RICK SCOTT
GOVERNOR

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SECRETARY

LONG RANGE PROGRAM PLAN

Agency for Health Care Administration
Tallahassee, Florida 32308

September 29, 2017

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Dear Directors:

Pursuant to chapter 216, F.S., our Long Range Program Plan (LRPP) for the Agency for Health Care Administration is submitted in the format prescribed in the budget instructions. The information provided electronically and contained herein is a true and accurate presentation of our mission, goals, objectives, and measures for the Fiscal Year 2018-19 through Fiscal Year 2022-23. 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 Justin M. Senior, 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 Years 2018-2019 through 2022-2023

Rick Scott
Governor

Justin M. Senior
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 and Fiscal Year 2022-2023.

Objective 1.B: To reduce by 30 percent the number of Division of Health Quality Assurance (HQA) public record requests manually processed by Fiscal Year 2022-2023.

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 2022-2023.

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 2022 – 2023.

Objective 2.B: To increase identification of the amount of overpayments prevented by prevention activities conducted by MPI staff by ten percent through Fiscal Year 2022 – 2023.

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

Health Care Services (Division of Medicaid)

Objective 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.

Objective 3.B: For the HEDIS measures that are in the Adult and Child Core Sets, improve the percentage of measures for MMA plans (weighted average for all plans by measure) that meet or exceed the National Medicaid 75th percentile to 75 percent by FISCAL YEAR 2019-20.

Objective 3.C: Transition and maintain 85 percent or more of Medicaid recipients eligible for managed care (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 5 percent as measured by 1115 Waiver Budget Neutrality.

Agency Service Outcomes and Performance Projection Tables

Goal 1: To operate an efficient and effective government.

Health Care Regulation (Division of Health Quality Assurance)

Service Outcome Measure 1.A: The average annual number of renewal license applications received electronically via the Online Licensing System.

Performance Projection Table 1.A:

Base Year FY 2016-2017	FY 2018-2019	FY 2019-2020	FY 2020-2021	FY 2021-2022	FY 2022-2023
3,555	5,903	6,641	7,379	7,379	7,379
Percent of renewal applications received via Internet	80.00%	90.00%	100.00%	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:

Base Year FY 2016-17	FY 2018-2019	FY 2019-2020	FY 2020-2021	FY 2021-2022	FY 2022-2023
3,291	2,962	2,797	2,633	2,468	2,304
Percent of reduction in the annual number of public record requests processed by HQA	10.00%	15.00%	20.00%	25.00%	30.00%

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:

Base Year FY 2013-2014	FY 2018-2019	FY 2019-2020	FY 2020-2021	FY 2021-2022	FY 2022-2023
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:

Base Year FY 2013-2014	FY 2018-2019	FY 2019-2020	FY 2020-2021	FY 2021-2022	FY 2022-2023
$27,450,000*	$35,033, 928	$36,785,624	$38,624,905	$40,556,150	$42,583,958
Projected Increase in Percent	5.00%	5.00%	5.00%	5.00%	5.00%

*The baseline was calculated by averaging four years of overpayment data as reported in the FISCAL YEAR 2013-14 Medicaid Fraud and Abuse Annual Report. Projections were made on the basis that MPI performs oversight on both Fee for Service and Managed Care.

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:

Base Year FY 2013-2014	FY 2018-2019	FY 2019-2020	FY 2020-2021	FY 2021-2022	FY 2022-2023
$25,320,000*	$40,778,113	$44,855,924	$49,341,516	$54,275,668	$59,703,235
Projected Increase in Percent	10.00%	10.00%	10.00%	10.00%	10.00%

*The baseline was calculated by averaging four years of prevention data as reported in the Fiscal Year 2013-14 Medicaid Fraud and Abuse Annual Report. Projections were made on the basis that MPI performs oversight on both Fee for Service and Managed Care.

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 3.A:

Measurement Criteria	Base Year FY 2013-14	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
Number of Long Term Care Recipients*	83,446	100,153	101,155	102,166	103,188	104,220
Target Number in Nursing Homes	45,728	45,540	42,960	40,325	37,633	34,882
Target Percentage in Nursing Homes	54.80%	45.47%	42.47%	39.47%	36.47%	33.47%
Target Percentage Transitioned	--	3.00%	3.00%	3.00%	3.00%	3.00%

*Source: August 2017 Social Services Caseload Estimating Conference. Actual future caseloads will change.

Service Outcome Measure 3.B: For the HEDIS measures that are in the Adult and Child Core Sets, improve the percentage of measures for MMA plans (weighted average for all plans by

measure) that meet or exceed the National Medicaid 75th percentile to 75 percent by Fiscal Year 2019-2020.

Service Outcome Measure Projection Table 3.B:

Measurement Criteria	Base Year FY 2012-13	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
Percentage of HEDIS measures >= 75th National Percentile	32.00%	66.00%	75.00%	75.00%	75.00%	75.00%

*Source: August 2017 Social Services Caseload Estimating Conference. Actual future caseloads will change.

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

Performance Projection Table 3.C:

Measurement Criteria	Base Year FY 2014-15	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
Total Medicaid Member Months	41,504,316	54,616,440	57,139,680	59,779,500	62,541,276	65,430,644
Target Recipient Member Months in SMMC	35,278,669	46,423,974	48,568,728	50,812,575	53,160,085	55,616,047
Projected Recipient Member Months in SMMC	31,199,904	44,452,584	46,506,264	48,654,828	50,902,644	53,254,315
Target Percentage of Medicaid Recipient Member Months in SMMC	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%

*Source: August 2017 Social Services Caseload Estimating Conference. Actual future caseloads will change.

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

Performance Projection Table 3.D:

Measurement Criteria	Base Year FY 2014-15	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	F 2022-23
Projected PMPM Costs for SMMC Enrollees	$318.69	$357.08	$375.65	$395.18	$415.73	$463.52
Estimated Growth Percentage from Previous Year	--	5.00%	5.00%	5.00%	5.00%	5.00%

*Source: August 2017 Social Services Caseload Estimating Conference. Actual future caseloads will change.

Linkage to Governor's Priorities

Number	Governor's Priorities	Agency Goals
1	**Improving Education** World Class Education	Goal 1: To operate an efficient and effective government. Goal 2: To reduce and/or eliminate waste, fraud, and abuse.
2	**Economic Development and Job Creation** Regulatory Reform	Goal 1: To operate an efficient and effective government. Goal 3: To assure access to quality and reasonably priced health services.
3	**Economic Development and Job Creation** Reduce Taxes	Goal 1: To operate an efficient and effective government.
4	**Public Safety** Protect our communities by ensuring the health, welfare and safety of our citizens.	Goal 1: To operate an efficient and effective government.

Trends and Conditions Statements

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

Health Quality Assurance

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

HQA licenses facilities and approves facilities' 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, and 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.

State Licensure and Federal Certification Annual Volume

- Licensure and renewal application processing including criminal background screening as required.
    - Annual volume: 20,000 licensure applications and over 400,000 criminal claims database background checks.
- Routine and complaint inspections, plans and construction reviews for certain facilities, and enforcement of penalties for violations.
    - Annual volume: 20,000 inspections, 10,900 complaints processed, and 5,200 plans and construction submission reviews.
- Consumer and public information regarding health care facilities including provision of licensure and inspection information to the public, public record requests and written response to inquiries.
    - Annual volume: 49,500 consumer calls to the Call Center, 3,200 public record requests, 2,200 written correspondence assignments, and 116,500 calls to the Background Screening Unit.

- Certificate of Need (CON) program to establish new facilities or additional beds for certain providers (nursing home, hospital, hospice) and enforce CON compliance issues.
    - Annual volume: 50-100 applications and reviews and nearly 700 condition compliance reviews.
- Emergency support functions to the State Emergency Operations Center for health facilities including maintenance of provider enrollment in the online FLHealthSTAT.
- Financial reviews and analysis for licensure, CONs, Florida Hospital Uniform Reporting System, Public Medical Assistance Trust Fund and Health Care Responsibility Act.
    - Annual volume: 2,700 reports and reviews.

