RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

LONG RANGE PROGRAM PLAN

Agency for Health Care Administration
Tallahassee, Florida 32308
September 30, 2016

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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 (AHCA) 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 2017-18 through Fiscal Year 2021-2022. 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,

Orlando Pryor
Deputy Chief of Staff

Florida Agency for Health Care Administration

Long Range Program Plan

Fiscal Year 2017-2018 through 2021-2022

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 and maintain 100 percent in Fiscal Year 2021-2022.

Objective 1.B: To reduce by 60 percent the number of Division of Health Quality Assurance (HQA) public record requests manually processed by Fiscal Year 2021-2022.

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 2021-2022.

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 2021-2022.

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 2021-2022.

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

Health Care Services (Division of Medicaid)

Objective 3.A: Transition 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 2015-2016	FY 2017-2018	FY 2018-2019	FY 2019-2020	FY 2020-2021	FY 2021-2022
3,815	5,165	5,903	6,641	7,379	7,379
Percent of renewal applications received via Internet	70.00%	80.00%	90.00%	100.00%	100.00%

With the passage of the Health Care Licensing Procedures Act (chapter 408, F.S., Part II), the Agency may accept 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 2015-2016	FY 2017-2018	FY 2018-2019	FY 2019-2020	FY 2020-2021	FY 2021-2022
3,224	2,579	2,257	1,934	1,612	1,289
Percent of reduction in the annual number of public record requests processed by HQA	20.00%	30.00%	40.00%	50.00%	60.00%

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 2017-2018	FY 2018-2019	FY 2019-2020	FY 2020-2021	2021-2022
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 2017-2018	FY 2018-2019	FY 2019-2020	FY 2020-2021	FY 2021-2022
$27,450,000*	$30,323,625	$31,839,806	$33,431,796	$35,103,386	$35,033,928
Projected Increase in Percent	5.00%	5.00%	5.00%	5.00%	5.00%

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 2017-2018	FY 2018-2019	FY 2019-2020	FY 2020-2021	FY 2021-2022
$25,320,000*	$30,637,200	$33,700,920	$37,071,012	$40,778,113	$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 three percent per year of statewide long term care recipients receiving care in nursing homes to community based care until no more than 35 percent of all Medicaid long-term care recipients receive care in nursing homes.

Performance Projection Table 3A.

Measurement Criteria	Baseline Year FY 2013-14	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21*	FY 2021-2022*
Number of Long Term Care Recipients*	83,446	92,690	93,617	94,553	95,499	96,454
Target Number in Nursing Homes	45,728	44,306	41,940	39,523	37,054	34,531
Target Percentage in Nursing Homes	54.80%	47.80%	44.80%	41.80%	38.80%	35.80%
Target Percentage Transitioned	--	3.00%	3.00%	3.00%	3.00%	3.00%

Source: Medicaid Program Finance

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 FY 2019-2020.

Service Outcome Measure Projection Table 3.B:

Measurement Criteria	Baseline Year FY 2012-13	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22
Percentage of HEDIS measures >= 75th National Percentile	32.00%	58.00%	66.00%	75.00%	75.00%	75.00%

Source: Bureau of Medicaid Quality

Service Outcome Measure 3.C: 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.

Performance Projection Table 3.C:

Measurement Criteria	Base Year FY 2014-15	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21*	FY 2021-22*
Total Medicaid Member Months	41,504,316	52,204,620	54,616,440	57,139,680	59,779,500	62,541,276
Target Recipient Member Months in SMMC	35,278,669	44,373,927	46,423,974	48,568,728	50,812,575	53,160,085
Projected Recipient Member Months in SMMC	31,199,904	42,354,228	44,452,584	46,506,264	48,654,828	50,902,644
Target Percentage of Medicaid Recipient Member Months in SMMC	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%

Source: Medicaid Program Finance. Total Member Months calculated as Average Caseload x 12

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 5 percent as measured by 1115 Waiver Budget Neutrality.

Performance Projection Table 3.D:

Measurement Criteria	Base Year FY 2014-15	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21*	FY 2021-22*
Projected PMPM Costs for SMMC Enrollees	$318.69	$340.40	$357.08	$375.65	$395.18	$415.73
Estimated Growth Percentage from Previous Year	--	5.00%	5.00%	5.00%	5.00%	5.00%

Source: Medicaid Program Finance

Linkage to Governor's Priorities

Number	Governor's Priorities	Agency Goals
1	**Economic Development and Job Creation** Focus on Job Growth and Retention Reduce Taxes Regulatory Reform Phase out Florida's Corporate Income Tax	Goal 1: To operate an efficient and effective government. Goal 2: To reduce and/or eliminate waste, fraud, and abuse.
2	**Public Safety** Protect our communities by ensuring the health, welfare, and safety of our citizens.	Goal 2: To reduce and/or eliminate waste, fraud, and abuse. Goal 3: To assure access to quality and reasonably priced health services.

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 of the Agency is "Better Health Care for All Floridians." The Agency is 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 cost and quality of the 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.

Health Quality Assurance

The Division of Health Quality Assurance (HQA) shares the Agency's mission by administering oversight of regulated health care providers, monitoring commercial managed care provider networks, and providing access to facility and health information through FloridaHealthFinder.gov. HQA strives to maximize the Agency's resources by operating efficiently and effectively to achieve positive outcomes and streamline the regulatory process. As the Agency becomes more technologically advanced, HQA continues to progress toward 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.

HQA licenses facilities and approves construction plans as authorized by chapters 381, 383, 390, 394, 395, 400, 408, 429, and 483, F.S. These chapters include facility types ranging from hospitals, nursing homes, assisted living facilities (ALFs), adult day care centers, to prescribed pediatric extended care centers, health care clinics, and clinical laboratories. HQA not only strives to increase quality in these regulated facility types but also to ensure the health, safety, and welfare of Floridians residing in those facilities. To achieve this goal, the Agency works in cooperation with a complex array of stakeholders that includes the provider community, associations, and advocacy groups.

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 the regularly updated AHCA Docs and FloridaHealthFinder.gov websites. The Agency also continues to maximize the use of available technological resources to provide 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

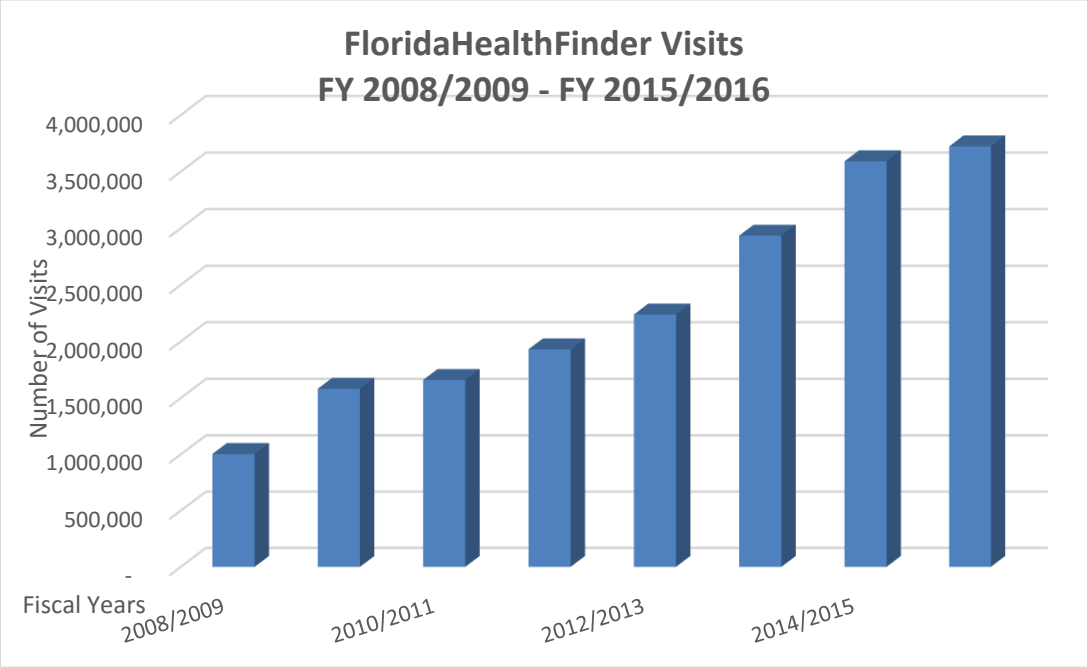
single location. Through AHCA Docs, consumers can review inspection reports and legal orders for specific health care providers.

As a result of these efforts, FloridaHealthFinder.gov, which provides easy access to health care information on ambulatory surgery centers, emergency departments and hospitals, has seen a growth in popularity. The website began in 2000 and has gained national recognition as a leader in health care transparency. The facility/provider locator tool continues to be the most popular tool of the website.

During the past fiscal year, there have been numerous enhancements to FloridaHealthFinder.gov. In August 2015, an overall 15-day readmission rate was added for each hospital's overall performance. This information is important as readmissions are costly and may indicate an opportunity for hospitals to improve quality of care. In October 2015, an Assisted Living Facility comparison tool went live. This tool allows users to compare all components of a facility to help them find the one that best fits their needs. A similar tool for home health agencies will be released later this year. Eliminating the information gap between the patient and their health care provider will better empower and inform Florida consumers and patients about the variations in costs and quality of health care services and will provide Floridians expanded information vital to making informed medical care decisions.

Site visits to FloridaHealthFinder.gov have increased substantially each year since the website was created, and as the Agency continues to promote transparency it is expected that this trend will continue. Overall, visits to the website for Fiscal Year 2015-2016 increased by 3.7 percent, totaling 3,722,855 visits *(Chart 1-1).*

Chart 1-1



The Commission on Healthcare and Hospital Funding

The Commission on Healthcare and Hospital Funding (Commission) was created in May 2015 by the Governor Rick Scott's Executive Order 15-99 to investigate and advise on the role of taxpayer funding for hospitals and health plans in the state. Nine Floridians were appointed by Governor Scott and tasked with reviewing hospital finances and other available information to ensure that consumers have access to affordable, quality health care, from providers with proven track records. The Agency provided the Commission with information from the Florida Hospital Uniform Reporting System (FHURS), which collects hospital financial data, as well as additional utilization and quality information that is collected regularly by the Florida Center for Health Information and Transparency. Much of this information is made continually available to the public through FloridaHealthFinder.gov.

The Commission held 15 public meetings throughout the state over a nine-month period in 2015 and 2016, receiving presentations from more than 25 industry experts, researchers, and stakeholders. Commission meetings were open to the public and materials from the meetings, including interactive data charts and presentations, remain available on the Commission's website at healthandhospitalcommission.com. The Commission's final observations were delivered to Governor Scott on January 21, 2016 and served as a basis for successful transparency legislation in 2016.

Expanding Transparency

This year, the Florida Center for Health Information and Policy Analysis changed its name to the Florida Center for Health Information and Transparency (Florida Center) in response to newly passed legislation and to reflect a shifting priority toward providing improved health care cost transparency in the state. In addition to its historical functions, the Florida Center will oversee the implementation of an All Payer Claims Database (APCD) to collect health care claims and payment information from health insurance plans and implement website enhancements for consumers to find health care pricing information. These tools will enable Floridians to make informed health care choices and enhance competition among health care providers based on price and quality.

The Florida Center contracts with a vendor to provide and maintain the APCD, perform analysis of the claims data, and develop a website for consumers to look up pricing information on common conditions and procedures. The vendor is expected to begin collecting claims data from insurers and health maintenance organizations that participate in the state group insurance program and Medicaid managed care by July 1, 2017. Once complete, the website will be accessible to the public and will provide comparison tools for the costs of common surgical procedures, hospitalizations, and other treatments.

In combination with FloridaHealthFinder.gov, the APCD will improve health care transparency by providing Floridians improved pricing information for health care services in addition to quality ratings, inspection reports, and sanctions.

Electronic Health Care Exchange - Improving the Continuum of Care

Funding from the American Recovery and Reinvestment Act (ARRA) has been utilized for the development of the Florida Health Information Exchange (Florida HIE) as well as the administration of the Medicaid Electronic Health Record (EHR) Incentive Program. The incentive program distributes payments to eligible Medicaid professionals and hospitals who demonstrate successful adoption and use of certified EHR technologies. The final year for eligible professionals and hospitals to begin participating in the program is 2016 and the program will operate through 2021. The program period is a maximum of six years for eligible professionals and three years for hospitals. As of August 2016, there were 8,165 Medicaid professional providers and 179 hospitals participating in the incentive program.

The Agency implemented the Florida HIE pursuant to a cooperative agreement with the Office of the National Coordinator for Health Information Technology. The Agency terminated the agreement on September 30, 2013 to enable the Florida HIE to initiate its sustainability plan. The Florida HIE is currently sustained by user fees.

The Florida HIE provides three services: Patient Look-Up (PLU), Event Notification Service (ENS), and Direct Messaging, a HIPAA compliant email service that allows participants to send and receive messages and attachments containing a patient's clinical data.

The PLU service connects existing health care provider networks for the exchange of health information for treatment purposes. There are currently nine large hospital systems and health information exchange organizations connected to the PLU service. Each of these organizations comprises numerous facilities and ambulatory providers.

The ENS provides alerts to health plans about their members' hospital encounters which the health plan then provides to the patient's primary care provider for care coordination. Currently, 94 percent of acute care hospital beds in the state are covered by ENS. There are 6 health plans and 20 Accountable Care Organizations subscribing to the service. There are 1.8 million lives covered by the ENS as of August 2016, with 140,000 alerts delivered to subscribers.

The Florida HIE is actively working with Long-term Care (LTC) provider networks to facilitate their participation in the exchange of patient information for improved coordination of care.

The Florida HIE is a participant in the eHealth Exchange, enabling health care providers participating in the Florida HIE to exchange health information nationally with other eHealth Exchange participants. The eHealth Exchange is a group of federal agencies such as the Veterans Administration and the Social Security Administration and non-federal organizations such as health information exchanges and large provider networks 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.

Florida HIE adoption statistics are reported on the Florida Health Information Network website at www.fhin.net.

Telehealth

Telehealth expands patient and provider access to health care services through telecommunications technology. Telehealth allows for consultation and treatment without having to be physically present in a clinical setting, and can provide access to providers over long distances. Understanding the benefits of telehealth can help policy makers and providers improve access to efficient health care in the state, often reducing costs.

In 2016, the Agency will convene the Telehealth Advisory Council (Council) to advise and make recommendations regarding best practices for telehealth in the state. The council is composed of 13 appointed members, the state Surgeon General, and the Secretary of AHCA who serves as the chair. The Council will utilize findings from a statewide telehealth survey and will prepare a report of their recommendations for the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 31, 2017. The report and recommendations will focus on increasing telehealth services and addressing existing barriers.

The Council will be coordinating with the Agency, as well as the Department of Health and the Office of Insurance Regulation to survey health care facilities, professionals, and insurers in the state to collect information about existing telehealth services, accessibility, costs, and coverage levels. The Agency will prepare a report of survey findings for the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 31, 2016. The Agency also created the Telehealth Advisory Council website.

Primary Care Grant Awards

The Agency received an appropriation of $28,550,939 in non-recurring general revenue funds during FY 2015-2016 to increase access to primary care services for Florida's underinsured and uninsured populations and to decrease unnecessary emergency room visits and hospitalizations in the state. The Agency facilitated a competitive grant program and awarded 61 health care providers with Primary Care Grant Awards. These funds will allow award recipients to implement a variety of programs including expanded clinic hours, added capacity to expand primary care services, engagement in disease management and health education, expanded dental/oral health services, and the addition of behavioral health services to existing service options. The Agency began executing the agreements in 2016 and will continue to work with the awardees through FY 2016-2017.

