Medicaid program services purchased	86,872	615.30	53,452,401	
Elderly And Disabled/Fee For Service/Medipass - Hospice * Number of case months Medicaid program services purchased	7	4,278,598.14	29,950,187	
Elderly And Disabled/Fee For Service/Medipass - Private Duty Nursing * Number of case months Medicaid program services purchased	131,545	451.70	59,419,004	
Elderly And Disabled/Fee For Service/Medipass - Other * Number of case months Medicaid program services purchased	64,612	9,764.33	566,280,917	
Women And Children/Fee For Service/Medipass - Hospital Inpatient * Number of case months Medicaid program services purchased	356,875	724.34	258,497,182	
Women And Children/Fee For Service/Medipass - Prescribed Medicines * Number of case months Medicaid program services purchased	390,597	298.99	116,785,689	
Women And Children/Fee For Service / Medipass - Physician Services * Number of case months Medicaid program services purchased	356,875	6.54	2,332,607	
Women And Children/Fee For Service / Medipass - Hospital Outpatient * Number of case months Medicaid program services purchased	356,875	423.11	150,997,016	
Women And Children/Fee For Service / Medipass - Supplemental Medical Insurance * Number of case months Medicaid program services purchased	1,187	170,091.67	201,886,814	
Women And Children/Fee For Service / Medipass - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	232,794	95.46	22,222,917	
Women And Children/Fee For Service / Medipass - Patient Transportation * Number of case months Medicaid program services purchased	257,722	37.54	9,674,143	
Women And Children/Fee For Service / Medipass - Case Management * Number of case months Medicaid program services purchased	2,569,846	0.22	553,841	
Women And Children/Fee For Service / Medipass - Home Health Services * Number of case months Medicaid program services purchased	356,875	78.16	27,893,231	
Women And Children/Fee For Service / Medipass - Clinic Services * Number of case months and Medicaid program services purchased	356,875	85.76	30,604,779	
Women And Children/Fee For Service / Medipass - Other * Number of case months Medicaid program services purchased	242,623	562.59	136,497,689	
Medically Needy - Hospital Inpatient * Number of case months Medicaid program services purchased	26,647	1,754.82	46,760,733	
Medically Needy - Prescribed Medicines * Number of case months Medicaid program services purchased	26,647	1,917.55	51,097,022	
Medically Needy - Physician Services * Number of case months Medicaid program services purchased	32,231	2.19	70,685	
Medically Needy - Hospital Outpatient * Number of case months Medicaid program services purchased	32,231	658.79	21,233,617	
Medically Needy - Supplemental Medical Insurance * Number of case months Medicaid program services purchased	3,331	2,050.64	6,830,669	
Medically Needy - Patient Transportation * Number of case months Medicaid program services purchased	32,231	12.63	407,063	
Medically Needy - Case Management * Number of case months Medicaid program services purchased	32,231	2.53	81,417	
Medically Needy - Home Health Services * Number of case months Medicaid program services purchased	26,647	17.44	464,794	
Medically Needy - Other * Number of case months Medicaid program services purchased	26,647	82,777.45	2,205,770,610	
Refugees - Hospital Inpatient * Number of case months Medicaid program services purchased	6,129	49.53	303,583	
Refugees - Prescribed Medicines * Number of case months Medicaid program services purchased	6,129	74,441.23	456,250,287	
Refugees - Hospital Outpatient * Number of case months Medicaid program services purchased	6,129	30.19	185,026	
Refugees - Early Periodic Screening Diagnosis And Treatment * Number of case months Medicaid program services purchased	33	220.97	7,292	
Refugees - Patient Transportation * Number of case months Medicaid program services purchased	6,129	1.02	6,234	
Refugees - Case Management * Number of case months Medicaid program services purchased	14,131	1.15	16,274	
Refugees - Home Health Services * Number of case months Medicaid program services purchased	6,129	5.16	31,631	
Refugees - Other * Number of case months Medicaid program services purchased	6,129	43.52	266,760	
Nursing Home Care * Number of case months Medicaid program services purchased	45,644	64,611.27	2,949,116,769	
Home And Community Based Services * Number of case months Medicaid program services purchased	39,629	29,356.91	1,163,384,977	
Intermediate Care Facilities For The Developmentally Disabled - Sunland Centers * Number of case months Medicaid program services purchased	680	491,299.00	334,083,317	
Purchase Medikids Program Services * Number of case months Medicaid Program services purchased	29,492	1,837.10	54,179,609	
Purchase Children's Medical Services Network Services * Number of case months	13,109	8,273.49	108,448,776	
Purchase Florida Healthy Kids Corporation Services * Number of case months	148,688	1,741.62	258,960,089	
Certificate Of Need/Financial Analysis * Number of certificate of need (CON) requests/financial reviews conducted	3,356	537.52	1,803,913	
Health Facility Regulation (compliance, Licensure, Complaints) - Tallahassee * Number of licensure/certification applications	44,355	333.52	14,793,244	
Facility Field Operations (compliance, Complaints) - Field Offices Survey Staff * Number of surveys and complaint investigations	43,006	1,109.60	47,719,596	
Health Standards And Quality * Number of transactions	2,976,087	1.22	3,617,943	
Plans And Construction * Number of reviews performed	4,599	1,372.99	6,314,375	
Managed Health Care * Number of Health Maintenance Organization (HMO) and workers' compensation arrangement surveys	182	6,425.75	1,169,486	
Background Screening * Number of requests for screenings	255,833	3.61	922,562	
Subscriber Assistance Panel * Number of cases	238	1,637.94	389,828	
TOTAL			22,523,846,407	
SECTION III: RECONCILIATION TO BUDGET				
PASS THROUGHS				
TRANSFER - STATE AGENCIES				
AID TO LOCAL GOVERNMENTS				
PAYMENT OF PENSIONS, BENEFITS AND CLAIMS				
OTHER			1,099,164,352	
REVERSIONS			161,092,956	
TOTAL BUDGET FOR AGENCY (Total Activities + Pass Throughs + Reversions) - Should equal Section I above. (4)			23,784,103,715	

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

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

Glossary of Terms and Acronyms

- **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.

- **SIU** - Special Investigative Units investigate suspected provider fraud, the MPI assesses the adequacy of the preliminary investigation conducted by these units while seeking to avoid the duplication and delay of their own preliminary investigation.

- **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.