Managed Care Regulation Annual Volume

- Health Care Provider Certificate applications processed for managed care plan licensure either for an initial, renewal or expansion of health care services/area. On average 25 applications are processed annually. Accreditation surveys are performed triennially for all managed care plans.
- Subscriber Assistance Program on average receives 275 complaints annually.
    - Annual volume: On average 66 of those requests are processed for a panel hearing with 37 cases heard by the panel.
- 40 balance billing complaints received and processed.
- Workers' compensation initial and renewal applications.
    - Annual volume: 20-40 applications.

<u>Transparency</u>

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. The Agency aims to accomplish this goal by expanding the nationally recognized FloridaHealthFinder.gov consumer website and by implementing a Multi-Payer Claims Database (claims database) in response to recently passed legislation.

In addition to its historical functions, the Florida Center for Health Information and Transparency (Florida Center) is overseeing the implementation of the claims database, which will 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.

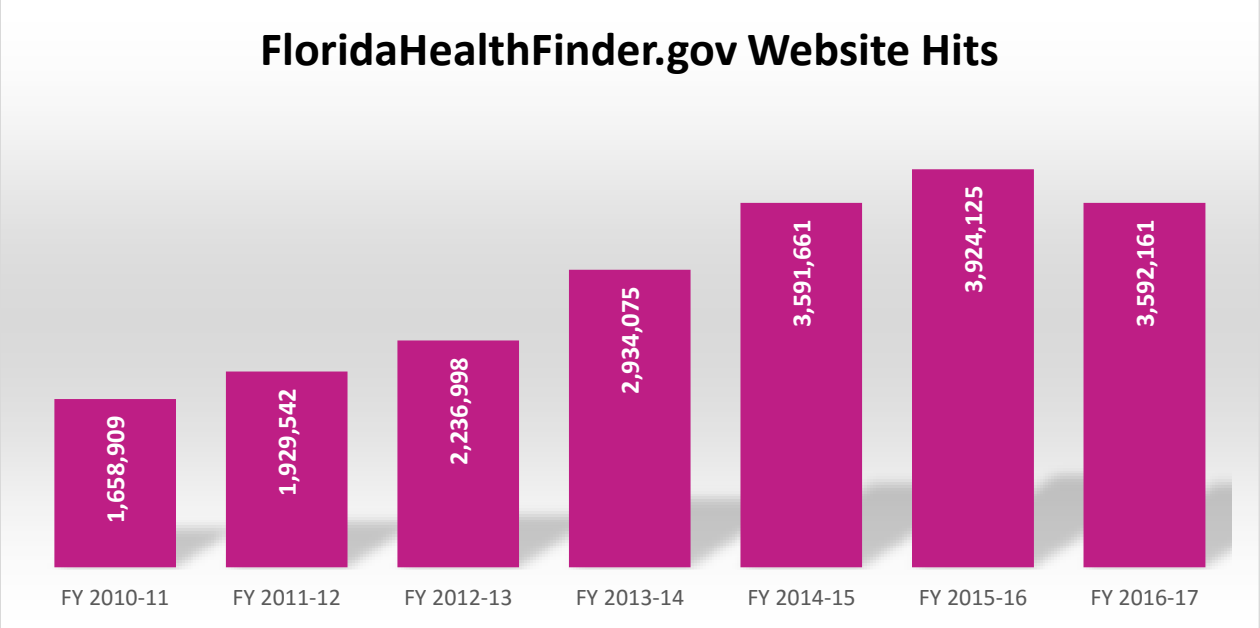
The Florida Center contracted with a vendor in April of 2017, to provide and maintain the claims database, perform analysis of the data, and develop a website for consumers to look up pricing information on common conditions and procedures. Once complete, the website will be accessible to the public and will provide comparison tools for the costs of common surgical procedures, hospitalizations, and other treatments.

Additionally, HQA is submitting a legislative budget request for a claims data analytics tool to be used in conjunction with the claims database. The publication of health care pricing information

for consumers is only the initial use of this information in terms of the value that health care claims data can provide to the state. The Florida health care claims dataset will be comprised of billions of lines of information, compiled from millions of consumers and thousands of providers. The funding request is for a comprehensive analytics service that will allow authorized Agency users to easily convert vast amounts of data into dashboards and reports that can be disseminated and viewed by others including industry stakeholders, policy makers, and the public.

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

FloridaHealthFinder.gov continues to be a heavily used public resource offering comparative tools for hospitals, nursing homes, assisted living facilities, hospices and more. Visits to the website continue to exceed three million annually.



Expanding Health Care Provider Access

The Agency continues efforts to enhance the health care provider experience through a comprehensive online licensure system that improves access and reduces administrative burdens for licensure and Medicaid enrollment. The online licensing system is fully operational allowing providers to file license renewals and updates, and is moving toward integration of other Agency systems that address Medicaid, background screening, accounts receivable, and Department of Health practitioner regulation. The system is expanding to automate verification of Medicaid enrollment, appropriate business registration, and outstanding monetary obligations.

The online licensing system currently interacts with the Agency's licensure database, Versa Regulation (VR), 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 contained in VR, which helps reduce 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 paper and Agency resources needed for document scanning.

Currently, online licensing is available for renewal and updates (changes during the licensure period) for all licensure types. From July 2015, through June 2017, the percentage of renewal applications submitted online rose from 37.4 percent to 54.8 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. Once implemented, these expansions will further reduce the number of paper applications processed and provide additional efficiencies.

The Agency will also continue to enhance the Care Provider Background Screening Clearinghouse (Clearinghouse), a secure web-based database designed to house, manage, and share screening results with multiple state agencies. These enhancements include adding national registries, implementing federal screening updates, and streamlining screening renewals. These projects reduce undue burdens on businesses and state agencies by eliminating duplicative screenings and lowering costs. The following agencies now also participate in the Clearinghouse: Agency for Persons with Disabilities (APD), Department of Elder Affairs (DOEA), Department of Children and Families (DCF), Department of Health (DOH), Department of Juvenile Justice (DJJ), and Vocational Rehabilitation (VR).

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 nearly $25 million for employers since January 2013. During Fiscal Year 2016-17, 147,935 background screening results were shared among participating agencies and Medicaid health plans resulting in an overall cost savings of $11,095,125 to Agency providers, DOH licensees, Medicaid health plans, Medicaid providers, DCF, DOEA, VR, and APD providers.

The Clearinghouse also includes a state Rap Back requirement, also known as "retained prints," which immediately notifies the Agency of a Florida arrest of an employee to determine if the arrest affects allowable access to vulnerable clients. The Clearinghouse also notifies providers of an arrest and prompts the provider to check eligibility. During Fiscal Year 2016-17, the Background Screening Unit processed 29,356 Rap Backs. Of these, 23.6 percent were found to be for criminal charges that resulted in the applicant's eligibility status being updated to not eligible.

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. This process will be put into place after the Federal Bureau of Investigation (FBI) has implemented the process with the Florida Department of Law Enforcement (FDLE).

The Agency monitors provider compliance with patient protections, including provider responsibility to maintain current employment information in the Clearinghouse and remove employees from patient access if they become ineligible after employment.

Field Operations Activities

The Bureau of Field Operations directs facility investigations, which evaluate factors such as: management and administration, nursing services, social services, dietary services, laboratory services, and compliance with state and federal fire safety codes. Additionally, the bureau is responsible for surveyor training and data management and support functions related to the Minimum Data Set (MDS—A resident assessment tool system used by nursing homes) and the Outcome and Assessment Information Set (OASIS—A patient assessment system used by home health agencies). The bureau also develops and implements quality assurance initiatives and strategies to improve consistency throughout field offices in relation to the Survey & Certification functions of the Agency under contract with the federal Centers for Medicare and Medicaid Services (CMS).

In Fiscal Year 2016-17, 281 surveyors completed 20,078 health care provider surveys. The surveys completed include initial, standard (re-licensure, recertification, and validations), complaints, and other interim or specialty surveys. The bureau's Complaint Administration Unit (CAU) continues to process calls that come in through the Agency's published toll-free consumer call center. During Fiscal Year 2016-17, CAU staff answered over 4,000 calls a month. These calls include complaints about care provided in health care facilities, Medicaid information, and other Agency business, as well as referrals to other government entities. In Fiscal Year 2016-17 CAU received 10,948 total complaints and surveyors conducted 5,905 inspections based on these complaints.