Optimizing Resources in Challenging Economic Times

Efficiency continues to be a goal of the Agency, and over the past six years, HQA's full-time equivalent (FTE) positions (Table 1-1) have remained relatively stable (The Florida Center became part of the Division of Health Quality Assurance in FY 2012-2013). However, from FY 2010-2011 to FY 2015-2016, HQA's number of licensed, registered, certified, and regulated

service providers and facilities increased from 44,229 to 48,638 in FY2015-2016 (Table 1-2). Overall, this represents a 9.96 percent increase in regulated providers.

Table 1-1

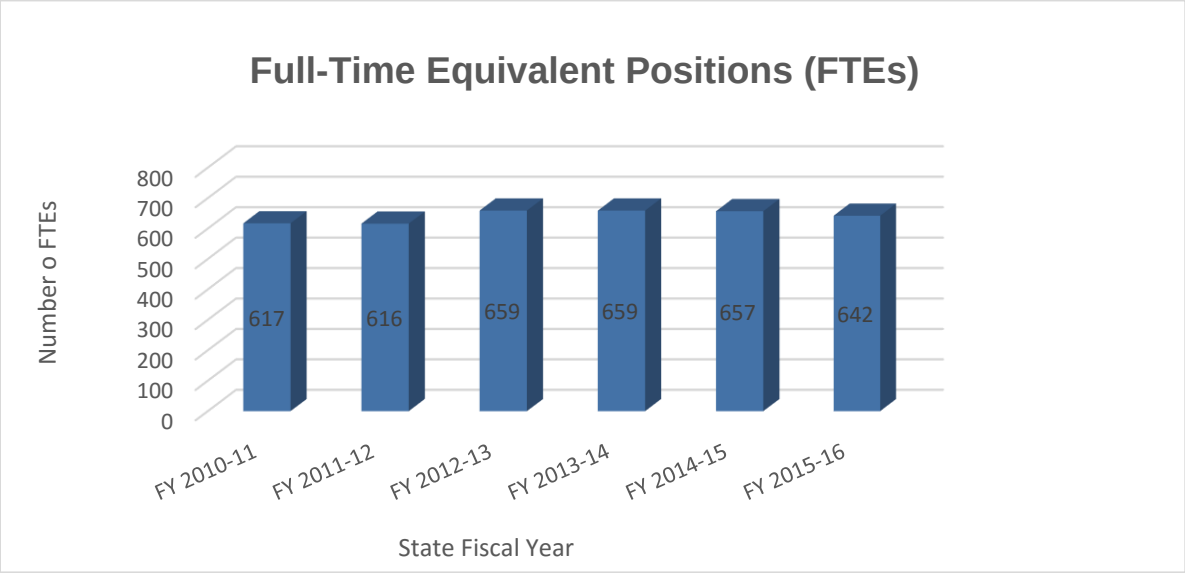
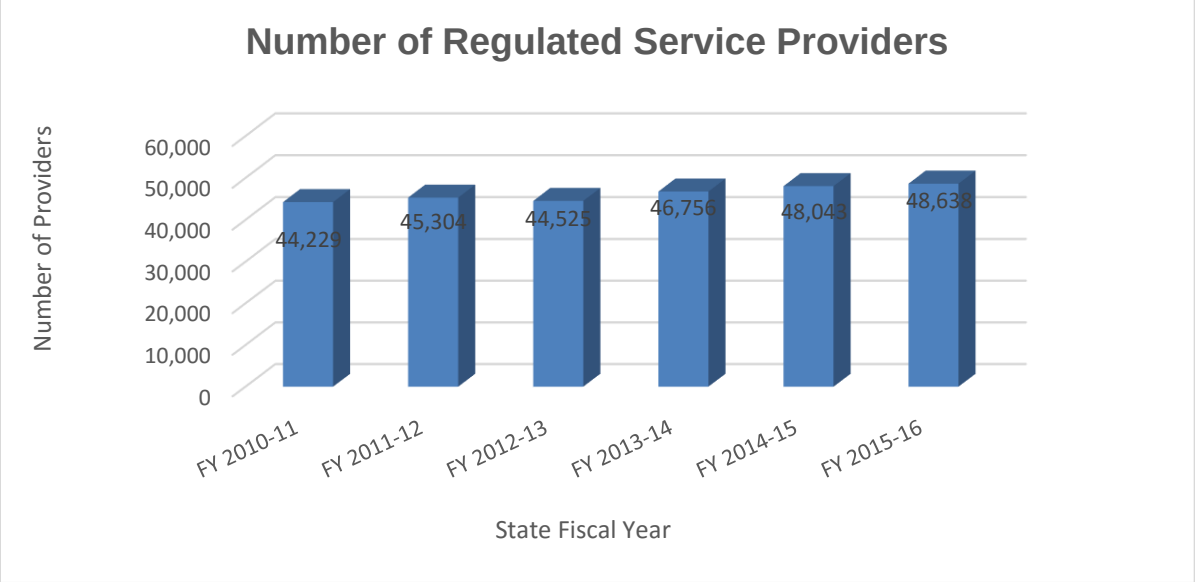


Table 1-2



Enhancing the Application Process through Streamlining

In order to better serve its consumers, the Agency utilizes information technology to enhance streamlining efforts. HQA continues to focus on the implementation of an online licensing system and the Care Provider Background Screening Clearinghouse. These major projects allow the Agency to maximize its resources and enhance the license application process for providers. Streamlining background screening and implementing a plan for single submission of provider

information will speed up the connection between health care providers and the Floridians they intend to serve.

Online Licensing

The Agency continues to move toward the ultimate goal of a comprehensive, integrated, online licensure system to expand health care provider access and reduce administrative burdens on Florida businesses through an expedited licensure and enrollment process. The online licensing system is fully operational for all license renewals and is moving toward greater intra/inter-departmental connectivity with other automated systems, such as those used by Medicaid, managed health care, background screening, accounts receivable, and the Department of Health practitioner regulation. It is being developed with the ability to interact with other internal and external agency databases for verification of Medicaid enrollment and appropriate business registration as well as identification of outstanding monetary obligations to facilitate the Agency's collections before licenses are issued or renewed.

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 pre-populates 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 is notified of these errors and is instructed to address them prior to submission. These features help reduce the number of applications that are received with missing or incomplete information. 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 2015, through June 2016, the percentage of renewal applications submitted online rose from 37.4 percent to 45 percent as more providers opted to go paperless.

Over the next two years, the Agency plans to expand the online licensing system to allow providers to submit initial and change of ownership applications as well as submit information changes during the licensure period. Once implemented, these expansions should further reduce the number of paper applications processed and provide additional efficiencies to the state of Florida.

Electronic Background Screening

The Agency continues to enhance 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 our Agency and the following agencies to share those results: 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 (DJJ), and Vocational Rehabilitation (VR) at the Department of Education (DOE).

For the selected agencies and persons subject to background screenings, the elimination of duplicative screenings for employees working in Long-term Care and other health care related provider types has resulted in an overall cost savings of $13.4 million for employers since January 2013. Integration with the state agencies began in January 2013, and all seven specified agencies are now fully implemented. The Clearinghouse provides individuals the opportunity to avoid the cost of duplicate screenings, and the health care providers and employers benefit by being able to use screenings per month from the Clearinghouse. During FY 2015-2016, more than 90,000 background screening results were shared among participating agencies and managed care health plans resulting in an overall cost savings of over $6,750,000 to Agency providers, DOH licensees, managed care health plans, Medicaid providers, and DCF and APD providers. The Clearinghouse also includes a “Rap Back” feature which notifies an agency of an employee arrest. This allows state agencies to become immediately informed when an individual is no longer eligible to work with vulnerable citizens. In the past, the agency might not have been notified until the employee’s next scheduled background check.

Now that all specified agencies have implemented the Clearinghouse, the next step is to implement the Federal Rap Back process. The implementation of the Federal Rap Back 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 additional system enhancements include:

1. Implementation of the required 5-year renewal of screenings scheduled to begin January 2018.
2. Additional functionality for the legislatively required employee/contractor roster.
3. Additional functionality for criminal registration to improve tracking registered sex offenders, career offenders, and sexual predators.
4. Additional quality assurance workflow processing for criminal history review and exemptions.
5. Reporting capabilities.
6. Connection 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. Functionality to give individual applicants access to initiate their own screenings, providing additional avenues for DOH licensees and others to request Clearinghouse screenings.
8. Functionality to give third party employment contractors access to initiate screenings and maintain employee rosters on behalf of state agency providers.

9. Connection 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 identity concerns arise.
10. Enhanced Livescan vendor and location management within the application.

The Agency has also focused resources on monitoring provider compliance with patient protections including maintaining current employment information in the Clearinghouse and removing employees from patient access if they become ineligible after employment.

Business Intelligence Competency Center

The Agency's Business Intelligence Competency Center (BICC) was created to integrate silos of information and data that the Agency collects and maintains. A business intelligence environment allows the Agency to understand and improve the quality of our delivery systems as well as internal performance. The use of business analytics assists the Agency by eliminating redundant systems and processes.

The BICC initiatives include:

- Reviewing of Agency procurements with a technology component;
- Participation in project teams for development and design of proposed technology projects to assure that enterprise needs are considered;
- Developing and maintaining a survey of existing business intelligence infrastructure and identify additional needs or potential efficiencies;
- Establish a sole source of truth among data resources and work to assure integration at the enterprise level; and
- Recommending industry best practices in data governance and data access policies.

A team within the BICC Unit has also led the Agency in visualizing performance metrics through analytical tools. These tools were used in several projects including the dashboards for the Commission on Healthcare and Hospital Funding.

Cross-Divisional Enforcement Efforts

In addition to collaborative investigative activities, the Agency continues to align legal actions and sanctions between HQA licensure and Medicaid. Adverse licensure actions 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. 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 publishes a monthly press release identifying the final orders and other legal actions that are assessed against providers by HQA and Medicaid Program Integrity. The monthly press releases can be viewed on the Agency's website under Communications/Media Relations. The provisions in Senate Bill 1986 (2008) have 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. Periodic reports submitted to the Senate Committee on Health Regulation include 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 MPI 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.

Administration and Support (Division of Information Technology)

The Division of Information Technology (IT) oversees the Agency's use of existing and emerging technologies in government operations and its use in delivering services to customers and the public. IT strives to maximize the Agency's efficiency through technology. Currently, there are three functional bureaus within the Division of IT, each with clear and distinct responsibilities. These 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 is critical to the continued success of the Agency and its mission. With the national and state spotlight 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, efficiency, and customer service by reducing administrative burdens. 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, self-service customer service, cybersecurity, and collaboration skills and efforts.

The Florida Agency for State Technology

The Agency for State Technology (AST) was established in 2014 by the Florida Legislature, House Bill 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 agencies IT projects as outlined in s. 282.0051, F.S.

In FY 2015-16, the AST promulgated rule 74-1 and 74-2, Florida Administrative Code, to establish and refine project management and cybersecurity definitions and standards. The Agency is working with AST to ensure compliance with these new standards.

Vision for Information Technology

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. The main focuses of the Agency's use of information technology are:

- The rapidly growing need for technology to implement and support health policy legislation at a federal and state level; and
- The increasing need for transparency and self-service aggregate analysis along with the importance of securing data from threats and inappropriate disclosure.

Strategic Planning in Information Technology

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. Information technology 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. State data security is governed by s. 282.318, F.S., which provides comprehensive guidelines on conducting risk analyses and assessments, 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.

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

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 three 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 third is the Agency's long-term information technology policy of consolidating and integrating all information technology systems.

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 and cost avoidance. 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 is reported, to recover overpayments, and impose sanctions, as appropriate.

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

FY 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 and program oversight;
- Detection;
- Managed care oversight and compliance; and
- Overpayment recoupment.

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 appropriate oversight of the Medicaid program.

Prevention and Program Oversight – The Prevention and Program Oversight Unit was established to enhance the effectiveness of MPI operations. The unit conducts research supplemented by field reviews to identify issues in the Medicaid program, deter fraud and abuse issues, and 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 Medicaid Fraud Control Unit (MFCU). In FY 2014-2015, referrals to MFCU increased exponentially and this pattern continued in FY 2015-2016.

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 assessments and validation to develop leads and support data driven information.

In August 2014, the Agency entered into a contract with SAS Institute, Inc. (SAS), a leading data analytic organization, 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 and Compliance – The Managed Care Oversight and 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 unit evaluates reports and ensures 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 advanced analytic services by continuing to use staff in the most effective and efficient manner, procuring an audit vendor(s) to be paid via a contingency basis or other arrangement that ensures a high return on investment, and by continuing to work collaboratively with the Centers for Medicare and Medicaid Services (CMS) and the Medicaid integrity contractor 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 Florida Medicaid program is established in chapter 409, F.S., (Social and Economic Assistance) and chapter 59G, F.A.C., (Medicaid). Other relevant statutes that mandate the management and administration of state and federal Medicaid programs and child health insurance programs as well as the development of plans and policies for Florida's health care industry include chapters 20, 216, 393, 395, 400, 408, 409, 440, 626, and 641, F.S.. Medicaid must meet federal standards, or obtain a federal waiver of such, to receive federal financial participation in the program. Although rates of federal participation vary each year and by activity 60.67 percent of the expenditures for most Medicaid services were reimbursed with federal funds in FY 2015-16. According to CMS, federal share of expenditures for FY 2016-17 will be 61.1 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. According to the U.S. Census Bureau, the population of Florida was estimated to be more than 20.27 million as of July 2015, making it the third most populous state in the nation. Florida's growth rate has been among the fastest in the nation for decades.

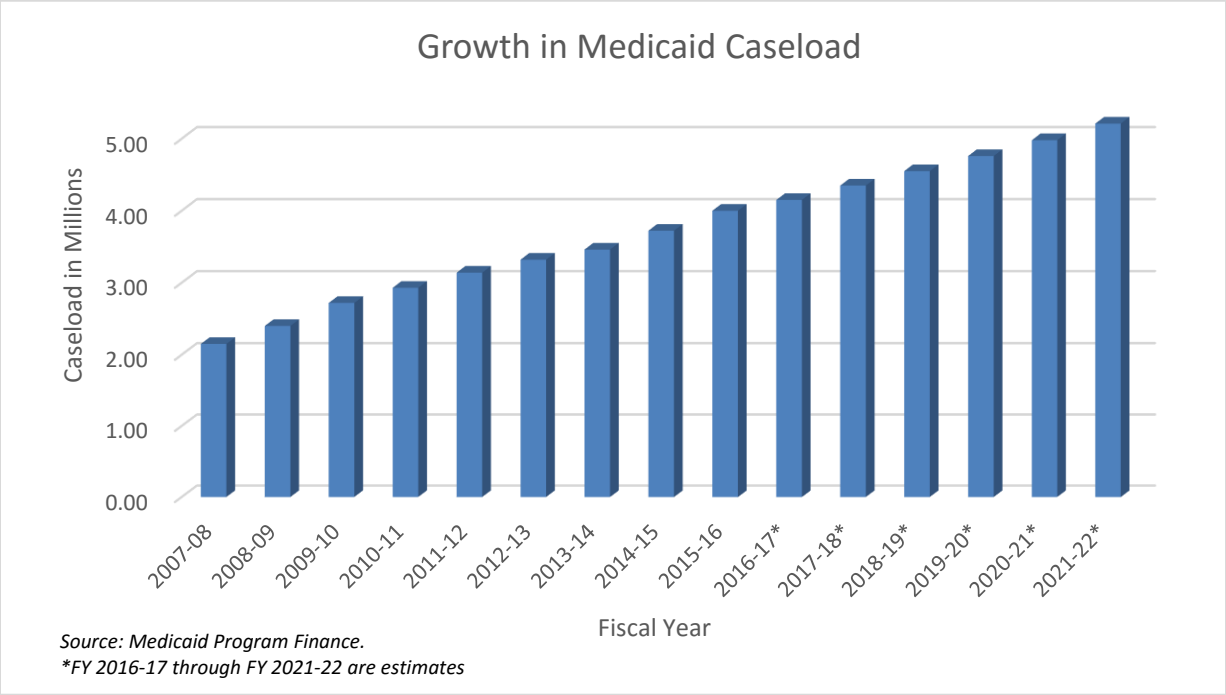
At the time of the 2010 U.S. Census, Florida had the highest percentage,17.3 percent, of elderly residents in the nation, increasing to 19.4 percent by 2015. As the baby boom generation, those born between 1946 and 1964 per U.S. Census Bureau, begins reaching retirement age in the next few years and substantial numbers of retirees relocate to Florida, the demand for health care services will continue to grow. 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 would indicate.