Due to the complex nature of scheduling inspections, HQA is submitting a legislative budget request for an automated survey scheduling tool. The majority of inspections are unannounced and require strict confidentiality. Scheduling requires the integration of legislatively mandated timeframes for various types of licensure, certification, and complaint inspections, as well as consideration of team composition, surveyor qualifications, surveyor conflicts of interest, geographic location of the provider and surveyors, and surveyor availability.

Currently, inspection scheduling heavily relies on manual processes and coordination between separate systems and databases, as well as frequent monitoring of inspection timeframes through a substantial number of reports. The request is for funding for an intelligent and automated survey inspection scheduling system that enables tight restriction of access to inspection dates and integrates information across various data sources, inclusive of pre-defined criteria and improved business processes.

Additionally, HQA is submitting a legislative budget request for licensed registered nurse (RN)

salary increases as the majority of staff required to conduct inspections are RNs. There are currently 163 Registered Nurse Specialists (RNS) and Registered Nurse Consultant (RNC) positions in HQA. Due to training required, including successful completion of federal qualification testing, on average RNs are not fully qualified to independently inspect facilities for the first 9 to 15 months of employment. In addition to the personnel costs during this orientation period, training costs exceed $7,000 for new RNs. Key reasons for RN staff separation are comparatively low salary, heavy travel involved with the inspection duties, and rigorous hours when patient complaints and quality of care concerns require inspections during evenings, weekends and holidays.

Recruitment and retention of RNs has proven difficult given competition with the health care industry for these medical professionals. Florida ranks 4th in employment of registered nurses, but 30th in salary paid. The request is for funding to increase all RNS annual salaries to a minimum of $55,000 and to increase all RNC annual salaries to a minimum of $60,000.

Construction Project Review

The Office of Plans and Construction (OPC) reviews and approves plans and specifications for construction projects in health care facilities. The OPC received 608 project applications and 737 desk review applications in Fiscal Year 2016-17. Desk reviews are cursory reviews and do not include a survey for completeness.

Of the 608 project applications, the OPC received 84 nursing home, 476 hospital, 46 ambulatory surgical center, and two intermediate care facility new project applications.

The 608 project applications resulted in 5,266 project submissions for the corresponding facility types in Fiscal Year 2016-17, as follows:

- 4,200 for hospitals;
- 710 for nursing homes;
- 342 for ambulatory surgical centers; and
- 14 for intermediate care facilities for the developmentally disabled.

The 5,266 project submission types for Fiscal Year 2016-17 included:

- 1,606 for Mail-In Reviews (the application and plans are mailed to the OPC and reviewed by OPC reviewers);
- 526 Stand-Up Reviews (the application is emailed and the plans are reviewed on-site by the OPC reviewers along with the provider); and
- 3,134 Surveys (each project must be surveyed at least once by the OPC reviewers for project completeness).

In November 2016, the OPC opened a new office in Tampa to better serve facilities on Florida's west coast. The office is staffed by two teams of architects and engineers. A new team was created for the office and an existing team was transferred from the Orlando office. The Tampa office will serve the rapidly growing Tampa Bay area including Hernando, Pasco, Hillsborough, Pinellas, Manatee, and Sarasota counties. The expansion will allow the OPC to reallocate team territories to keep up with growth in other parts of the state as well.

Hurricane Response

Hurricane Hermine was the first hurricane to make landfall in Florida since Hurricane Wilma in 2005. Following the hurricane, which made landfall in the first days of September 2016, the Agency provided technical support to Emergency Function 8 (Health and Medical) and DOH. The Agency opened an event in EMResource (Emergency Status Database) which provided reporting and system update assistance to providers in impacted areas. This was done in collaboration with the Florida Hospital Association and the Florida Health Care Association. Several health care facilities lost power during this event.

Hurricane Matthew struck Florida's east coast in October 2016. In preparation for the impacts, the Agency again provided technical support to Emergency Support Function 8 (Health and Medical) and DOH and opened an event in EMResource. The Agency assisted with the evacuations of facilities in affected areas and maintained communication with those who had lost power. Agency staff worked through the Agency desk at the Emergency Operations Center at DOH, contacting facilities in affected areas and assisting the DOH with site visits. The Agency received information that 139 facility evacuations occurred and 155 facilities lost power. Varying degrees of damage occurred to roads, roofs, walls, and windows.

Health Care Alerts Webpage

The Agency introduced a new Health Care Alerts webpage in May 2016. This addition expanded upon a process already in place for interested parties to receive information about the Medicaid program and its providers. The change made it easier for the public to sign up for health care alerts that interest them and created a uniform system for sending out the email alerts. Users are able to sign up for alerts involving program updates for Agency initiatives such as telehealth, health care providers and facilities regulatory updates and emergency actions, and a range of other topics in one place. Members of the public may sign up for as many or as few categories as desired. The Health Care Alerts system can be accessed by visiting http://www.ahca.myflorida.com/MCHQ/alerts/alerts.shtml.

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 convened 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 coordinated with the Agency, as well as DOH 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 law directed the Agency to compile survey results and research findings and submit a report by the end of 2016. The final report can be found by visiting http://www.ahca.myflorida.com/SCHS/telehealth/docs/Telehealth_Report_Final.pdf.

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 was 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 2017, 8,668 eligible providers were paid a total of $230,861,485 and 182 hospitals were paid a total of $319,435,818.

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 then operated under a contract with Harris Corporation, which ended June 30, 2017. Audacious Inquiry (Ai) currently supports the Florida HIE through a no-cost agreement with the Agency. User fees currently sustain the Florida HIE. Through three primary initiatives, the Florida HIE fosters electronic exchange statewide.

Direct Messaging is a Health Insurance Portability and Accountability Act (HIPAA) compliant email service that allows participants to send and receive messages and attachments containing a patient's clinical data. The Patient Look-Up (PLU) service connected existing health care provider networks for the exchange of health information for treatment purposes. There are national services available for provider networks to utilize for this exchange, and Ai is providing consulting and technical support as needed for PLU participants to shift to other solutions for exchange.

The Event Notification Service (ENS) provides alerts to health plans, accountable care organizations and provider groups about their member or patient's hospital encounters for care coordination. Currently, ENS covers 94 percent of acute care hospital beds in the state. There are 10 health plans, 24 accountable care organizations, and three provider groups subscribing to the service. There are four million lives covered by the ENS as of August 2017, with 300,000 alerts delivered to subscribers each month.

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

Pediatric Cardiology Technical Advisory Panel

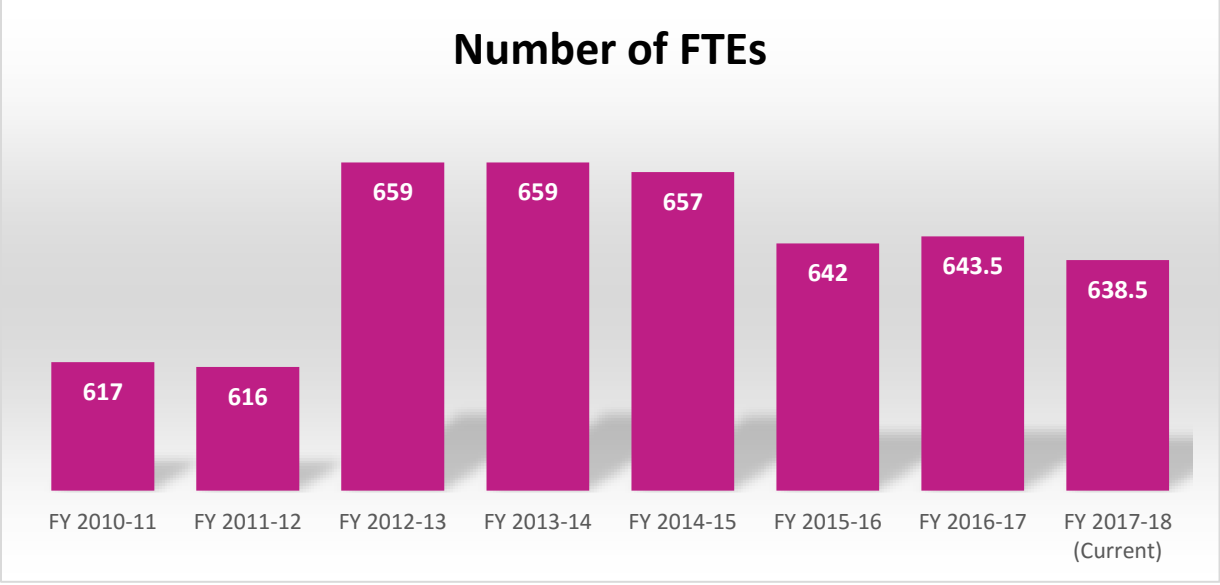
In 2017, legislation was passed requiring the Agency to develop a technical advisory panel to

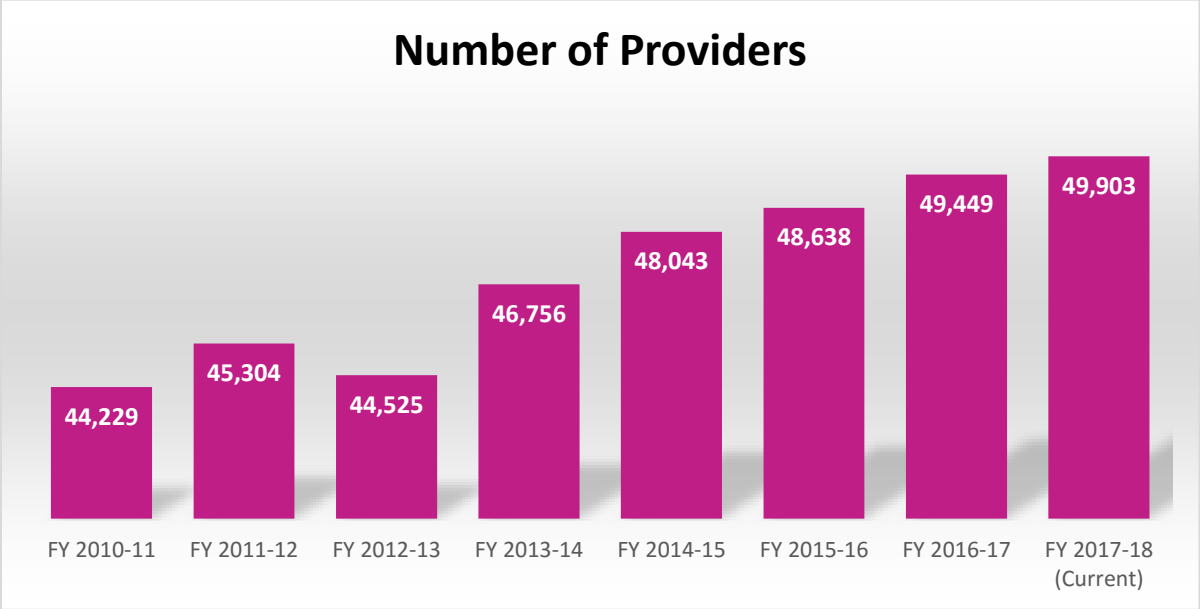
develop procedures and standards for measuring outcomes of pediatric cardiac catheterization programs and pediatric open-heart surgery programs. The panel must consist of three at-large cardiologists selected by the Secretary of the Agency with certain qualifications. The remainder of the panel shall be composed of a pediatric cardiologist or a pediatric cardiovascular surgeon, from each of 10 specified hospitals: John Hopkins All Children's Hospital in St. Petersburg, Arnold Palmer Hospital for Children in Orlando, Joe DiMaggio Children's Hospital in Hollywood, Nicklaus Children's Hospital in Miami, St. Joseph's Children's Hospital in Tampa, University of Florida Health Shands Hospital in Gainesville, University of Miami Holt Children's Hospital in Miami, Wolfson Children's Hospital in Jacksonville, Florida Hospital for Children in Orlando, and Nemours Children's Hospital in Orlando.

The Agency is required to develop and adopt rules concerning pediatric cardiology based on the recommendations of the panel. The subsection of statute governing the panel is set to expire on July 1, 2022. More information about the panel can be found by visiting http://ahca.myflorida.com/SCHS/PCTAP/index.shtml.

Optimizing Resources in Challenging Economic Times

Efficiency continues to be a goal of the Agency. The following charts illustrate HQA's full-time equivalent (FTE) positions and the number of providers regulated over the past recent fiscal years. The Florida Center became part of HQA in Fiscal Year 2012-13, explaining the increase in FTEs for this year. From Fiscal Year 2010-11 to the start of Fiscal Year 2017-18, HQA's number of licensed, registered, certified, and regulated service providers and facilities increased from 44,229 to 49,903. Overall, this represents a 13 percent increase in regulated providers. Although workload has increased, the number of full-time equivalent positions has decreased as a result of program efficiencies.





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 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 agency IT projects as outlined in s. 282.0051, F.S.

In Fiscal Year 2015-16, AST promulgated rule 74-1 and 74-2, Florida Administrative Code, to establish and refine project management and cybersecurity definitions and standards. In Fiscal Year 2017-18, AST promulgated rule 74-5, Florida Administrative Code, to establish statewide identity management 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. Several factors strongly influence the Agency's ability to fulfill its current responsibilities and achieve its future goals. The main objectives 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. The 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.

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, including:

- Finding new and more effective ways to support health care services, such as salary increases to retain and attract competent IT staff;
- Improving the governance process of all IT staff through a thorough business case process; and
- 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. The Bureau of Medicaid Program Integrity (MPI) assists in carrying out this purpose for the Medicaid program. 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 Fiscal Year 2013-14, 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-service (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.

Fiscal Year 2014-15, 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 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 continues 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 Fiscal Year 2014-15, referrals to MFCU increased over the prior year and this pattern continued in Fiscal Year 2016-17.

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. These 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 (primarily the Department of Health and Health Quality Assurance), 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 continues to conduct assessments and validation to develop leads and support data driven information.

In July 2016, the state adopted s. 409.907(12), F.S., and s. 409.908(25), F.S., which establishes the criteria for a Medicaid provider to be determined to be out of business. In Fiscal Year 2016-17, MPI initiated, as the result of the new law, the process to certify a Medicaid provider "out of business." In accordance with 42 CFR 433.318(d), upon the certification of a Medicaid provider being out of business, the state is not required to refund to CMS the federal share of an unpaid overpayment if the provider is out of business and the overpayment cannot be collected under state law. The filing of the matter is time sensitive.

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 continues 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.

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, 61.10 percent of the expenditures for most Medicaid services were reimbursed with federal funds in Fiscal Year 2016-17. Administrative costs continue to be reimbursed at 50 percent (accounting for less than one percent of the total Medicaid expenditures in Florida), 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 affect employment and income. According to the U.S. Census Bureau, the population of Florida was estimated to be more than 20.44 million as of July 2017, making it the third most populous state in the nation. Florida's growth rate has been among the fastest in the nation for decades.