In order to help manage the growth in demand for Medicaid services and to provide greater predictability of cost increases, Florida implemented the Statewide Medicaid Managed Care program (SMMC). SMMC has two key program components: Long-term Care (LTC) and Managed Medical Assistance (MMA). 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

At the end of FY 2015-2016, Medicaid had more than 113,500 fully enrolled providers, providing services to both FFS and health plan recipients, and over 18,000 limited enrollment and registered providers, providing services only as part of health plan provider networks, serving over 3.9 million recipients. With expenditures of an estimated $23.8 billion, 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 the fiscal year were more than 80.2 percent higher than the previous decade (Figure 3-1). Total caseload increased by 5.7 percent in FY 2015-2016 over the prior fiscal year and is projected to continue increasing in FY 2016-2017 by more than 4.3 percent.

Figure 3-1



Source: Medicaid Program Finance.
**FY 2016-17 through FY 2021-22 are estimates*

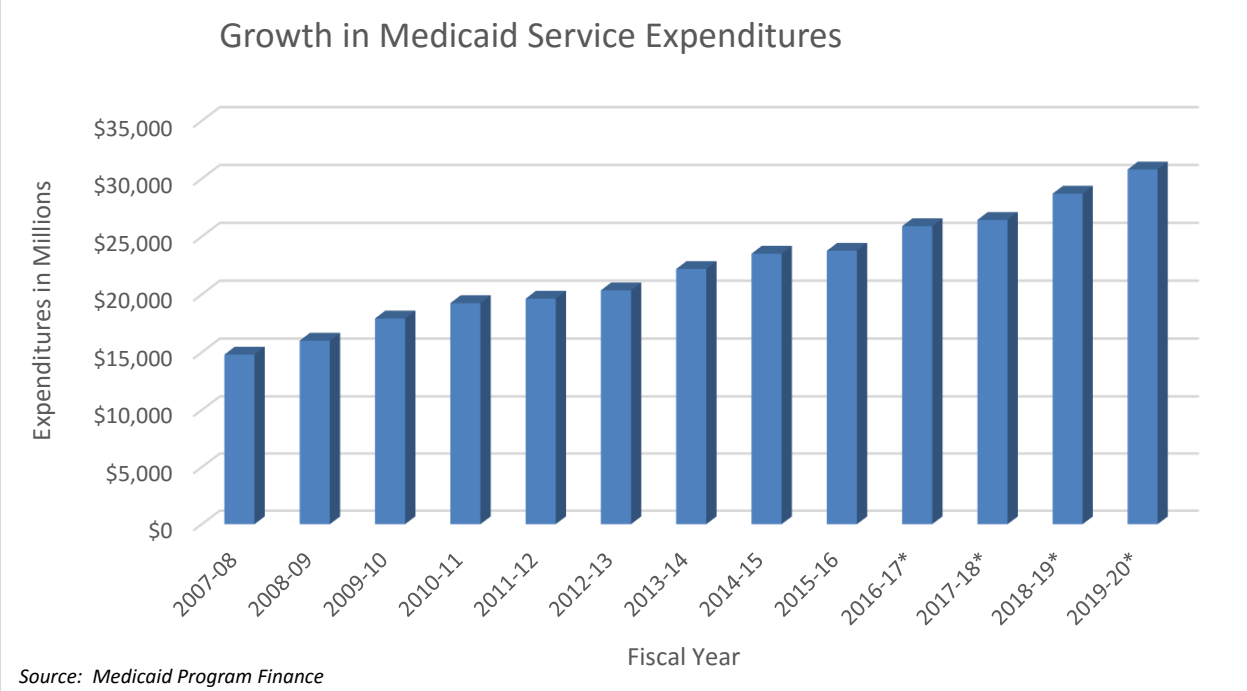
The caseload increases in recent years reflect external factors such as the launch of the Affordable Care Act and the transition of many children previously covered by the Children's Health Insurance Program (CHIP) to Medicaid.

Medicaid Expenditures

In the last 10 years, expenditures in the Medicaid program grew 71.2 percent, from almost $13.9 billion in FY 2005-2006 to $23.8 billion in FY 2015-16 (Figure 3-2). The primary factors contributing to expenditure growth have been an increase in the total caseload and an increase in the cost of providing medical services and Long-term Care. The largest estimated expenditure categories for FY 2015-2016 were:

- Prepaid Health Plans ($12.2 billion);
- Prepaid Health Plan/Long-term Care ($3.9 billion);
- Supplemental Medical Insurance ($1.4 billion)
- Home and Community-Based Services ($1.0 billion);
- Low Income Pool (LIP) ($1.0 billion); and
- Hospital Inpatient Services ($773.4 million).

Figure 3-2



Source: Medicaid Program Finance
**FY 2016-17 through FY 2019-20 are estimates.*

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 increased 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. Eventually this led to a program that was a mix of special programs, waiver programs, a FFS population, a FFS primary care case management population - MediPass, and a population in prepaid health plans. Florida implemented a managed care pilot program, known as Medicaid Reform or simply Reform, in Broward and Duval counties in 2006 which was expanded to Baker, Clay and Nassau counties in 2007. By July 1, 2013, there were 1.54 million Medicaid recipients enrolled in managed care including more than 1.2 million in 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.

During 2013 and 2014, Florida Medicaid implemented significant program changes that have resulted in improved efficiency, cost predictability and accountability for the program and enhanced service delivery for program recipients. The single greatest change in Medicaid since the program was adopted was the implementation of the SMMC program. Rollout of the SMMC program was completed in September 2014.

Statewide Medicaid Managed Care

Florida Medicaid implemented significant program changes that have resulted in improved efficiency, cost predictability and accountability for the program and enhanced service provision for program recipients. The single greatest change in Medicaid since the program was adopted was the implementation of the SMMC program. During FY 2015-16 the division of Medicaid has built on those past achievements to provide increased accountability and transparency in the Medicaid program while continuing quality improvement.

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 of Florida Medicaid 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.

SMMC Long-Term Care

The LTC portion of the SMMC program is designed to provide streamlined options for care and care coordination for Medicaid LTC recipients who in the past have received services through a variety of waivers and programs. Long-term Care under the Florida Medicaid program includes institutional care, assistive care services, and home based services. Institutional care includes care in nursing facilities and intermediate care facilities for Individuals with Intellectual Disabilities (ICF/IID). Home based care is provided in assisted living facilities, adult family care homes, and in an individual's own home or family member's home.

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.

As part of the implementation of the SMMC program, several home and community based waivers were ended, and their enrollees rolled into the LTC program, including:

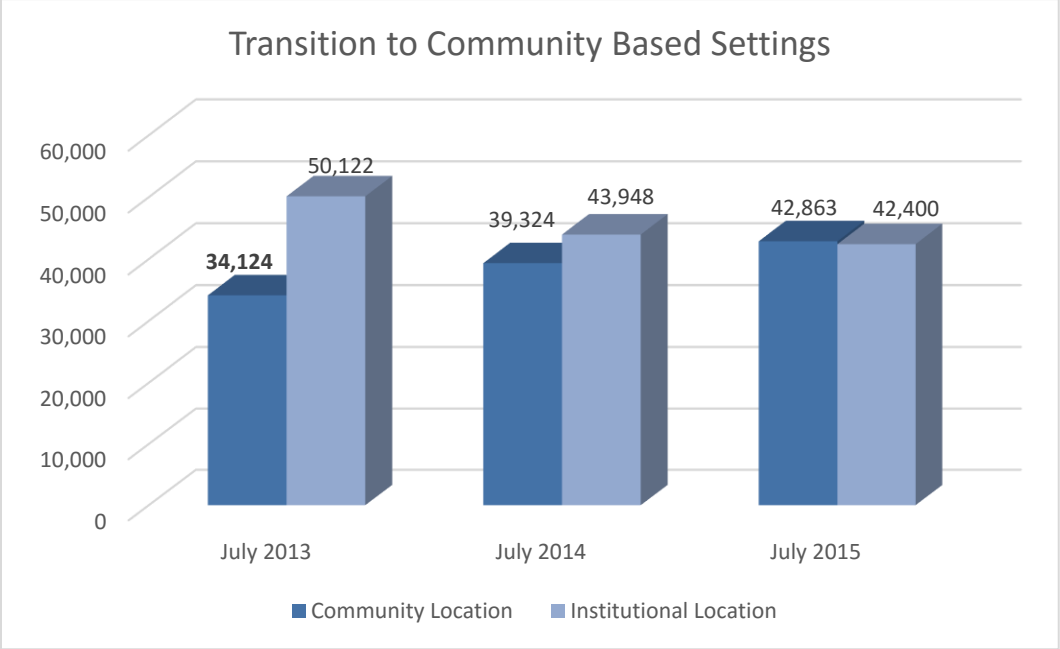
- The Assisted Living for the Frail Elderly Waiver;
- The Aged and Disabled Adult Waiver and its Consumer-Directed Care Plus component as described in s. 409.221;
- The Adult Day Health Care Waiver; and

- The Channeling Services Waiver for Frail Elders.

This waiver consolidation provides for a more consistent and larger benefit package for waiver recipients, is easier for waiver recipients to understand, and reduces administrative burden by no longer having to maintain and monitor multiple waivers. Recipients enrolled in the LTC program are required to receive their LTC services from the LTC plan.

The LTC program was designed with incentives to ensure a stronger health care delivery system by getting the incentives in Medicaid right. As a result, patients are able to reside in the least restrictive setting possible and have access to home and community based providers and services that meet their needs. LTC plans are incentivized to transition recipients from institutionalized settings to community settings. Rates paid to the LTC plans were developed to provide an incentive to shift services from nursing facilities to community based care.

Figure 4-1



As of June 30, 2016, SMMC LTC had six health plans statewide providing care and services to 46,899 institutional facility residents and 45,451 waiver recipients for a total enrollment of 92,350 individuals.

SMMC Managed Medical Assistance

The MMA component of the SMMC program operates under an 1115 Demonstration Waiver and is designed to implement a statewide managed care delivery system without increasing overall

program costs. The MMA program provides primary and acute medical care, behavioral health, and dental care for certain populations through high quality, competitively selected health 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.

Implementation of SMMC MMA began in May 2014, and was complete in all regions of the state by August 1, 2014. As of June 30, 2016, there were a total of 3,186,511 individuals enrolled in the MMA program's 17 health plans.

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 fee-for-service 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, and adoption; and
- Enhanced standards related to claims processing, prior authorization, and enrollee/provider help line, call center operations.

Enhanced Compliance Systems and Structures

In conjunction with implementation of the SMMC program, Florida created a centralized tracking system known as HealthTrack as a way to streamline processes, track enrollment, and track and

respond to all complaints and issues received by the Agency related to Florida's SMMC program. The Agency encouraged, and continues to encourage, all stakeholders to report any potential issues, concerns, or complaints regarding the SMMC Program. All reported contact is recorded and all complaints and issues are logged and tracked regardless of whether they are found to be accurate or substantiated. The Division of Medicaid produces monthly reports of plan specific issues which are reviewed by Agency staff. The centralized tracking of these complaints and issues has allowed the Agency to be more efficient in reporting and tracking trends of program issues and escalate issues for action to ensure compliance based on this data.

In addition to assisting individual recipients and providers with resolving specific issues, the Division of Medicaid utilizes the complaint system to assess health plan compliance with contractual obligations. Utilizing the competitive procurement method to secure health plan contracts allowed the Agency to develop health plan contracts that provide more accountability than ever through robust health plan reporting requirements and capability to assess liquidated damages and/ or sanctions for any contract violation.

In addition to the HealthTrack system, Medicaid maintains several offices throughout the state that offer support for the Florida Medicaid program. These operations include:

- Recipient Complaints and Inquiries;
- Field-based Choice Counseling;
- Medicaid Fair Hearings;
- Skilled nursing facilities and Assisted living facilities Closures/Medicaid Terminations;
- Provider Complaints and Inquiries;
- Provider Technical Assistance;
- Provider Training;
- New Provider Enrollment;
- Provider Recruitment;
- Community Outreach;
- Government and Community Partnerships/Alliances;
- Local Planning/Coordination Boards/Groups; and
- Special Initiatives.

Highlights and Successes During FY 2015-16

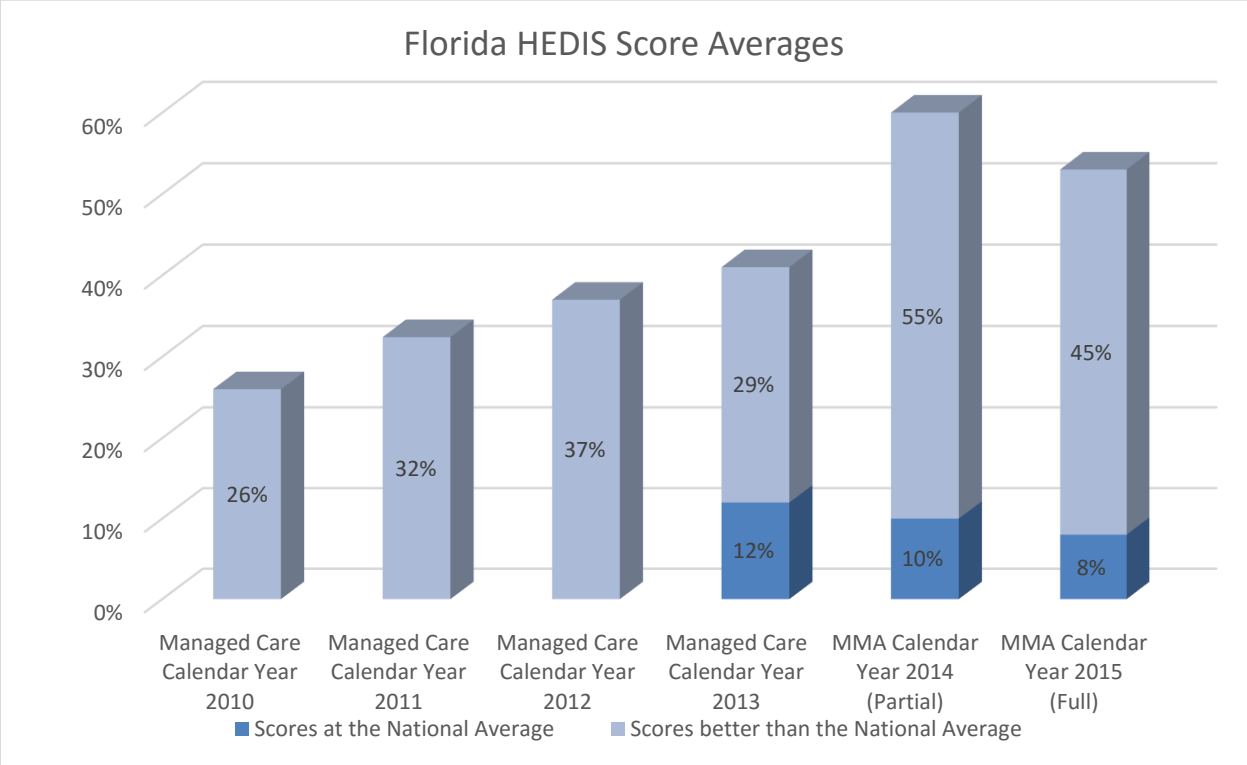
Improved Quality and Enrollee Satisfaction

During FY 2015-16, the Division of Medicaid continued to work on improving quality and has several accomplishments that will help realize these program goals. Medicaid has implemented multiple tools that track quality and performance in health plans. Plans are required to report Healthcare Effectiveness Data and Information Set (HEDIS) scores which show how well plans are performing on various aspects of providing care to recipients. Medicaid also completed enrollee satisfaction surveys for MMA and LTC plans. MMA plan enrollees were surveyed using the national Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey instrument while LTC enrollees were surveyed using an instrument designed by the Agency to specifically address program components in LTC. Medicaid now publishes a consumer-focused Medicaid Health Plan Report Card using these findings which is available online and is linked

from the Medicaid Choice Counseling website to help individuals choose an MMA plan. Finally, the Division of Medicaid completed implementation of the ICD-10 classification of procedures which provides greater levels of detail on the services provided to recipients.