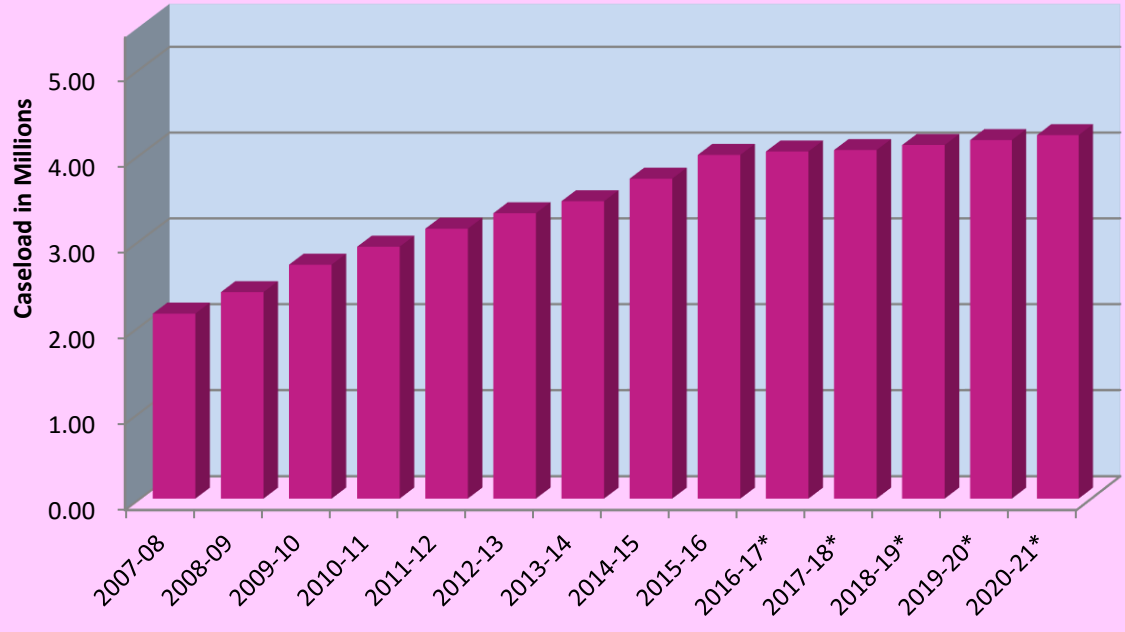
At the time of the 2010 U.S. Census, Florida had the highest percentage of population age 65 and older accounting for more than 19 percent of the state's total population. As the baby boom generation, those born between 1946 and 1964, begins reaching retirement age in the next few years and substantial 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). The SMMC program 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 Fiscal Year 2016-17, Medicaid had more than 4 million recipients. These individuals receive health care services from 124,750 providers that offer services to recipients in both FFS and MMA health plans and over 17,000 providers providing services only as part of health plan provider networks. Medicaid caseloads in fiscal year 2016-17 were almost 88 percent higher than a decade ago in fiscal year 2007-08 (Figure 3-1). Total caseload increased by just over one percent in Fiscal Year 2016-17, over the prior fiscal year and is projected to increase in Fiscal Year 2017-18, by approximately 0.5 percent or just over 15,000 recipients.

Figure 3-1
Growth in Medicaid Caseload



Source: Medicaid Program Finance
**FY2016-17 are estimates from the March 2017 Social Services Estimating Conference*
**FY 2017-18 through FY 2020-21 are estimates. based on the August 2017 Social Services Estimating Conference*

The caseload increases in recent years reflect external factors such as the launch of the Affordable Care Act, which requires people to be automatically referred to Medicaid if eligible, and

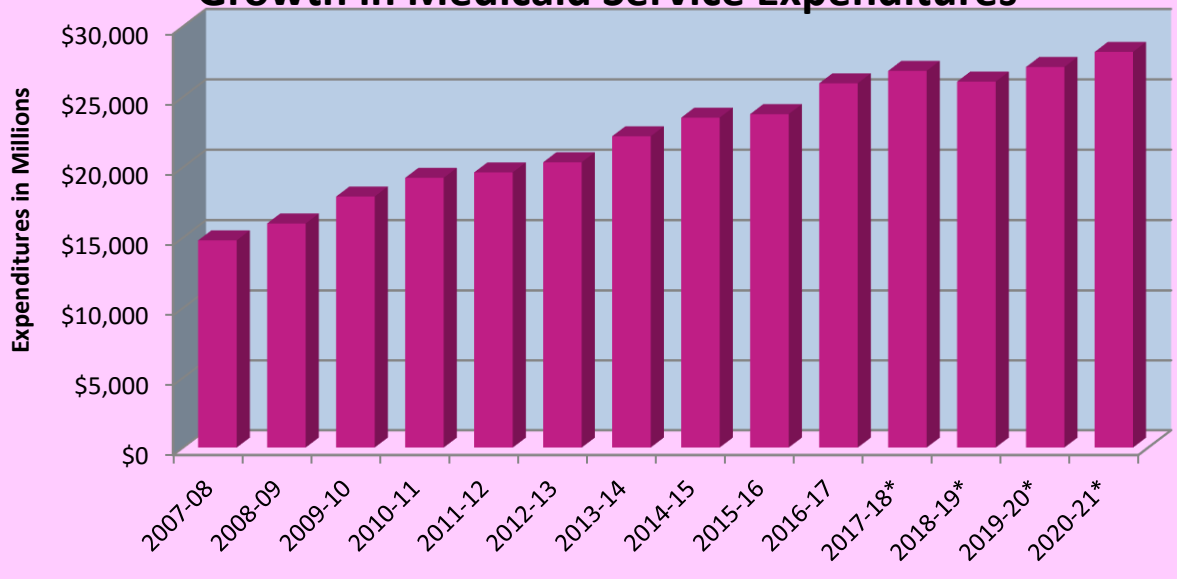
the transition of many children previously covered by the Children's Health Insurance Program (CHIP) to Medicaid.

Medicaid Expenditures

With expenditures of an estimated $25.9 billion in Fiscal Year 2016-17, Medicaid is the largest single program in the state, accounting for almost one-third of the state's total budget. It is also the largest source of federal funding for the state. Since Fiscal Year 2007-08, expenditures in the Medicaid program grew 75.3 percent, from almost $14.8 billion in Fiscal Year 2007-08, to $25.96 billion in Fiscal Year 2016-17, (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 and long-term care services. The largest expenditure categories for Fiscal Year 2016-17, were:

- Prepaid Health Plans ($13.7 billion);
- Prepaid Health Plan/Long-term Care ($4.1 billion);
- Supplemental Medical Insurance ($1.6 billion);
- Home and Community-Based Services ($1.1 billion);
- Hospital Inpatient Services ($1.0 billion); and
- Low Income Pool ($607.8 million).

Figure 3-2
Growth in Medicaid Service Expenditures



Source: Medicaid Program Finance
**FY2016-17 are estimates from the March 2017 Social Services Estimating Conference*
**FY 2017-18 through FY 2020-21 are estimates. Based on the August 2017 Social Services Estimating Conference*

The Evolution of Florida Medicaid

Medicaid was implemented as a FFS program more than four decades ago and, historically, had been primarily a FFS program.

Medicaid evolved into 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, in Broward and Duval counties in 2006, which expanded to Baker, Clay and Nassau counties in 2007. By July 1, 2013, 47 percent of Medicaid recipients were enrolled in managed care, 35 percent enrolled in FFS, and 18 percent enrolled in MediPass.

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. In response, the Legislature directed the single biggest change in program history, the implementation of the SMMC program in 2013 and 2014.

Statewide Medicaid Managed Care

Now that the transition of Florida Medicaid to SMMC is complete, many of the previous FFS functions supported by Medicaid staff have been significantly diminished. This has allowed staff to shift their focus to the oversight of health plans. This has resulted in improved efficiency, cost predictability, and accountability for the program and enhanced service provision for program recipients. During Fiscal Year 2016-17 the Division of Medicaid has built on those achievements to provide increased accountability and transparency in the Medicaid program while continuing quality improvement. Medicaid also began preparing for re-procurement of the health plans for the next five-year period.

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 had received services through a variety of waivers and programs. Long-term Care under the Florida Medicaid program includes nursing facility care and home and community-based services. Home and community 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 due to disability, and who need nursing facility level of care.

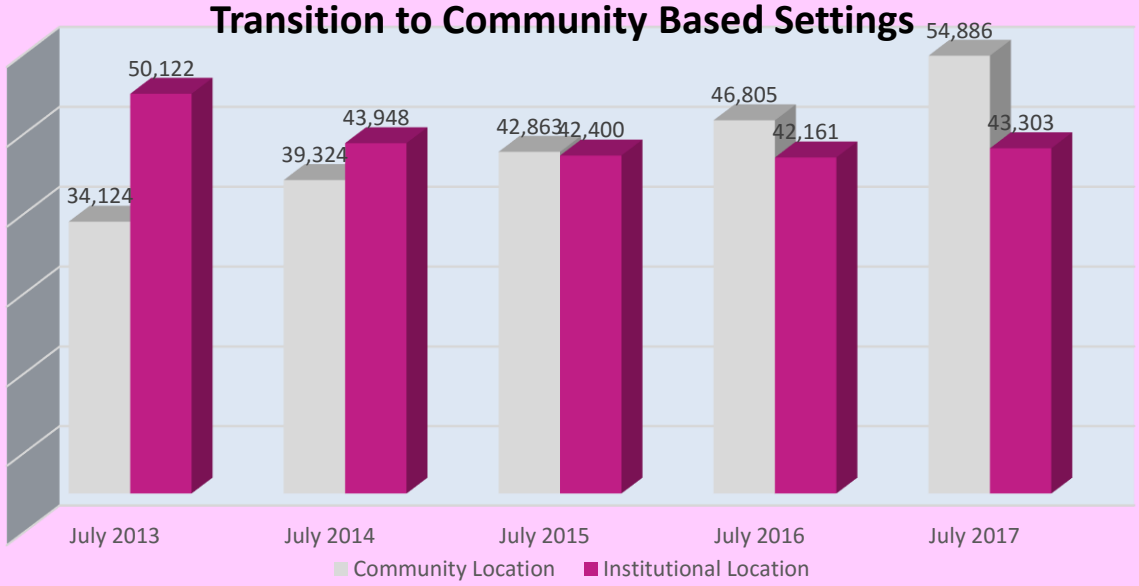
As part of the implementation of the SMMC program, several home and community-based waivers were ended, and their enrollees rolled into the LTC program, including:

- The Assisted Living for the Frail Elderly Waiver;
- The Aged and Disabled Adult Waiver and its Consumer-Directed Care Plus component;
- The Adult Day Health Care Waiver;
- The Channeling Services for Frail Elders Waiver; and
- The Nursing Home Diversion Waiver.

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 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. The Agency is required by statute to incentivize the LTC plans, through the capitation rate structure, to transition recipients from institutionalized settings to community settings. This has been successful, and for the first time in program history there are more individuals being served in home and community-based settings than in nursing facilities. As of June 2017, there were six SMMC LTC plans providing care and services to 43,303 nursing facility residents and 54,886 waiver recipients.

Figure 3-3
Transition to Community Based Settings



Source: July 2013 data us based on paid claims for NH to identify institutional recipients; and paid claims for LTC waivers (ADA, ALE, CHL, and NHD) for HCBS recipients. July 2014 and 15 data is from Plan Submitted Enrollee Residence Report, March 2014 – July 2015, and Florida Medicaid Managed Information System (FLMMIS) Eligibility Information, March 2014 –

Additional Waiver Consolidation

During the 2017 legislative session, the Agency was directed to consolidate three waivers that offer similar services into the Statewide Medicaid Managed Care program. The three waivers are Project AIDS Care (PAC), Traumatic Brain Injury and Spinal Cord Injury (TBI/SCI), and Adult Cystic Fibrosis (ACF).

The Agency is aggressively planning and conducting targeted outreach to ensure recipients and providers are prepared for this transition. The Agency has extensive experience in successfully transitioning recipients into the SMMC program. In fact, in 2013-2014, millions of recipients smoothly transitioned into the SMMC program, including 40,000 individuals with complex care needs. This transition will involve about 7,500 people (PAC – 7,000; TBI/SCI – 350; ACF – 150).

The Agency anticipates a December 1, 2017 transition date for TBI/SCI and ACF Waiver recipients and a January 1, 2018, transition date for PAC Waiver recipients. For more information, please visit our Web site at:

http://ahca.myflorida.com/Medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/waiver_changes.shtml

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 2017, there were 3,181,088 individuals enrolled in the MMA program's 17 health plans.

The MMA component of the SMMC program provides medical and behavioral health care services to recipients eligible for enrollment. Dental services were part of the set of services offered by MMA plans, but no later than March 2019, dental services will be provided separately through prepaid dental plans. 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 only a few health plans include:

- Assistive Care Services;
- Child Welfare Behavioral Health Overlay Services;
- Community Substance Abuse Services;
- Comprehensive Behavioral Health Assessments;
- 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 Medicaid services that MMA plans offer, they also offer a set of additional benefits and services that would otherwise not be covered by Medicaid. These expanded benefits vary by plan and can include services like adult hearing and vision screening, post-discharge meal delivery, and even art or pet therapy. Recipients choose which plan they wish to enroll in their region, which allows them to choose the plan that best fits their needs.

MMA plans are held to high standards of service, quality, and transparency. These requirements include enhanced provider networks, which help ensure that Medicaid recipients can conveniently, and quickly access health care services. To assist health care providers there are enhanced standards for claims processing, prior authorization, enrollee/provider help line, and call center operations. All of these increased standards help ensure provider and recipient satisfaction are high and that care provided is of the highest quality possible.

Monitoring Health Plan Compliance

The Division of Medicaid rigorously monitors health plan compliance with contractual obligations. Health plan contracts provide accountability through robust health plan reporting requirements and the capability to assess liquidated damages and/ or sanctions for any contract violation. The table below shows the nine issue types and the total number of final actions taken by issue during Fiscal Year 2016-17:

Marketing	5
Enrollee Services and Grievances	24
Medicaid Fair Hearing	10
Covered Services	35
Provider Network	9

Quality and Utilization Management	19
Administration and Management	38
Finance	7
Reporting	4

In all, there were 151 final actions in Fiscal Year 2016-17 resulting in $17.25 million in liquidated damages and $30,000 in sanctions.

SMMC Extension and Health Plan Re-procurement

The Agency sought and received a five-year extension of the federal waiver for the MMA program through June 2022. In addition, as the SMMC program nears the end of its initial five-year health plan contract period, the Agency has begun re-procurement of SMMC contracts. The Invitation to Negotiate (ITN) to re-procure SMMC health plan contracts was released on July 14, 2017. Vendor responses are due November 1, 2017, and the Posting of Notice of Intent to Award is scheduled for April 16, 2018. There are 11 separate regional procurements with one ITN per region for both Long-term Care and Managed Medical Assistance services.

Bidders can choose from four plan types:

Type of Plan	Description
Comprehensive	MMA to all members, plus LTC to anyone who qualifies
LTC Plus	Serves only LTC members, but provides all MMA services to them
MMA	MMA only
Specialty	MMA only; targeted populations

The ITN was structured to require plans to demonstrate how they can help the Agency reach the following Medicaid goals:

- Reduce potentially preventable hospital admissions, readmissions, and emergency department use and use of unnecessary ancillary services;
- Improve birth outcomes; and
- Rebalance long-term services and supports systems by increasing the percentage of enrollees receiving services in the community instead of nursing facilities.

During the 2016 legislative session, Medicaid dental services were “carved-out” of MMA plans. The Agency is currently preparing the prepaid dental procurement for release in the fall of 2017. The program is anticipated to include:

- All state plan covered dental services; and
- All eligible adults and children enrolled in Medicaid.

Recipient transition to the prepaid dental program will occur at the same time as recipient transition to the SMMC plans awarded contracts through the SMMC re-procurement.