Initial evidence shows that Florida's Medicaid program is currently operating at the highest level of quality in its history, and that it is doing so at a substantial per person savings to Florida's taxpayers. This means that the most vulnerable Floridians are getting the right care, in the right setting, preventing costly health crises and leading to better health care for all Floridians. Medicaid expects to see the trend of improvements in quality and performance continue.

HEDIS scores are used by more than 90 percent of America's health plans to measure performance on important standards of care and service. Florida Medicaid health plan's HEDIS scores under MMA are trending upward and continue to be higher than before implementation of the program.



Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. Consumer satisfaction surveys show that MMA enrollees have high levels of satisfaction with the care they are receiving. Below are some highlights from 2016 CAHPS results:

CAHPS Items/Composites	Rate Description	2015 Result	2016 Result
Child: Overall Plan Satisfaction	% rating 8, 9, or 10	81%	84%
Child: Health Care Rating	% rating 8, 9, or 10	85%	86%
Child: Ease in Getting Needed Care	% reporting Usually or Always	82%	83%
Child: Getting Help from Customer Service	% reporting Usually or Always	86%	88%
Adult: Getting Help from Customer Service	% reporting Usually or Always	87%	88%

The LTC Enrollee satisfaction survey shows high satisfaction with care and improvement in overall health and quality of life. Survey respondents reported the following regarding their experience with the LTC program:

- 76 percent reported that their quality of life had improved since enrolling in their LTC plan.
- 78 percent of respondents rated their Long-term Care plan an 8, 9, or 10.
- 80 percent of respondents reported it usually or always being easy to get in contact with their case manager.
- 81 percent of respondents rated their case manager an 8, 9, or 10.
- 89 percent of respondents reported their long-term care services are usually or always on time.
- 80 percent of respondents rated their LTC services an 8, 9, or 10.
- 60 percent reported that their overall health had improved since enrolling in their LTC plan.

During 2015, Florida State University completed an evaluation of the LTC program. The evaluation analyzed several program components related to access to care and quality of care. Key findings relating to access to care included:

- Diligent outreach was conducted prior to and during program implementation.
- Complex program implementation effort was coordinated successfully with no large scale access to care failures.
- Complaints related to access to care were fairly uncommon.
- Network of LTC providers appears to be robust.

Key findings relating to quality of care included:

- Overall, quality levels remained the same or improved.
- 76 percent of satisfaction survey respondents indicated that their quality of life had improved since enrolling in the LTC program.

Publication of MMA health plan report cards mean enrollees can now choose plans based on quality. Measures include important topics such as pregnancy related care, keeping kids healthy, keeping adults healthy, and others. Health Plan Report Cards are available online through FloridaHealthFinder.gov and are linked through the Medicaid Choice Counseling website.

Recipient and Provider Enrollment Improvements

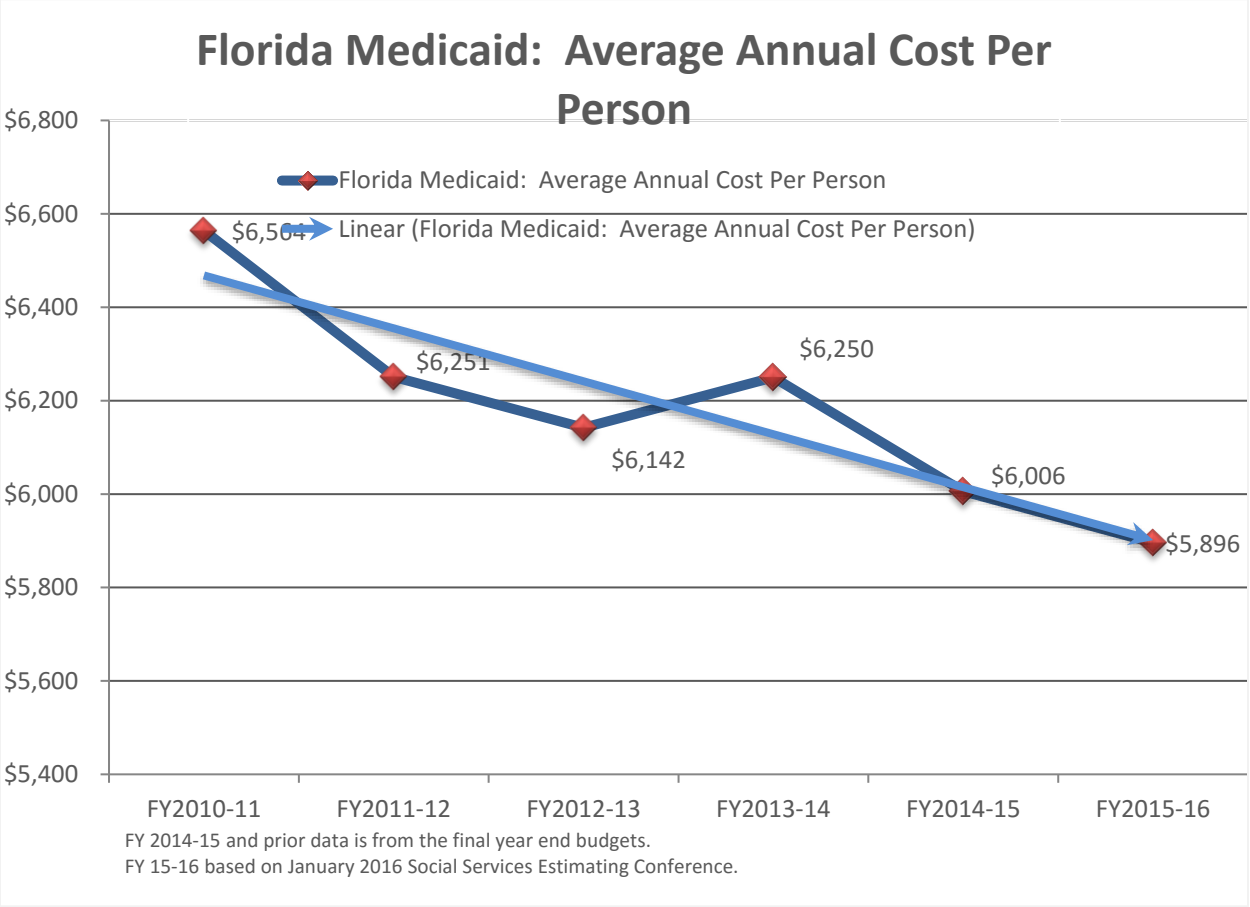
As part of the implementation and continuing operation of the SMMC program, the Agency made programmatic changes to facilitate recipient and provider managed care enrollment through the implementation of Express Enrollment for recipients, and Limited Enrollment for providers.

The Agency implemented Express Enrollment for recipients in February 2016. Under Express Enrollment, the Agency gives recipients the opportunity to make a health plan choice when they apply for eligibility and assigns Medicaid-eligible individuals who are mandated to participate in the MMA program to a health plan immediately after eligibility determination. This allows new enrollees to immediately take advantage of robust provider networks, access standards, and expanded benefits offered by health plans, and choose a health plan based on quality and customer service to ensure Florida Consumers receive the care they need and deserve.

In addition, the Agency implemented Limited Enrollment for providers in December 2015. The Agency created a streamlined application, or Limited Enrollment, for providers who do not hold a Medicaid identification number and need to complete the basic credentialing which may be a prerequisite to seeking a contract with a Medicaid health plan. Providers seeking to participate in a health plan's network have the option to utilize a web-based Limited Enrollment application wizard which guides them through creation of the application. The streamlined application and corresponding review process allows approved providers to receive their Medicaid IDs faster than with traditional full enrollment.

SMMC Program Savings

One of the primary goals of the SMMC program is to incentivize higher quality without causing inflation. The health plans selected to participate in the SMMC program bid payment rates through the procurement process. Actuarial analysis suggesting that the rates that were successfully negotiated with the MMA plans represent approximately a 5 percent savings as compared to the cost of providing the same services to the same recipients in the Medicaid environment that existed prior to SMMC. This savings has contributed to lower per-person costs in the Medicaid program, which can be seen in the chart below, which shows per member per year expenditures for the entire program.



In addition to the 5 percent savings required in the initial procurement, health plans are required to coordinate care, manage chronic disease and prevent the need for costlier care, and that such effective care management should enable plans to redirect available resources and increase compensation for physicians.

Finally, as part of the SMMC authorizing statute, provisions were put in place to require plans to increase compensation for physicians utilizing savings from effective care management.

The Agency has designed the MMA Physician Incentive Program with the expectation that health plans should be able to fund higher physician reimbursement out of managed care savings, as specified by section 409.967(2) (a), F.S.

Beginning October 1, 2016, Board Certified Pediatricians and Board Certified Obstetricians who meet specified criteria and/or access and quality measures and who are contracted with one or more MMA plans will be eligible for enhanced payments that are equivalent to Medicare rates for specific services. The Agency intends to add additional physician types to the program over time.

Medicaid Over the Next Five Years/Legislative Budget Requests

Over the next five years Florida Medicaid will continue to focus on increased accountability to recipients, improved access to quality care, and greater transparency for all stakeholders. Florida will be implementing a comprehensive plan for assessing individuals for evidence of serious mental illness and/or intellectual disability and related conditions prior to nursing facility admission. In addition, Medicaid will be exploring ways to improve efficiency and quality of services for recipients in federal waiver programs. The Division of Medicaid is also looking at ways to improve data collection and reporting and continue to pursue quality improvement efforts throughout the program. Medicaid will continue the development and upgrade to its Information Technology Architecture, and is pursuing integration of Medicaid Enterprise Systems to improve interoperability and communication between different platforms.

Medicaid anticipates submitting LBRs in the future to improve the overall administration of the SMMC program and Medicaid as a whole. Medicaid will evaluate program and plan performance and will continue to evaluate ways to measure and track performance as well as seeking to improve patient care and outcomes on an ongoing basis.

List of 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
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

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
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
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
Division of 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

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
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
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 402.281, F.S.	Governor's Panel on Excellence in Long-Term Care (Gold Seal Program)	Ongoing responsibilities
29.	section 408.7056 and section 408.7057, F.S.	Statewide Provider and Subscriber Assistance Panel	Ongoing responsibilities
30.	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
31.	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
32.	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

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
33.	section 429.19, F.S.	Assisted Living Facilities Annual Report on Fines	Annually/July 30
34.	section 627.6699, F.S.	Florida Health Insurance Advisory Board (FHIAB)	Ongoing responsibilities
35.	section 408.05(3)(c), F.S.	Internet platform to research price of health care services and perform price comparisons	Ongoing Responsibilities
36.	section 408.05(3)(j), F.S.	Health Care Transparency report on one or more research topics that can be investigated using data collected from the APCD	Annually/due date unspecified
37.	section 408.05(6), F.S.	State Consumer Health Information and Policy Advisory Council	Ongoing Responsibilities
38.	section 408.0611(4), F.S.	Annual Electronic Prescribing Report	Annually/January 31
39.	section 408.062(1)(e), F.S.	Health Care Expenditures Report	Annually/due date unspecified
40.	section 408.062(1)(h), F.S.	Retail prices charged by pharmacies for the 100 most frequently prescribed medications	Quarterly (met as ongoing)
41.	section 408.062(1)(i), F.S.	Annual Report of Emergency Department Utilization and Services	Annually/January 1

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
42.	section 408.062(1)(j), F.S.	Publication of data on patient charges, volume, length of stay, and quality/performance indicators; and annual status report	At least quarterly; with annual status report/due date unspecified
43.	chapter 2016-240 L.O.F.	Telehealth survey of health care facilities, practitioners, and health plans – report of findings	Non-recurring report due by December 31, 2016
44.	chapter 2016-240 L.O.F.	Telehealth Advisory Council report of recommendations on increasing accessibility to telehealth	Non-recurring report due by October 31, 2017
45.	section 394.761, F.S.	Revenue Maximization Plan to increasing availability of federal Medicaid funding for behavioral health care	Non-recurring report due by December 31, 2016
46.	section 394.879, F.S.	Consolidated license plan for mental providers	Non-recurring report due by November 1, 2016
47.	section 395.0197(8), F.S.	Quarterly and Annual summaries and trend analyses of adverse incidents	Quarterly and Annually
48.	section 408.05(6), F.S.	State Consumer Health Information and Policy Advisory Council	Ongoing Responsibilities
49.	section 20.055(5)(i), F.S.	Annual long-term and audit plans – Inspector General audit plans submitted to the Agency Head, Chief Inspector General, and Auditor General.	Annually/September 30

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
Division of Information Technology			
50.	None.		
Division of Medicaid			
51.	section 409.913, F.S.	Annual Medicaid Fraud and Abuse Report	Ongoing responsibilities
52.	section 409.91211, F.S.	Enhanced Benefits Panel	Ongoing responsibilities
53.	section 409.818, F.S.	Florida KidCare Grievance Committee	Ongoing responsibilities
54.	section 409.91213, F.S.	Low Income Pool (LIP)	Quarterly progress reports and annual reports for 1115 waivers
55.	section 409.911, F.S.	LIP Council	Ongoing responsibilities
56.	section 409.91211, F.S.	Medicaid Reform Technical Advisory Panel	Ongoing responsibilities
57.	section 381.0602, F.S.	Organ Transplant Advisory Council	Ongoing responsibilities
58.	section 400.235, F.S.	Pharmaceutical and Therapeutics Committee	Ongoing responsibilities
59.	section 16.615, F.S.	Council on the Social Status of Black Men and Boys	Ongoing responsibilities

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
60.	section 409.818(2)(c), F.S.	Kid Care Coordinating Council (Membership Only)	Ongoing responsibilities
61.	section 409.8177(2), F.S.	Florida KidCare Enrollment Report on enrollment for each component of Florida KidCare Program	Ongoing responsibilities
62.	section 409.908(2)(b)5, F.S.	Nursing Care Cost Report: Annual Report on direct and indirect care costs	Ongoing responsibilities
63.	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
64.	section 409.91213, F.S.	Medicaid Reform Quarterly Report: Agency analysis and the status of various operational areas	Ongoing responsibilities
65.	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
66.	section 409.912 (44), F.S.	HSD annual report of audit results to ensure cost effectiveness relating to Medicaid Managed Care	Ongoing responsibilities

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
67.	section 409.8177(1), F.S.	Florida KidCare Evaluation Annual Report: the Agency, in consultation with the DOH, the DCF and Florida Healthy Kids contract for evaluation and report on KidCare program	Ongoing responsibilities
68.	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
69.	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
70.	section 409.912(28), F.S.	EPSDT (Child Health Check-Up) Screening Rates	Ongoing responsibilities
71.	SB 12, Sec. 18; Section 394.879, F.S.	Mental Health Substance Abuse Providers Consolidated License	One time plan to provide options for a single, consolidated license for a provider that offers multiple types of either mental health services or substance abuse services, or both, regulated under chapters 394 and 397, respectively. In the plan, the department and the agency shall identify the statutory revisions necessary to accomplish the consolidation.