SMMC Highlights and Successes During Fiscal Year 2016-17

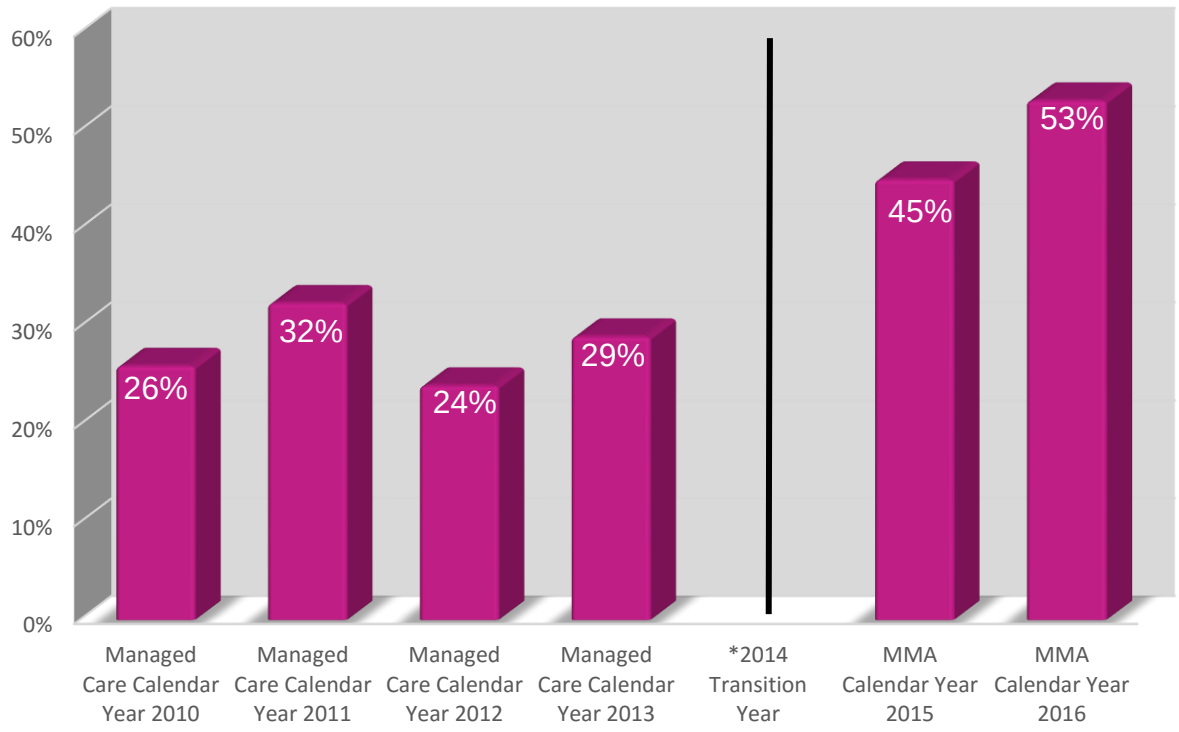
Improved Quality and High Satisfaction

The Division of Medicaid continued to work on improving quality of health care services and has several tools that will help realize these program goals. Medicaid used multiple tools that track quality and performance in health plans. Plans are required to report Healthcare Effectiveness Data and Information Set (HEDIS) scores that show how well plans are performing on various aspects of providing care to recipients. Quality scores for Medicaid health plans showed continued improvement in calendar year 2016. 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.

Improvements in Health Care Quality

The National Committee for Quality Assurance (NCQA) uses HEDIS to measure health plans on their levels of care and service. 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. Florida’s Medicaid health plans performed above the national average on 53 percent of HEDIS measures. Figure 3-4 shows the percentage of HEDIS measures that met or exceeded the national average for all Medicaid health plans in a given year.

Figure 3-4
Percentage of Scores Better than the National Average



Calendar Year 2014 was a transition year between Florida's prior managed care delivery system and the SMMC program implementation.

High Levels of Recipient Satisfaction

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 and that levels of satisfaction have been stable during the MMA program. These levels of satisfaction are higher than the average satisfaction levels for commercial plans. Below are some highlights from 2017 CAHPS results along with 2015 and 2016 results for comparison:

Adult Survey Results

CAHPS Item	Rate Description	2015 (CY 2014 Data)	2016 (CY 2015 Data)	2017* (CY 2016 Data)
Health Plan Rating	% of Respondents rating their Health Plan an 8, 9, or 10 on a scale of 0-10	74%	73%	76%
Getting Needed Care	% of Respondents reporting it is usually or always easy to get needed care	82%	80%	83%
Getting Care Quickly	% of respondents reporting it is usually or always easy to get care quickly	83%	82%	84%
Customer Service	% of respondents reporting they usually or always get the help/info needed from their plan's customer service	87%	88%	88%
Health Care Rating	% of respondents rating their health care an 8, 9, or 10 on a scale of 0-10	76%	75%	77%

Child Survey Results

CAHPS Item	Rate Description	2015 (CY 2014 Data)	2016 (CY 2015 Data)	2017* (CY 2016 Data)
Health Plan Rating	% of Respondents rating their Health Plan an 8, 9, or 10 on a scale of 0-10	81%	84%	86%
Getting Needed Care	% of Respondents reporting it is usually or always easy to get needed care	82%	83%	83%
Getting Care Quickly	% of respondents reporting it is usually or always easy to get care quickly	89%	89%	89%
Customer Service	% of respondents reporting they usually or always get the help/info needed from their plan's customer service	86%	88%	88%
Health Care Rating	% of respondents rating their health care an 8, 9, or 10 on a scale of 0-10	85%	86%	89%

*2017 statewide rates are preliminary and may change slightly.

LTC Surveys

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

Survey Item	Rating Description	2015 (CY 2014 Data)	2016 (CY 2015 Data)	2017* (CY 2016 Data)
LTC Plan Rating	% of respondents rating their LTC Plan an 8, 9, or 10 on a scale of 0-10	80%	78%	80%
Contacting Case Manager	% of respondents reporting it is usually or always easy to get in contact with their case manager	83%	80%	81%
Case Manager Rating	% of respondents rating their case manager an 8, 9, or 10 on a scale of 0-10	84%	81%	83%
Timeliness of Services	% of respondents reporting that their LTC services are usually or always on time	90%	89%	90%
LTC Services Rating	% of respondents rating their LTC Services an 8, 9, or 10 on a scale of 0-10	83%	80%	83%
Overall Health	Improved Since Enrolled in LTC Plan	59%	60%	60%
Quality of Life	Improved Since Enrolled in LTC Plan	77%	76%	77%

Health Plan Report Cards

Medicaid continues to publish health plan report cards for the MMA plans, which are based on HEDIS scores. Publication of MMA health plan report cards allows enrollees to 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.

MMA Physician Incentive Program

Florida Statutes require Medicaid health plans to increase compensation for physicians, using funds achieved through savings from effective care management. Qualified physicians earn the Medicare rate for providing Medicaid services. The Agency began implementing this provision through the MMA Physician Incentive Program on October 1, 2016. Board Certified Pediatricians and Board Certified OB/GYNs who met specified criteria and/or access and quality measures were eligible for enhanced payments.

The provider types included in Year 2 (which begins October 1, 2017) will be expanded to also include the following, regardless of board certification:

- Pediatricians;
- Family practitioners who serve children (under age 21); and
- General practice physicians who serve children (under age 21).

Year 2 will also include the following board certified providers:

- Pediatric cardiologists;
- Pediatric endocrinologists;
- Pediatric nephrologists;
- Pediatric neurologists; and
- Pediatric psychiatrists.

Recipient and Provider Complaints

As part of the SMMC program, the Agency collects and records information on both recipient and provider complaints. All stakeholders are encouraged to bring any potential issue, concern, or complaint regarding the SMMC Program to the SMMC Complaint Operations Center. All allegations and issues are recorded, regardless of whether they were found to be accurate or substantiated. The number of complaints, whether or not they prove to be accurate or substantiated, is very low.

Table 3-5 Average Number of Recipient and Provider Complaints per 1,000 Enrollees June 1, 2016, through June 30, 2017 (for both MMA and LTC Programs)

Average Monthly SMMC Enrollment	**3,316,705**
Provider Issues per 1,000 Enrollees	0.12
Recipient Issues per 1,000 Enrollees	0.21

Potentially Preventable Healthcare Events (PPEs)

The Agency's responsibility for ensuring access to quality health care services for Medicaid recipients amid growing healthcare costs in the U.S. requires identifying opportunities for healthcare efficiencies that do not compromise quality of care.

One opportunity for improving healthcare efficiencies and increasing life saving outcomes is identifying and reducing potentially preventable healthcare events (PPEs). PPEs are health care services including hospital admissions, readmissions, and emergency department visits that might have been prevented with better access to primary care, improved medication management, or better coordination of care. During Fiscal Year 2016-17 Medicaid completed a study of PPEs for the period August 2014, to July 2015. The Agency will use this study to design quality improvement initiatives that drive down the rates of these undesirable healthcare events. This study is just one example of Medicaid's commitment to improving quality of care.

For more information, the complete report is available on the Medicaid website.