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
72.	SB 12, Sec. 17; Section 394.761, F.S.	Behavioral Health Care Funding	One time report on written plan to increase behavioral health care funding.
73.	HB 5001, S.A. 186	NH Services Independent Consultant for Prospective Payment Conversion	One time report to identify steps necessary for the budget neutral transition to and the impact of a prospective payment system on Medicaid reimbursement rates for hospice providers.
74.	Section 385.203(1)(c), F.S.	Diabetes Advisory Council Report	Annual (Odd Numbered Years): AHCA, in conjunction with DOH and DMS report to the Legislature the public health consequences and financial impact on the state of all types of diabetes and resulting health complications. The report must include information on all of the diabetes programs implemented by each state agency.

LRPP Exhibit II: Performance Measures and Standards

Approved Performance Measures for FY 2016-2017 (Words)		Approved Prior Year Standards FY 2015-2016 (Numbers)	Prior Year Actual FY 2015-2016 (Numbers)	Approved Standards for FY 2016-2017 (Numbers)	Requested FY 2017-2018 Standard (Numbers)
Program: Administration and Support			**Code: 68200000**		
1	Administrative costs as a percent of total agency costs	0.11%	0.13%	0.11%	0.11%
2	Administrative positions as a percent of total agency positions	11.45%	11.84%	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	18.23%	25.00%	20.00%
4	Percent of eligible uninsured children receiving health benefits coverage	100.00%	See New Measure 4A Below	100.00%	DELETE[4]

	Approved Performance Measures for FY 2016-2017 (Words)	Approved Prior Year Standards FY 2015-2016 (Numbers)	Prior Year Actual FY 2015-2016 (Numbers)	Approved Standards for FY 2016-2017 (Numbers)	Requested FY 2017-2018 Standard (Numbers)
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	76.70%	90.00%	75.00%
5	Percent of children enrolled with up-to-date immunizations	85.00%	N/A	85.00%	DELETE[4]
6	Percent of compliance with the standards established in the Guidelines for Health Supervision of Children and Youth as developed by the American Academy of Pediatrics for children eligible under the program	97.00%	N/A	97.00%	DELETE[4]
7	Percent of families satisfied with the care provided under the program	95.00%	92.30%	95.00%	90.00%
8	Total number of Title XXI-eligible children enrolled in KidCare	228,159	186,506	228,159	171,323
9	Number of Title XXI-eligible children enrolled in Florida Healthy Kids	195,867	153,961	195,867	139,279
10	Number of Title XXI-eligible children enrolled in MediKids	2,100	23,321	21,000	21,723
11	Number of Title XXI-eligible children enrolled in Children's Medical Services Network	111,292	9,224	10,053	10,321

	Approved Performance Measures for FY 2016-2017 (Words)	Approved Prior Year Standards FY 2015-2016 (Numbers)	Prior Year Actual FY 2015-2016 (Numbers)	Approved Standards for FY 2016-2017 (Numbers)	Requested FY 2017-2018 Standard (Numbers)
Program: Health Care Services			**Code: 68500000**		
Service/Budget Entity: Executive Direction and Support Services			**Code: 68500200**		
12	Program administrative costs as a percent of total program costs	1.44%	0.88%	1.44%	2.00%
13	Average number of days between receipt of clean Medicaid claim and payment	15	8.75	15	15
14	Number of Medicaid claims received	145,101,035	82,662,014	145,101,035	Per Appropriations Estimate
Program: Health Care Services			**Code: 68500000**		
Service/Budget Entity: Medicaid Services - Individuals			**Code: 68501400**		
15	Percent of hospitalizations that are preventable by good ambulatory care	11.00%	N/A	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	7.55%	25.00%	20.00%

Approved Performance Measures for FY 2016-2017 (Words)		Approved Prior Year Standards FY 2015-2016 (Numbers)	Prior Year Actual FY 2015-2016 (Numbers)	Approved Standards for FY 2016-2017 (Numbers)	Requested FY 2017-2018 Standard (Numbers)
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	16.68%	20.00%	20.00%
16	Percent of women receiving adequate prenatal care	86.00%	83.70%	86.00%	86.00%
17	Neonatal mortality rate per 1000	4.70%	4.20%	4.70%	5.00%
18	Average number of months between pregnancies for those receiving family planning services	35.00%	N/A	50.00%	DELETE[4]
18A	New Measure - Percentage of women with an Interpregnancy Interval (IPI) greater than or equal to 18 months.	N/A	74.80%	50.00%	75.00%
19	Percent of eligible children who received all required components of EPSDT screening	64.00%	60.00%	64.00%	64.00%
20	Number of children ages 1-20 enrolled in Medicaid	1,249,276	2,317,358	1,249,276	Per Appropriations Estimate
21	Number of children receiving EPSDT services	407,052	313,196	407,052	Per Appropriations Estimate
22	Number of hospital inpatient services provided to children	92,960	143,514	92,960	Per Appropriations Estimate

	Approved Performance Measures for FY 2016-2017 (Words)	Approved Prior Year Standards FY 2015-2016 (Numbers)	Prior Year Actual FY 2015-2016 (Numbers)	Approved Standards for FY 2016-2017 (Numbers)	Requested FY 2017-2018 Standard (Numbers)
23	Number of physician services provided to children	6,457,900	8,097,538	6,457,900	Per Appropriations Estimate
24	Number of prescribed drugs provided to children	4,444,636	4,000,642	4,444,636	Per Appropriations Estimate
25	Number of hospital inpatient services provided to elders	100,808	13,007	100,808	Per Appropriations Estimate
26	Number of physician services provided to elders	1,436,160	790,091	1,436,160	Per Appropriations Estimate
27	Number of prescribed drugs provided to elders	15,214,293	220,148	15,214,293	Per Appropriations Estimate
28	Number of 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]

	Approved Performance Measures for FY 2016-2017 (Words)	Approved Prior Year Standards FY 2015-2016 (Numbers)	Prior Year Actual FY 2015-2016 (Numbers)	Approved Standards for FY 2016-2017 (Numbers)	Requested FY 2017-2018 Standard (Numbers)
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	N/A	20.00%	DELETE
30	Number of case months (home and community-based services)	550,436	39,629	550,436	Per Appropriations Estimate
31	Number of case months services purchased (Nursing Home)	619,387	45,644	619,387	Per Appropriations Estimate
Program: Health Care Services			**Code: 68500000**		
Service/Budget Entity: Medicaid Prepaid Health Plan			**Code: 68501600**		
32	Percent of hospitalizations for conditions preventable by good ambulatory care	16.00%	See New Measures 33A and 33B Below	16.00%	DELETE[4]
33	Percent of women and child hospitalizations for conditions preventable with good ambulatory care	16.00%	See New Measure 33A Below	16.00%	DELETE[4]

Approved Performance Measures for FY 2016-2017 (Words)		Approved Prior Year Standards FY 2015-2016 (Numbers)	Prior Year Actual FY 2015-2016 (Numbers)	Approved Standards for FY 2016-2017 (Numbers)	Requested FY 2017-2018 Standard (Numbers)
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	17.65%	25.00%	20.00%[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	15.51%	20.00%	20.00%[4,5] (Budget Entity 68501600 no longer exists, standard should be in Medicaid Services - Individuals Budget Entity 68501400)
34	Number of case months services purchased (elderly and disabled)	1,877,040	N/A	1,877,040	DELETE[4]
35	Number of case months services purchased (families)	9,850,224	N/A	9,850,224	DELETE[4]
Program: Program: Health Care Regulation			**Code: 68700700**		
Service/Budget Entity: Health Care Regulation			**Code: 68700700**		

	Approved Performance Measures for FY 2016-2017 (Words)	Approved Prior Year Standards FY 2015-2016 (Numbers)	Prior Year Actual FY 2015-2016 (Numbers)	Approved Standards for FY 2016-2017 (Numbers)	Requested FY 2017-2018 Standard (Numbers)
36	Percent of nursing home facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0.00%	1.47%	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%	31.05%	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	100.00%	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%	47.38%	25.00%	DELETE[4]
40	Percent of validation surveys that are consistent with findings noted during the accreditation survey	98.00%	100.00%	98.00%	DELETE[4]
41	Percent of assisted living facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0.00%	0.74%	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%	0.00%	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%	1.16%	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%	1.61%	0.00%	DELETE[4]

	Approved Performance Measures for FY 2016-2017 (Words)	Approved Prior Year Standards FY 2015-2016 (Numbers)	Prior Year Actual FY 2015-2016 (Numbers)	Approved Standards for FY 2016-2017 (Numbers)	Requested FY 2017-2018 Standard (Numbers)
45	Percent of hospitals with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0.00%	1.63%	0.00%	DELETE[4]
46	Percent of hospitals that fail to report serious incidents (agency identified)	6.00%	2.29%	6.00%	DELETE[4]
47	Percent of new Medicaid recipients voluntarily selecting managed care plan	50.00%	51.00%	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%	DELETE[4]
48A	New Measure - Percent of complaints of HMO access to care received that are investigated.	100.00%	N/A	N/A	DELETE[4]
49	Percent of complaints of facility patient dumping received that are investigated	100.00%	100.00%	100.00%	DELETE[4]
50	Number of inquiries to the call center regarding practitioner licensure and disciplinary information3	30,000	N/A	30,000	DELETE[4]
51	Total number of full facility quality-of-care surveys conducted	7,550	6,072	7,550	DELETE[4]
52	Average processing time (in days) for Subscriber Assistance Program cases.	53	18	53	18

	Approved Performance Measures for FY 2016-2017 (Words)	Approved Prior Year Standards FY 2015-2016 (Numbers)	Prior Year Actual FY 2015-2016 (Numbers)	Approved Standards for FY 2016-2017 (Numbers)	Requested FY 2017-2018 Standard (Numbers)
52A	New Measure - Average processing time (in days) for Subscriber Assistance Program and Beneficiary Assistance Program cases	53	18	53	DELETE[4]
53	Number of construction reviews performed (plans and construction)	4,500	5,282	4,500	DELETE[4]
54	Number of new enrollees provided with choice counseling	520,000	1,051,638	520,000	Per Estimates[1] TRANSFER[4,5] (This is a Medicaid program - 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	30.00%	45.00%	N/A	60.00%
56	New Measure - Average processing time (in days) for financial reviews	3	1.23	N/A	3
57	New Measure - Number of FloridaHealthFinder.com website hits	N/A	3,722,855	N/A	3,800,000

[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 budget entity.

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: This measure used a set of ambulatory sensitive conditions based on a 1993 Health Affairs article. Medicaid recommends deleting this so that the Agency for Healthcare Research and Quality's (AHRQ) standard quality assurance measures, which are nationally recognized and continually updated, can be used. Medicaid is requesting that this measure be deleted and replaced by the following:

- 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)

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 2016

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 Agency does not have a mechanism to determine the number of uninsured children who may be eligible for the Medicaid program. Therefore, there is no way to accurately establish a denominator to determine the percentage that have enrolled and are receiving benefits.

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 2016

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%	76.7%	(13.3%)	-14.78%

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.

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

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

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

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect ☒ Other (Identify)
Explanation: This measure originally included the number of children who had all their immunizations when starting kindergarten. Since it was a requirement to have updated immunizations before enrolling in school, the measure was not meaningful. Medicaid originally attempted between 2004 and 2006 to use survey data to statistically determine the immunization percentage but the self-reported data based on parental or caregiver recall were not reliable. In 2007, Medicaid sought to replace the measure with the percentage of 2-year olds who had up to date immunizations based on the State Online Health Tracking System (SHOTS) data. However, Medicaid records alone did not show every immunization which could be coded differently, masked by another code (e.g., a well-child visit) or received by the child from a provider other than a Medicaid provider. We therefore requested that this measure be deleted.

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

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

Office of Policy and Budget – July 2016

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: The guidelines on which this standard was based have been updated and/or replaced several times and the original guidelines no longer exist. Updated, similar guidelines include guidelines for care that fall well outside the scope of Medicaid and which are not captured in CMSN or Medicaid data (such as caregiver counseling or levels of depression among parents). Since the original standard no longer exists and data for the new standards cannot be collected by Medicaid, this measure is being requested to 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: Data are not available 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 unavailability of data.

Office of Policy and Budget – July 2016

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%	92.30%	2.70%	2.84%

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	186,506	(41,653)	18.26%

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. 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	153,961	(41,906)	21.40%

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
2,100	23,321	(21,221)	1010.52%

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

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☒ Target Population Change
☐ This Program/Service Cannot Fix the Problem
☐ Current Laws Are Working Against the Agency Mission
☐ Technological Problems
☐ Natural Disaster
☒ Other (Identify)
Explanation: The approved standard does not reflect recent trends for the population in this program. Enrollment targets should be based on estimating conference predictions developed the previous year from anticipated economic and population indicators. Measures such as this are not performance measures and only provide an indication of the size and scope of the various program components

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☐ Other (Identify)
Recommendations: It is recommended that the standard for this measure be changed to 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	9224	(102,068)	1,015.30%

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 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.

Office of Policy and Budget – July 2016

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #15: Percent of Hospitalizations that are Preventable by Good Ambulatory Care

Action:

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
11.00%	N/A	N/A	N/A

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

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

Explanation: This measure applied to all individuals regardless of age who received care in FFS, MediPass, or a PSN. A better measurement would be to separate populations by Adults and Children. Therefore, the measure has been replaced using the national AHRQ standards, for both Children (ages 1-20) and Adults (ages 21+). The existing measure for which Medicaid is seeking deletion does not use up to date standards and makes no distinction between adults, children, or the elderly. It is being requested for deletion for two measures that better reflect the services and populations of the Medicaid population:

- 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
- 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.

External Factors (check all that apply):

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

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

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

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

Recommendations: This measure should be deleted in favor of a more relevant measure. New measures 15A and 15B have been created to reflect current, measurable data.

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #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%	83.70%	2.30%	2.70%

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

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

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

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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%	60.00%	4.00%	6.25%

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	220,148	14,994,145	98.55%

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 Medicaid Long-term Care and 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: Medicaid initially sought to delete this measure in 2007 and replace it with a measure that included those receiving care in institutions or those receiving care on a FFS basis through a 1915(b)/(c) waiver. With implementation of the Long-term Care component of the Statewide Medicaid Managed Care program, all Medicaid eligibles receiving long-term care services are now enrolled in a health plan. This measure no longer applies and 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: 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: This measure no longer applies and 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 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: This measure included any individual regardless of age who received health services through any kind of prepaid arrangement. Medicaid is requesting that it be replaced with two measures, one for services to Children (ages 1-20) and one for Adults (ages 20+) who are enrolled in a Managed Medical Assistance plan.

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: (*Note also that these measures should be moved under the budget item in Medicaid Service to Individuals.)* Replace with new measures; the new measures include:

• 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

• 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.

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: Women and children combined account for more than 85% of the Medicaid population and the existing measure is not significantly different than that for the Medicaid population as a whole. Further, adults and children have very different conditions for which preventive care is effective for preventing hospitalizations. Combining women and children together and excluding adult males gives at best an incomplete picture of access to health care and can also yield a result that unclear or misleading. Medicaid is requesting that the existing measure be replaced with the two measures noted above (33A and 33B), i.e., one for services to Children (ages 1-20) and one for Adults (ages 20+) who are enrolled in an MMA plan. Note also that these measures should be moved under the budget item in Medicaid Service to Individuals.

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: (*Note also that these measures should be moved under the budget item in Medicaid Service to Individuals.)* Medicaid is requesting that the existing measure be replaced with the two measures noted above (33A and 33B), i.e., one for services to Children (ages 1-20) and one for Adults (ages 20+) who are enrolled in an MMA plan.

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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	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 target population and activity group have changed. Number of case months purchased is based upon current law and legislative policy. This group no longer exists.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: With implementation of the Long-term Care component of the Statewide Medicaid Managed Care program these individuals now receive services through a health plan. The population should no longer exist in this budget entity and the measure should be deleted. A new budget activity has been requested for these individuals under the Long-term Care budget entity as shown on Exhibit VI.

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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 ☐ 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
9,850,224	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 target population and activity group have changed. Number of case months purchased is based upon current law and legislative policy. This group no longer exists.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: With implementation of the Managed Medical Assistance component of the Statewide Medicaid Managed Care program, these individuals now receive services through a managed care plan. The population should no longer exist in this budget entity and the measure should be deleted. A new budget activity has been requested for these individuals under the Medicaid Service to Individuals budget entity as shown on Exhibit VI.

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0.00%	1.47%	1.47% (Over)	1.47%

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

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

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

Explanation: Although this is a legitimate measure of facility performance, it is not a reasonable measure of Agency performance.

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

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

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #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%	31.05%	27.05% (Over)	27.05%

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

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

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

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

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

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

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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:
☒ 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
100.00%	100.00%	None	0.00%

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

Explanation: Adequate training and preceptor mentoring has enabled the Agency to investigate all P1 complaints within the two business day timeframe.

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: Agency met the goal for this measure.

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

Recommendations: None

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #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%	47.38%	22.38% (Over)	22.38%

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 run the gamut from minor to severe. The Agency can find and require correction of deficiencies, but cannot prevent those deficiencies from occurring.

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

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

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

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

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #40: Percent of Validation Surveys That Are Consistent with Findings Noted During the Accreditation Surveys

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
98.00%	100.00%	2.00% (Over)	2.00%

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

Explanation: Accreditation is an evaluative process in which a healthcare facility undergoes an examination of its policies, procedures and performance by an external organization (accrediting body) to ensure that it is meeting predetermined criteria. The Centers for Medicare and Medicaid Cervices (CMS) grants authority to a selected group of accrediting organizations to determine, on CMS' behalf, whether a health care facility evaluated by the organization is in compliance with corresponding regulations. The Agency in turn accepts inspections performed by CMS approved accrediting organizations in lieu of State licensure surveys. A validation survey assesses whether the review by the accrediting organization has adequately evaluated the facility according to the minimum state standards.

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

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

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

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

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0.00%	0.74%	0.74% (Over)	0.74%

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

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

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

Explanation: The Agency has no control over whether there will be serious deficiencies in health care facilities. We can only site and require correction of these deficiencies.

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

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

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0.00%	0.00%	None	0.00%

I

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

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

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

Explanation: The Agency has no control over whether there will be serious deficiencies. We can only site and require correction of these deficiencies.

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

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

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #43: Percent of Clinical Laboratories with Deficiencies That Pose a Serious Threat to The Health, Safety, Or Welfare of the Public

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0.00%	1.16%	1.16% (Over)	1.16%

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

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

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

Explanation: The Agency has no control over whether there will be serious deficiencies. We can only site and require correction of these deficiencies.

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

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

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0.00%	1.61%	1.61% (Over)	1.61%

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

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

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

Explanation: The Agency has no control over whether there will be serious deficiencies. We can only site and require correction of these deficiencies.

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

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

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #45: Percent of Hospitals with Deficiencies That Pose a Serious Threat to The Health, Safety, Or Welfare of the Public

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0.00%	1.63%	1.63% (Over)	1.63%

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

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

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

Explanation: The Agency has no control over whether there will be serious deficiencies. We can only site and require correction of these deficiencies.

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

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

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
6.00%	2.29%	3.71% (Under)	-3.71%

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 impact the Agency's ability to meet this standard.

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

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

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

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

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
50.00%	N/A	N/A	N/A

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

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

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

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Managed Health Care
Service/Budget Entity: Health Care Regulation/68700700
Measure #48: Percent of Complaints of HMO Patient Dumping Received That Are Investigated

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
100.00%	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 have been no HMO patient dumping complaints received for several years. Any complaints received would be investigated.

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 due to becoming obsolete.

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
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:
☒ 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
100.00%	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: Any complaints of HMO access to care received would be investigated.

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: Any complaints of HMO access to care received would be investigated.

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

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

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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
100.00%	100.00%	None	0.00%

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

Explanation: The Agency met its goals 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 Agency met its goals for this measure.

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

Recommendations: The Agency has no recommendations at this time.

Office of Policy and Budget– July 2016

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

Action:
☐ Performance Assessment of Outcome Measure ☐ 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	30,000	100.00%

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

Explanation: This measure is now handled by the Department of Health.

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: AHCA discontinued handling practitioner-related calls effective July 1, 2009 because the Department of Health (DOH) had already established an active toll-free number for these types of calls. To reduce costs, an agreement was made with DOH that the Agency's 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 the deletion of this measure.

Office of Policy and Budget– July 2016

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
7,550	6,072	1,478 (Under)	-19.58%

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

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

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

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

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

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

Office of Policy and Budget– July 2016

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
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	18	35 (Under)	66.00%

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

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

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: 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
☐ Personnel
☐ Technology
☒ Other (Identify)

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

Office of Policy and Budget– July 2016

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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
53	18	35	66.00%

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

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

Explanation: The Agency met its goals 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 Beneficiary Assistance Program (409.91211(3)(q), F.S.) was modeled after the Subscriber Assistance Program. Section 409.91211, F.S. was repealed in its entirety effective October 2, 2014, upon full implementation of the Statewide Medicaid Managed care program.

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

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

Recommendations: The Agency is requesting deletion of this measure.

Office of Policy and Budget– July 2016

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
4,500	5,582	782 (Over)	17.38%

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

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

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

Explanation: The Agency has no control over the numbers of plan reviews required since they are dependent upon the number of reviews requested by facilities the Agency licenses and regulates.

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

Explanation: The Agency is requesting deletion of this measure.

Office of Policy and Budget– July 2016

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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 System

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
40.00%	45.00%	5.00% (Over)	12.50%

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 met its goals 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 Agency met its goals for this measure.

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

Recommendations: The Agency is actively promoting the benefits to providers of submitting renewal applications online via brochures and presentations provided at conferences and meetings that involve the providers that we regulate. With completion of the deployment of the Online Licensing system for all providers, we anticipate that the percentage of providers choosing to utilize the online licensing system will continue to increase.

Office of Policy and Budget– July 2016

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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:
☒ 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
3 Business Days	1.23 Days	1.77 Days (Under)	59.00%

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

Explanation: Staff in these positions are highly trained and have been doing this job for many years and have become extremely efficient at it as a group.

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: There are no external factors affecting this measure.

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

Recommendations: The Agency has no recommendations at this time.

Office of Policy and Budget– July 2016

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #57: Number of FloridaHealthFinder.gov website hits

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	3,800,000	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 is the first year that the Agency is reporting this measure and does not yet have an approved 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 the first year that the Agency is reporting this measure and does not yet have an approved measure.

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

Recommendations: The Agency will continue to promote FloridaHealthFinder.gov through its communications and interactions with the health care industry and population. Strategies to achieve this goal include hosting weekly webinars for healthcare professionals, stakeholders, and consumers; distribution of promotional materials at targeted venues; participation and presentations at meetings and conferences with stakeholders; and provision of highly visible links on the Agency's primary webpage as well as other sites.

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Children's Special Health Care (KidCare)/68500100
Measure #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: This measure used a set of ambulatory sensitive conditions based on a 1993 Health Affairs article. We recommend deleting this so that we can use the Agency for Healthcare Research and Quality's (AHRQ) standard quality assurance measures that are nationally recognized and continually updated. Medicaid is requesting that this measure be deleted and replaced by the following:

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)

Data Sources and Methodology:

Proposed Standard/Target:

Validity:

Reliability:

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

Office of Policy and Budget – July 2016

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 Services 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. Hospital data is then matched against Medicaid eligibility files to identify CMS enrolled children. 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 the measure target group (i.e., CMS children in this case) are divided by the total hospitalizations for that group to arrive at a percentage. This measure is calculated annually for the LRPP based on prior calendar year encounters/claims (e.g., Calendar Year 2013 for the LRPP published in 2014).

Proposed Standard/Target:
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.

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 the Department of Children and Families through Medicaid Contract Management is reliable for identification of eligibility group. Eligibility information is used to approve and pay for benefits and must be accurate.

Office of Policy and Budget – July 2016

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Children's Special Health Care (KidCare)/68500100
Measure #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 deletion of measure.
☐ Backup for performance measure.

Proposed Change to Measure: Deletion of measure.

Data Sources and Methodology:

Proposed Standard/Target:

Validity:

Reliability:

Discussion: The Agency does not have a mechanism to determine the number of uninsured children who may be eligible for the Medicaid program. Therefore, there is no way to accurately establish a denominator to determine the percentage that have enrolled and are receiving benefits.

Office of Policy and Budget – July 2016

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 Renew KidCare Coverage

Action (check one):

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

Proposed Change to Measure:
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 – 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 percent would reflect a historically high, but desirable outcome.

Office of Policy and Budget – July 2016

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Children's Special Health Care (KidCare)/68500100
Measure #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 deletion of measure.
☐ Backup for performance measure.

Proposed Change to Measure: Deletion of measure.

Data Sources and Methodology:

Proposed Standard/Target:

Validity:

Reliability:

Discussion: This measure originally included the number of children who had all their immunizations when starting kindergarten. Since it was a requirement to have updated immunizations before enrolling in school, the measure was not meaningful. Medicaid originally attempted between 2004 and 2006 to use survey data to statistically determine the immunization percentage but the self-reported data based on parental or caregiver recall were not reliable. In 2007, Medicaid sought to replace the measure with the percentage of 2-year olds who had up to date immunizations based on SHOTS data. However, Medicaid records alone did not show every immunization which could be coded differently, masked by another code (e.g., a well-child visit) or received by the child from a provider other than a Medicaid provider. We therefore requested that this measure be deleted.

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Children's Special Health Care (KidCare)/68500100
Measure #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 deletion of measure.
☐ Backup for performance measure.

Proposed Change to Measure: Delete the measure due to data collection issues.

Data Sources and Methodology:
The guidelines on which this standard was based have been updated and/or replaced several times and the original guidelines no longer exist. Updated, similar guidelines include guidelines for care that fall well outside the scope of Medicaid and which are not captured in CMSN or Medicaid data (such as caregiver counseling or levels of depression among parents). Since the original standard no longer exists and data for the new standards cannot be collected by Medicaid, this measure is being requested to be deleted.

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: 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% 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 identifying consumer and patient satisfaction with their health care. Using the nationally proven survey instrument for this measure ensures that 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.

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: 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 Social Services Estimating Conference (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 2016

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 Social Services Estimating Conference (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.

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: 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 Social Services Estimating Conference (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 2016

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 Social Services Estimating Conference (SSEC).

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

Proposed Standard/Target: Based on SSEC appropriations estimates.

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 2016

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

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

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

Office of Policy and Budget – July 2016

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare 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.

Data Sources and Methodology:
The data is derived from the monthly/yearly Operational Performance Summary report (FLMM0300-R001) generated from the Medicaid Claims record of the Florida Medicaid Management Information System.

The measure is calculated using the total number of days from the claim entry date to the claim payment date divided by the total number of adjudicated claims paid. The date of receipt for a claim is the date the claim form enters the mailroom or is electronically received**.**

Validity:
This calculation measures the efficiency of the state's fiscal agent in processing claims submitted by Medicaid providers. The Medicaid program relies on enrolled providers to meet the needs of Florida's Medicaid beneficiaries. The level of efficiency in processing claims can influence a Medicaid provider's continued participation in the program.

Reliability:
Claims are received and processed by the Medicaid fiscal agent in a highly controlled and monitored process. Processing is under the control of the Florida Medicaid Management Information System (FMMIS), subject to regular monitoring by state staff and annual SAS 70 Audit. Fields within the claim form contain the date a claim is received by the fiscal agent, its disposition determination, and the date its respective payment is made.

Office of Policy and Budget – July 2016

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare 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.

Data Sources and Methodology:
This is a count of the total paid fee-for-service claims in Florida Medicaid during the preceding fiscal year. Data are obtained through SQL query of the Florida Medicaid Management Information System (FMMIS).

Validity:
N/A

Reliability:
N/A

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid 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 deletion of 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 2016

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 through 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 Department of Health 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 2013 for the LRPP published in 2014).

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 through 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 Children's Medical Service Network;
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 Department of Children and Families is reliable for identification of eligibility group. Eligibility information is used to approve and pay for benefits and must be accurate.

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #15B: Percent of all Hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (Conditions Preventable by Good Ambulatory Care): Ages 21 and Older 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 2013 for the LRPP published in 2014).

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 #15B: Percent of all Hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (Conditions Preventable by Good Ambulatory Care): Ages 21 and Older 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:
20.0 percent, based on baseline calculations utilizing the updated AHRQ methodology.

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

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

Reliability:
The reliability of the diagnoses data is high. Hospitals provide the information to the Agency and must certify that it is accurate. The Diagnoses Related Group (DRG) grouping is used for hospital billing and payment. The ICD-9 and/or ICD-10 codes are used for hospital report cards. Therefore, hospitals have incentives to be accurate in their use of the codes. Similarly, the eligibility information provided by DCF through MCM is reliable for identification of eligibility group. Eligibility information is used to approve and pay for benefits and must be accurate.

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #16: Percent of 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.

Data Sources and Methodology:
The data source is the Medicaid Maternal and Child Health Program Development Project Final Report for the year for which data is provided. These data are taken directly from the report prepared by the University of Florida (UF). Adequate prenatal care is defined as prenatal care initiation begun earlier than the 5th month of pregnancy or more than 50% of prenatal visits were received (adjusted for gestational age). Data on the timing and number of prenatal visits is obtained from birth certificate data for women found to be Medicaid eligible by matching the birth certificate data with the Medicaid eligibility file. The percent is derived by dividing the number of Medicaid eligible women receiving adequate prenatal care by the total number of women delivering who were Medicaid eligible during their pregnancy.

Validity:
Over 40 percent of women giving birth were Medicaid eligible during their pregnancy. Timely diagnosis and treatment of pre-pregnancy complications or reducing risk factors amenable to treatment improve birth outcomes. The measure (Kotelchuch APNCU index) takes into account when prenatal care was initiated and the expected number of prenatal visits based on prenatal care visitation standards. It does not measure the quality or content of the care provided. Medicaid providers are expected to meet quality standards and refer high-risk beneficiaries to Healthy Start for additional services. MediPass physicians who serve as gatekeepers for Medicaid beneficiaries electing this form of managed care are to coordinate pregnancy benefits and ensure that enrollees access prenatal care early in their pregnancy. Beneficiaries are not necessarily enrolled in Medicaid throughout their pregnancy. Some only become eligible when pregnant. The longer the individual was enrolled in Medicaid during their pregnancy, the better Medicaid does on this measure.

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

Reliability:
Reliability of the measure is high. The measure is only as accurate as the birth certificate and eligibility files. The Department of Health is responsible for maintaining the birth certificate file. Inaccuracies have been documented particularly in the prenatal care and gestational age data. Inaccuracies are not serious enough to jeopardize comparisons between programs or over time.

Measure #16: Percent of women receiving adequate prenatal care – Page 2

Eligibility files are the responsibility of the Department of Children and Families. Early in the development of the eligibility system, some inaccuracies were found. The system is now considered accurate. It forms the basis on which claims for Medicaid services are paid.

Another source of potential error is the matching of the two files. Currently, a deterministic match between social security numbers is used. If a social security number is missing from a file, the file is omitted from the analysis. In 1996, 4.1 percent of the files were missing a social security number. Further, if a case was missing a value needed for the calculation the record was omitted from the analysis. Gestational age was computed based on the clinical estimate as listed on the birth certificate. If this was not present, the date of last menses as indicated on the birth certificate was used to estimate gestational age. If neither were present, the conception was computed as 270 days prior to delivery date. UF verified computer coding used in the analyses using a different analyst than originally created the code. Some problems were found. All programs are now considered accurate.

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #17: Neonatal mortality rate per 1,000

Action (check one):

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

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

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

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

Proposed Standard/Target: 5.0 per 1,000

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

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

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

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

Discussion:
The non-Medicaid statewide 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 average. The target measure should reflect the statewide average when controlling for such factors as overall health status, socio-economic factors, and so on.

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #18A: Percentage of Women with an Inter-Pregnancy Interval (IPI) Greater than or Equal to 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 Florida Medicaid Management Information System (FMMIS) that has been merged with a data set maintained by the University of Florida, Family Data Center which contain 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 contain the social security number of the person. UF compares this information to the number of women giving birth in the following year and identifies those who had a birth. The inter-pregnancy interval (IPI) is the total number of months between pregnancies measured from the end of the first pregnancy to the beginning of the subsequent pregnancy. The IPI for each of the women identified with a subsequent birth is calculated. The total number of those with an inter-pregnancy interval 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 Healthcare 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 screen

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 data source is the Medicaid Claims History File from the Florida Medicaid Management Information System (FMMIS), which is a complete year of claims processed and utilization data submitted by the Medicaid Managed Medical Assistance (MMA) health plans. This data is obtained from the FMMIS Annual EPSDT Participation Report Health Care Financing Administration (CMS-416) for the year reported. The report is extracted from FMMIS using specified procedure codes and the utilization reports required from the Health plans.

Validity:
The measure is a required measure by the federal Centers for Medicare and Medicaid Services (CMS) and is considered a critical element of quality. ESPDT screening is designed to ensure that health problems are detected early so that future problems can be averted. For example, vision or hearing problems can be detected and corrected prior to a child experiencing poor academic performance. Screening requirements meet the American Academy of Pediatrics guidelines for quality.

Reliability:
CMS issues detailed guidelines on how the measure is to be calculated. The General Accounting Office found that inaccuracies still existed. As of March 1998 CMS issued some new guidelines for completing the form. The instructions and forms were developed by a national work group composed of representatives from CMS central and regional offices, state Medicaid officials, state Maternal and Child Health administrators, the American Public Welfare Association and the American Academy of Pediatrics.

The numbers are only as good as the FFMIS and health plan reporting. Some variation in number could occur as a result of the time that the extract from FFMIS is made. Providers have up to two years to submit claims and thus a few may be missed in order to present information in a timelier manner. Some oversight is provided to health plan utilization reporting, but full audits have not been conducted. However, numbers obtained from these sources are similar to those obtained from a review of a random sample of beneficiary files by the peer review organization.

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #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.

Data Sources and Methodology:
The data source is the Medicaid Claims History from the Florida Medicaid Management Information System (FMMIS) accessed through the Medicaid Data Warehouse.

Using the data warehouse claims table, an unduplicated count is made for all beneficiaries who have at least one month of eligibility during the fiscal year and are between the ages of 1 and 20.

Validity:
The purpose is to identify the number of children (age 1-20) who are enrolled in Medicaid during the fiscal year.

Reliability:
The unduplicated population can be reliably calculated.

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #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.

Data Sources and Methodology:
The data source is the Medicaid Claims History from the Florida Medicaid Management Information System (FMMIS) accessed through the Medicaid Data Warehouse.

Using the data warehouse claims table, an unduplicated count is made for all beneficiaries who have at least one claim for the EPSDT (Early Periodic Screening Diagnosis and Treatment) procedure code during the fiscal year and are between the ages of 1 and 20.

Validity:
The purpose is to identify the number of children (age 1-20) who received child health screening services in the year.

Reliability:
The unduplicated population can be reliably calculated. However, this figure does not include the frequency of screening services for children or whether the appropriate referrals from the screenings occurred.

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #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.

Data Sources and Methodology:
The data source is the Medicaid Claims History from the Florida Medicaid Management Information System (FMMIS) accessed through the Medicaid Data Warehouse.

Using the data warehouse claims table, a count is made of the number of paid claims for children (ages 1-20) for hospital inpatient admissions for the fiscal year.

Validity:
This measure helps to identify the volume of hospital inpatient services the Medicaid children population receives in a year.

Reliability:
The number of hospital inpatient services can be reliably calculated for fee-for-service settings. These figures do not include MMA (Managed Medical Assistance) health plan services to children.

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #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.

Data Sources and Methodology:
The data source is the Medicaid Claims History from the Florida Medicaid Management Information System (FMMIS) accessed through the Medicaid Data Warehouse.

Using the data warehouse claims table, a count is made of the number of paid claims for children (ages 1-20) for physician services for the fiscal year.

Validity:
This measure helps to identify the volume of physician services the Medicaid children population receives in a year.

Reliability:
The number of physician services can be reliably calculated for fee-for-service settings. These figures do not include MMA (Managed Medical Assistance) health plan services to children. For physician services, the total consolidates a mixture of services including visits, radiology, pathology, surgery and all other physician services.

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #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.

Data Sources and Methodology:
The data source is the Medicaid Claims History from the Florida Medicaid Management Information System (FMMIS) accessed through the Medicaid Data Warehouse.

Using the data warehouse claims table, a count is made of the number of paid claims for children (ages 1-20) for prescriptions for the fiscal year.

Validity:
This measure helps to identify the volume of prescribed drug services that the Medicaid children population receives in a year.

Reliability:
The number of prescribed drug services can be reliably calculated for fee-for-service settings. These figures do not include MMA (Managed Medical Assistance) health plan services to children. Prescriptions include all types of drugs, dosages and days supplied.

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #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.

Data Sources and Methodology:
The data source is the Medicaid Claims History from the Florida Medicaid Management Information System (FMMIS) accessed through the Medicaid Data Warehouse.

Using the data warehouse claims table, a count is made of the number of paid claims for the elderly (age 65+) for hospital inpatient admissions for the fiscal year.

Validity:
This measure helps to identify the volume of hospital inpatient services the Medicaid elderly population receives in a year.

Reliability:
The number of hospital inpatient services can be reliably calculated for fee-for-service settings. These figures do not include MMA (Managed Medical Assistance) health plan services to the elderly.

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #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.

Data Sources and Methodology:
The data source is the Medicaid Claims History from the Florida Medicaid Management Information System (FMMIS) accessed through the Medicaid Data Warehouse.

Using the data warehouse claims table, a count is made of the number of paid claims for the elderly (age 65+) for physician services for the fiscal year.

Validity:
This measure helps to identify the volume of physician services the Medicaid elderly population receives in a year.

Reliability:
The number of physician services can be reliably calculated for fee-for-service settings. These figures do not include MMA (Managed Medical Assistance) health plan services to the elderly. For physician services, the total consolidates a mixture of services including visits, radiology, pathology, surgery and all other physician services.

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Action (check one):

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

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

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

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

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 prescribed drugs provided to elders" should be measured against that standard

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #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 deletion of measure.
☐ Backup for performance measure.

Data Sources and Methodology:
The Medicaid Expansion referred to in this measure was a one-time expansion during Children's Health Insurance Program (CHIP) re-authorization in FY1998 to allow the state to use Medicaid funding and receive federal match for enrolling children in KidCare whose household incomes fell between 185 percent but no more than 200 percent of the federal poverty level. The statute did not apply to future populations subsequent to CHIP re-authorization and all children initially covered during the expansion have aged out of the program.

Validity:
N/A

Reliability:
N/A

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Long-Term Care /68501500
Measure #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 deletion of measure.
☐ Backup for performance measure.

Data Sources and Methodology:
N/A Measure should be deleted.

Validity:

Reliability:
N/A

Discussion: Medicaid initially sought to delete this measure in 2007 and replace it with Measure #29A that included those receiving care in institutions or those receiving care on a FFS basis through a 1915(b)/(c) waiver. With implementation of the Long-term Care component of the Statewide Medicaid Managed Care program, all Medicaid eligibles receiving long-term care services are now enrolled in a health plan. This measure no longer applies and should be deleted.

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Long-Term Care/68501500
Measure #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. 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 Diagnosis Related Groups (DRGs), using the algorithm and methodology outlined by the federal HHS, AHRQ. The percentage of hospitalizations that occur for Ambulatory Sensitive Conditions within an eligibility group are divided by the total hospitalizations for that group to arrive at a percentage. This measure is calculated annually for the LRPP based on prior calendar year encounters/claims (e.g., Calendar Year 2013 for the LRPP published in 2014).

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 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 Department of Children and Families is reliable for identification of eligibility group. Eligibility information is used to approve and pay for benefits and must be accurate.

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare 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 deletion of measure.
☐ Backup for performance measure.

Data Sources and Methodology:
N/A

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare 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 deletion of measure.
☐ Backup for performance measure.

Data Sources and Methodology:
N/A

Validity:
N/A

Reliability:
N/A

Discussion:
N/A

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Prepaid Health Plans/ 68501600
Measure #32: 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: Delete in favor of Measure #33A and #33B.

Data Sources and Methodology:

Proposed Standard/Target:

Validity:

Reliability:

Discussion: This measure included any individual regardless of age who received health services through any kind of prepaid arrangement. Medicaid is requesting that it be replaced with two measures, one for services to Children (ages 1-20) and one for Adults (ages 20+) who are enrolled in a Managed Medical Assistance plan. Note also that these measures should be moved under the budget item in Medicaid Service to Individuals. The new measures include:

- 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
- 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.

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Prepaid Health Plans/ 68501600
Measure #33: Percent of women and child hospitalizations 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: Delete in favor of Measure #33A and #33B.

Data Sources and Methodology:

Proposed Standard/Target:

Validity:

Reliability:

Discussion: Women and children combined account for more than 85% of the Medicaid population and the existing measure is not significantly different than that for the Medicaid population as a whole. Further, adults and children have very different conditions for which preventive care is effective for preventing hospitalizations. Combining women and children together and excluding adult males gives at best an incomplete picture of access to health care and can also yield a result that unclear or misleading. Medicaid is requesting that the existing measure be replaced with the two measures #33A and #33B, i.e., one for services to Children (ages 1-20) and one for Adults (ages 20+) who are enrolled in an MMA plan. Note also that these measures should be moved under the budget item in Medicaid Service to Individuals.

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #33A: Percent of All Hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (Conditions Preventable by Good Ambulatory Care): Ages 1 through 20 in Full Service Capitated Managed 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 Department of Health 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 2013 for the LRPP published in 2014).

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 #33A: Percent of All Hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (Conditions Preventable by Good Ambulatory Care): Ages 1 through 20 in Full Service Capitated Managed 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:
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 Department of Children and Families is reliable for identification of eligibility group. Eligibility information is used to approve and pay for benefits and must be accurate.

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #33B: Percent of All Hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (Conditions Preventable by Good Ambulatory Care): Ages 21 and Older in Full Service Capitated Managed 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 2013 for the LRPP published in 2014).

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 Older in Full Service Capitated Managed 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 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 Department of Children and Families is reliable for identification of eligibility group. Eligibility information is used to approve and pay for benefits and must be accurate.

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare 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 (check one):

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

Data Sources and Methodology:
With implementation of the Long-term Care component of the Statewide Medicaid Managed Care program these individuals now receive services through a health plan. The population should no longer exist in this budget entity and the measure should be deleted. A new budget activity has been requested for these individuals under the Long-term Care budget entity as shown on Exhibit VI.

Validity:
N/A

Reliability:
N/A

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Prepaid Health Plan/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 deletion of measure.
☐ Backup for performance measure.

Data Sources and Methodology:
With implementation of the Managed Medical Assistance component of the Statewide Medicaid Managed Care program, these individuals now receive services through a managed care plan. The population should no longer exist in this budget entity and the measure should be deleted. A new budget activity has been requested for these individuals under the Medicaid Service to Individuals budget entity as shown on Exhibit VI.

Validity:
N/A

Reliability:
N/A

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LRPP Exhibit IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #36: Percent of nursing home facilities with deficiencies that pose a serious threat to the health, safety or welfare of the public

Action (check one):

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

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

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

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

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

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LRPP Exhibit IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #37: Percent of investigations of alleged unlicensed facilities and programs that have been previously issued a cease and desist order that are confirmed as repeated unlicensed activity

Action (check one):

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

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

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

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

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

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

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

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

Data Sources and Methodology:

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

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

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

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LRPP Exhibit IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #38A: Percent of Priority 1 consumer complaints about licensed facilities and programs that are investigated within two business days

Action (check one):
☒ Requesting revision to approved performance measure – from 48 hours to two business days.
☐ Change in data sources or measurement methodologies.
☐ Requesting new measure.
☒ Backup for performance measure.

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

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

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

LRPP Exhibit IV: Performance Measure Validity and Reliability

Department: 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 (check one):

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

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

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

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

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

Office of Policy and Budget– July 2016

LRPP Exhibit IV: Performance Measure Validity and Reliability

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

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

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

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

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

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

Office of Policy and Budget– July 2016

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 assisted living facilities in which deficiencies are found during the period that pose a serious threat to the health, safety, or welfare of the public, divided by the total number of assisted living facilities during the period. Deficiencies that pose a serious threat to the health, safety, or welfare of the public are classified as Class I deficiencies (statutorily defined). These deficiencies can arise from any type of survey (initial, renewal, complaint investigation, etc.).

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

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

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

Office of Policy and Budget– July 2016

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 2016

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 to the health, safety or welfare of the public

Action (check one):

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

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

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

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

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

Office of Policy and Budget– July 2016

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 2016

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 2016

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.
☐ 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 2016

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

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

Proposed Standard/Target:
Per Estimating Conference

Validity:
N/A

Reliability:
N/A

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

Office of Policy and Budget– July 2016

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 – Delete 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 2016

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

Data Sources and Methodology: Complaints regarding HMO access to care are received and investigated.

Validity: This information is currently tracked in the CIRTS data base.

Reliability: Complaints regarding HMO access to care are received and investigated.

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

Office of Policy and Budget– July 2016

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 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 2016

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

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

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

Reliability:
Due to being unable to collect the data, we are unable to assess the reliability.

Office of Policy and Budget– July 2016

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 2016

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

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

Office of Policy and Budget– July 2016

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 #52A: Average Processing Time (in Days) for Subscriber Assistance Program Cases and Beneficiary Assistance Program (SAP/BAP) cases

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:
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:
This measure should be deleted because the BAP is no longer relevant. The Agency only uses the SAP at this time.

Reliability:
The approved measure (#52) is more accurate and would yield a more compatible result.

Office of Policy and Budget– July 2016

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.

Office of Policy and Budget– July 2016

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 2016

LRPP Exhibit IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #55: Percent of Renewal Applications Received Electronically via the Online Licensing Application

Action (check one):

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

Proposed Change to Measure: This is a new measure and is relevant to determine the success and adoption of the Agency's transition to submission and completion of online renewal applications.

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

Proposed Standard/Target: 75%

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

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

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

Office of Policy and Budget– July 2016

LRPP Exhibit IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #56: Average Processing Time (in Days) for Financial Reviews

Action (check one):

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

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

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

Proposed Standard/Target:
3 Business Days

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

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

Office of Policy and Budget– July 2016

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 #57: Number of FloridaHealthFinder.gov website hits

Action (check one):

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

Proposed Change to Measure:

Data Sources and Methodology: The Agency's contracted vendor of the FloridaHealthFinder.gov website provides monthly website analytics which are analyzed, recorded and tracked by the Agency's contract manager.

Proposed Standard/Target: 3.8 million visits for CY2016

Validity: This is a valid measure of website traffic as it is a direct count of visits and the data is captured and reported electronically as they occur. Website traffic serves as an indicator of the success of various outreach and education strategies, the value of information published on the site, and visitor satisfaction with the information they were able to obtain through the site (higher satisfaction leads to return visits and also increases word of mouth referrals).

Reliability: The reliability of the data to measure website traffic is extremely high. There is limited reliability, however, in linking changes in this measure over time to specific strategies or root causes. Additional evaluation methodologies such as ongoing surveys of website users, participant evaluations of webinars and presentations, and solicitation of stakeholder feedback through the State Consumer Health Information and Policy Advisory Council are utilized to supplement this measure when assessing possible reasons for changes in the number of visits over time.

Discussion: FloridaHealthFinder.gov is the Agency's primary stakeholder and consumer resource for a wide variety of health care facility information, health services utilization trends, quality information, regulatory and compliance documentation, health plan information, and consumer education. Multiple strategies are employed to increase stakeholder and consumer awareness and use of this resource, and the primary goal is to increase utilization over time. The provision of this on-demand resource increases Transparency of healthcare information and has the potential to reduce public records requests and ad hoc data queries to the Agency.

Office of Policy and Budget– July 2016

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 and Budgeting ACT0090 Grants Management ACT0190; Finance and 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 and Budgeting ACT0090 Grants Management ACT0190; Finance and 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	Purchase MediKids Program Services ACT5110

Approved Performance Measures for FY 2014-2015 (Words)		Associated Activities Title
	ambulatory care	Purchase Children's Medical Services Network Services ACT5120 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 and Treatment ACT4260 Patient Transportation ACT4270
17	Neonatal mortality rate per 1000	Hospital Inpatient ACT4210 Physician Services ACT4220 Early Periodic Screening Diagnosis and 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 and 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 and Treatment ACT4260 School Based Services ACT4310 Clinic Services ACT4330
22	Number of hospital inpatient services provided to children	Hospital Inpatient ACT4210 Therapeutic Services for Children ACT4310

Approved Performance Measures for FY 2014-2015 (Words)		Associated Activities Title
23	Number of physician services provided to children	Physician Services ACT4230 Therapeutic Services for Children ACT4310
24	Number of prescribed drugs provided to children	Prescribed Medicines ACT4220 School Based Services ACT4320
25	Number of hospital inpatient services provided to elders	Hospital Inpatient -Elderly and Disabled/Fee for Service ACT4010 Prescribed Medicines- Elderly and Disabled/ Fee for Service ACT4020 Physician Services-Elderly and Disabled/ Fee for Service ACT4030 Hospital Insurance Benefit-Elderly and Disabled / Fee for Service ACT4140
26	Number of physician services provided to elders	Physician Services-Elderly and Disabled/ Fee for Service ACT4030 Supplemental Medical Insurance-Elderly and Disabled/Fee for Service ACT4050 Prescribed Medicines- Elderly and Disabled/Fee for Service ACT4020

Approved Performance Measures for FY 2014-2015 (Words)		Associated Activities Title
27	Number of prescribed drugs provided to elders	Prescribed Medicines- Elderly and Disabled/fee for service ACT4020
28	Number of uninsured children enrolled in the Medicaid Expansion	Purchase MediKids Program Services ACT5110 Purchase Children's Medical Services Network Services ACT5120 Purchase Children's Medical Services Network Services ACT5130
Medicaid Long-Term Care		**Code: 68501500**
29	Percent of hospitalizations for conditions preventable with good ambulatory care	Nursing Home Care ACT5020 Home and Community Based Services ACT5030 Capitates Nursing Home Diversion Waiver ACT5060
29A	New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Institutional Care and Waiver Programs	Nursing Home Care ACT5020 Home and Community Based Services ACT5030 Capitates Nursing Home Diversion Waiver ACT5060

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

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

Approved Performance Measures for FY 2014-2015 (Words)			Associated Activities Title
Program: Health Care Regulation			**Code: 68700700**
36	Percent of nursing home facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
37	Percent of investigations of alleged unlicensed facilities and programs that have been previously issued a cease and desist order that are confirmed as repeated unlicensed activity		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
~~38~~	~~Percent of Priority I consumer complaints about licensed facilities and programs that are investigated within 48 hours~~	-	~~Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030~~ ~~Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020~~
38A	New Measure - Percent of Priority I consumer complaints about licensed facilities and programs that are investigated within two business days		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020

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

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

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

Approved Performance Measures for FY 2014-2015 (Words)		Associated Activities Title
		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
53	Number of construction reviews performed (plans and construction)	Plans and Construction ACT7080
54	Number of new enrollees provided with choice counseling	Health Facilities and Practitioner Regulation - Medicaid Choice Counseling ACT7150

	Approved Performance Measures for FY 2014-2015 (Words)	Associated Activities Title
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
57	Number of FloridaHealthFinder.com website hits	Florida Center for Health Information and Transparency

LRPP Exhibit VI: Agency-Level Unit Cost Summary

AGENCY FOR HEALTH CARE ADMINISTRATION	FISCAL YEAR 2015-16			
SECTION I: BUDGET	OPERATING			FIXED CAPITAL OUTLAY
TOTAL ALL FUNDS GENERAL APPROPRIATIONS ACT			25,436,381,011	200,000
ADJUSTMENTS TO GENERAL APPROPRIATIONS ACT (Supplementals, Vetoes, Budget Amendments, etc.)			-1,071,939,599	-200,000
FINAL BUDGET FOR AGENCY			24,364,441,412	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	11,924.81	6,673,864,529	
Prepaid Health Plans - Families *	2,620,250	1,852.66	4,854,431,777	
Elderly And Disabled/Fee For Service/Medipass - Hospital Inpatient * **Number of case months Medicaid program services purchased**	25,378	18,330.88	465,201,154	
Elderly And Disabled/Fee For Service/Medipass - Prescribed Medicines * **Number of case months Medicaid program services purchased**	51,534	6,116.54	315,209,917	
Elderly And Disabled/Fee For Service/Medipass - Physician Services * **Number of case months Medicaid program services purchased**	129,606	2,015.47	261,217,617	
Elderly And Disabled/Fee For Service/Medipass - Hospital Outpatient * **Number of case months Medicaid program services purchased**	129,606	1,065.56	138,102,853	
Elderly And Disabled/Fee For Service/Medipass - Supplemental Medical Insurance * **Number of case months Medicaid program services purchased**	1,528,378	786.73	1,202,415,393	
Elderly And Disabled/Fee For Service/Medipass - Patient Transportation * **Number of case months Medicaid program services purchased**	259,213	37.03	9,597,486	
Elderly And Disabled/Fee For Service/Medipass - Case Management * **Number of case months Medicaid program services purchased**	731,355	28.09	20,545,137	
Elderly And Disabled/Fee For Service/Medipass - Home Health Services * **Number of case months Medicaid program services purchased**	25,378	339.38	8,612,901	
Elderly And Disabled/Fee For Service/Medipass - Hospital Insurance Benefit * **Number of case months Medicaid program services purchased**	104,228	552.38	57,573,804	
Elderly And Disabled/Fee For Service/Medipass - Hospice * **Number of case months Medicaid program services purchased**	129,606	175.94	22,803,259	
Elderly And Disabled/Fee For Service/Medipass - Private Duty Nursing * **Number of case months Medicaid program services purchased**	23,450	1,846.47	43,299,700	
Elderly And Disabled/Fee For Service/Medipass - Other * **Number of case months Medicaid program services purchased**	76,136	8,576.25	652,960,990	
Women And Children/Fee For Service/Medipass - Hospital Inpatient * **Number of case months Medicaid program services purchased**	220,804	1,565.53	345,676,250	
Women And Children/Fee For Service/Medipass - Prescribed Medicines * **Number of case months Medicaid program services purchased**	258,472	367.36	94,951,752	
Women And Children/Fee For Service / Medipass - Hospital Outpatient * **Number of case months Medicaid program services purchased**	451,799	407.91	184,295,546	
Women And Children/Fee For Service / Medipass - Supplemental Medical Insurance * **Number of case months Medicaid program services purchased**	6,368,089	34.50	219,725,651	
Women And Children/Fee For Service / Medipass - Patient Transportation * **Number of case months Medicaid program services purchased**	903,598	9.63	8,703,011	
Women And Children/Fee For Service / Medipass - Case Management * **Number of case months Medicaid program services purchased**	3,072,048	0.23	701,304	
Women And Children/Fee For Service / Medipass - Home Health Services * **Number of case months Medicaid program services purchased**	220,804	75.41	16,649,888	
Women And Children/Fee For Service / Medipass - Clinic Services * **Number of case months and Medicaid program services purchased**	5,899,420	24.48	144,429,080	
Women And Children/Fee For Service / Medipass - Other * **Number of case months Medicaid program services purchased**	662,412	247.04	163,639,677	
Medically Needy - Hospital Inpatient * **Number of case months Medicaid program services purchased**	24,075	2,865.21	68,980,046	
Medically Needy - Prescribed Medicines * **Number of case months Medicaid program services purchased**	24,075	1,725.61	41,544,069	
Medically Needy - Hospital Outpatient * **Number of case months Medicaid program services purchased**	29,085	925.91	26,930,198	
Medically Needy - Supplemental Medical Insurance * **Number of case months Medicaid program services purchased**	58,170	128.00	7,445,878	
Medically Needy - Patient Transportation * **Number of case months Medicaid program services purchased**	58,170	5.96	346,969	
Medically Needy - Case Management * **Number of case months Medicaid program services purchased**	29,085	3.54	103,095	
Medically Needy - Home Health Services * **Number of case months Medicaid program services purchased**	24,075	9.44	227,344	
Medically Needy - Other * **Number of case months Medicaid program services purchased**	72,226	15,914.63	1,149,449,934	
Refugees - Hospital Inpatient * **Number of case months Medicaid program services purchased**	5,649	306.67	1,732,404	
Refugees - Prescribed Medicines * **Number of case months Medicaid program services purchased**	5,649	82,319.26	465,021,499	
Refugees - Hospital Outpatient * **Number of case months Medicaid program services purchased**	5,649	157.81	891,460	
Refugees - Patient Transportation * **Number of case months Medicaid program services purchased**	11,299	13.42	151,619	
Refugees - Case Management * **Number of case months Medicaid program services purchased**	21,724	3.39	73,608	
Refugees - Home Health Services * **Number of case months Medicaid program services purchased**	5,649	7.89	44,582	
Refugees - Other * **Number of case months Medicaid program services purchased**	16,948	80.56	1,365,361	
Nursing Home Care * **Number of case months Medicaid program services purchased**	47,441	67,550.61	3,204,668,476	
Home And Community Based Services * **Number of case months Medicaid program services purchased**	43,921	28,050.26	1,231,995,335	
Intermediate Care Facilities For The Developmentally Disabled - Sunland Centers * **Number of case months Medicaid program services purchased**	680	486,296.62	330,681,704	
Purchase Medikids Program Services * **Number of case months Medicaid Program services purchased**	29,492	1,826.07	53,854,598	
Purchase Children's Medical Services Network Services * **Number of case months**	13,556	8,166.25	110,701,641	
Purchase Florida Healthy Kids Corporation Services * **Number of case months**	148,689	1,705.88	253,645,884	
Certificate Of Need/Financial Analysis * **Number of certificate of need (CON) requests/financial reviews conducted**	2,488	805.45	2,003,972	
Health Facility Regulation (compliance, Licensure, Complaints) - Tallahassee * **Number of licensure/certification applications**	39,029	456.69	17,824,232	
Facility Field Operations (compliance, Complaints) - Field Offices Survey Staff * **Number of surveys and complaint investigations**	39,110	1,423.49	55,672,528	
Health Standards And Quality * **Number of transactions**	2,950,581	1.51	4,457,463	
Plans And Construction * **Number of reviews performed**	5,282	1,349.00	7,125,435	
Managed Health Care * **Number of Health Maintenance Organization (HMO) and workers' compensation arrangement surveys**	259	6,490.62	1,681,070	
Background Screening * **Number of requests for screenings**	350,297	2.63	921,416	
Subscriber Assistance Panel * **Number of cases**	350	1,601.02	560,357	
TOTAL			22,944,710,863	
SECTION III: RECONCILIATION TO BUDGET				
PASS THROUGHS				
TRANSFER - STATE AGENCIES				
AID TO LOCAL GOVERNMENTS				
PAYMENT OF PENSIONS, BENEFITS AND CLAIMS				
OTHER			1,221,054,011	
REVERSIONS			198,504,947	
TOTAL BUDGET FOR AGENCY (Total Activities + Pass Throughs + Reversions) - Should equal Section I above. (4)			24,364,269,811	

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.
(5) For FY 2015-2016, the total in Section III differs from the total in Section I because of payables and receivables set up in the OPS (030000) and Expenses (040000) categories totaling $171,622. A01 accurately reflects total expenditures as paid by fund.

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.

- **APCD** – All Payer Claims Database is the system that collects and stores claims and payments data from health insurers and health maintenance organizations. Once implemented, an APCD allows consumers to compare health care costs.

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

- **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.

- **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.

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

- **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.

- **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.

- **HIE** – Health Information Exchange is the secure and electronic sharing of health information.

- **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.

- **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.

- **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.

- **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.

- **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.

- **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.

- **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.

- **SHOTS** – Florida State Online Tracking System is a free, statewide, centralized online immunization registry that helps healthcare providers and schools keep track of immunization records to ensure that patients of all ages received the vaccinations needed to protect them from vaccine-prevantable diseases.

- **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.