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. Procurement of the new five-year contracts with SMMC plans will provide additional tools and opportunities for continued increases in accountability and quality. 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 legislative budget requests for Medicaid re-procurement activities, and activities 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
20.	section 20.055(6)(i), F.S.	Long-term and annual audit plans submitted by the Inspector General to the Chief Inspector General, Agency Head, and Auditor General	Annually/September 30
21.	section 20.055(8)(a), 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
22.	section 409.913, F.S.	Annual Medicaid Fraud and Abuse Report	Annually/January 1
Division of Health Quality Assurance			
23.	section 408.909(9), F.S.	Annual report on Health Flex to be submitted jointly with the Office of Insurance Regulation	Annually/January 1
24.	section 408.7057(2)(g)2., F.S.	Annual Report on the Cases of the Statewide Managed Care Dispute Resolution Program	Annually/February 1
25.	section 400.191, F.S.(2)	Nursing Home Guide Quarterly Report	Ongoing responsibilities
26.	section 395.10972, F.S.	Risk Managers Advisory Group – This is a standing advisory group that has not met in several years.	Ongoing responsibilities
27.	section 483.26, F.S.	Clinical Laboratory Technical Advisory Panel	Ongoing responsibilities
28.	section 627.4236, F.S.	Bone Marrow Transplant Advisory Panel	Ongoing responsibilities
29.	section 409.912, F.S.	Drug Utilization Review Board	Ongoing responsibilities
30.	section 288.0656, F.S.	Rural Economic Development Initiative	Ongoing responsibilities
31.	section 402.281, F.S.	Governor's Panel on Excellence in Long-Term Care (Gold Seal Program)	Ongoing responsibilities
32.	section 408.7056 and section 408.7057, F.S.	Statewide Provider and Subscriber Assistance Panel	Ongoing responsibilities

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

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
42.	section 408.062(1)(i), F.S.	Annual Report of Emergency Department Utilization and Services	Annually/January 1
43.	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
44.	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
45.	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
46.	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
47.	section 394.879, F.S.	Consolidated license plan for mental providers	Non-recurring report due by November 1, 2016
48.	section 395.0197(8), F.S.	Quarterly and Annual summaries and trend analyses of adverse incidents	Quarterly and Annually
49.	section 408.05(6), F.S.	State Consumer Health Information and Policy Advisory Council	Ongoing Responsibilities
Division of Information Technology			

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
50.	None.		
Division of Medicaid			
51.	section 409.91211, F.S.	Enhanced Benefits Panel	Ongoing responsibilities
52.	section 409.818, F.S.	Florida KidCare Grievance Committee	Ongoing responsibilities
53.	section 409.91213, F.S.	Low Income Pool (LIP)	Quarterly progress reports and annual reports for 1115 waivers
54.	section 409.911, F.S.	LIP Council	Ongoing responsibilities
55.	section 409.91211, F.S.	Medicaid Reform Technical Advisory Panel	Ongoing responsibilities
56.	section 381.0602, F.S.	Organ Transplant Advisory Council	Ongoing responsibilities
57.	section 400.235, F.S.	Pharmaceutical and Therapeutics Committee	Ongoing responsibilities
58.	section 16.615, F.S.	Council on the Social Status of Black Men and Boys	Ongoing responsibilities
59.	section 409.818(2)(c), F.S.	Kid Care Coordinating Council (Membership Only)	Ongoing responsibilities
60.	section 409.8177(2), F.S.	Florida KidCare Enrollment Report on enrollment for each component of Florida KidCare Program	Ongoing responsibilities

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
61.	section 409.908(2)(b)5, F.S.	Nursing Care Cost Report: Annual Report on direct and indirect care costs	Ongoing responsibilities
62.	section 409.912 (39)(c), F.S.	Medicaid Prescribed-Drug Spending Control Quarterly Report must include at least the progress made in implementing this subsection and its effect on Medicaid prescribed-drug expenditures	Ongoing responsibilities
63.	section 409.91213, F.S.	Medicaid Reform Quarterly Report: Agency analysis and the status of various operational areas	Ongoing responsibilities
64.	section 409.91213, F.S.	Medicaid Reform Annual Report: Report documenting accomplishments, project status, quantitative and case-study findings, utilization data, and policy, and administrative difficulties in the operation of the Medicaid waiver demonstration program	Ongoing responsibilities
65.	section 409.912 (44), F.S.	HSD annual report of audit results to ensure cost effectiveness relating to Medicaid Managed Care	Ongoing responsibilities
66.	section 409.8177(1), F.S.	Florida KidCare Evaluation Annual Report: the Agency, in consultation with the DOH, the DCF and Florida Healthy Kids contract for evaluation and report on KidCare program	Ongoing responsibilities
67.	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

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
68.	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
69.	section 409.912(28), F.S.	EPSDT (Child Health Check-Up) Screening Rates	Ongoing responsibilities
70.	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.
71.	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.
72.	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

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
			payment system on Medicaid reimbursement rates for hospice providers.
73.	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 2017-2018 (Words)		Approved Prior Year Standards FY 2016-2017 (Numbers)	Prior Year Actual FY 2016-2017 (Numbers)	Approved Standards for FY 2017-2018 (Numbers)	Requested FY 2018-2019 Standard (Numbers)
Program: Administration and Support			**Code: 68200000**		
1	Administrative costs as a percent of total agency costs	0.11%	0.07%	0.11%	0.11%
2	Administrative positions as a percent of total agency positions	11.45%	10.88%	11.45%	11.45%
Program: Health Care Services			**Code: 68500000**		
Service/Budget Entity: Children's Special Health Care			**Code: 68500100**		
3	Percent of hospitalizations for conditions preventable by good ambulatory care	7.70%	See New Measure 3A Below	7.70%	DELETE[4]
3A	New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): CMSN enrollees (Title XIX and Title XXI)	N/A	8.08%	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]
4A	New Measure - Percentage of all Title XXI KidCare Enrollees Eligible for Renewal Who Renew KidCare Coverage	N/A	74.90%	90.00%	75.00%

	Approved Performance Measures for FY 2017-2018 (Words)	Approved Prior Year Standards FY 2016-2017 (Numbers)	Prior Year Actual FY 2016-2017 (Numbers)	Approved Standards for FY 2017-2018 (Numbers)	Requested FY 2018-2019 Standard (Numbers)
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%	93.80%	95.00%	90.00%
8	Total number of Title XXI-eligible children enrolled in KidCare	228,159	195,641	228,159	171,323
9	Number of Title XXI-eligible children enrolled in Florida Healthy Kids	195,867	160,564	195,867	139,279
10	Number of Title XXI-eligible children enrolled in MediKids	2,100	24,045	21,000	21,723
11	Number of Title XXI-eligible children enrolled in Children's Medical Services Network	111,292	11,032	10,053	10,321
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%

Approved Performance Measures for FY 2017-2018 (Words)		Approved Prior Year Standards FY 2016-2017 (Numbers)	Prior Year Actual FY 2016-2017 (Numbers)	Approved Standards for FY 2017-2018 (Numbers)	Requested FY 2018-2019 Standard (Numbers)
13	Average number of days between receipt of clean Medicaid claim and payment	15	11.4	15	15
14	Number of Medicaid claims received	145,101,035	65,593,277	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	1.56%	25.00%	20.00%
15B	New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Ages 21 and Over enrolled in Fee-for-Service, MediPass, and Provider Service Networks	N/A	6.99%	20.00%	20.00%
16	Percent of women receiving adequate prenatal care	86.00%	84.00%	86.00%	86.00%

Approved Performance Measures for FY 2017-2018 (Words)		Approved Prior Year Standards FY 2016-2017 (Numbers)	Prior Year Actual FY 2016-2017 (Numbers)	Approved Standards for FY 2017-2018 (Numbers)	Requested FY 2018-2019 Standard (Numbers)
17	Neonatal mortality rate per 1000	4.70%	7.10%	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	75.00%	50.00%	Per Appropriations Estimate
19	Percent of eligible children who received all required components of EPSDT screening	64.00%	72.00%	64.00%	Per Appropriations Estimate
20	Number of children ages 1-20 enrolled in Medicaid	1,249,276	2,757,835	1,249,276	Per Appropriations Estimate
21	Number of children receiving EPSDT services	407,052	2,243,945	407,052	Per Appropriations Estimate
22	Number of hospital inpatient services provided to children	92,960	60,020	92,960	Per Appropriations Estimate
23	Number of physician services provided to children	6,457,900	3,175,697	6,457,900	Per Appropriations Estimate

	Approved Performance Measures for FY 2017-2018 (Words)	Approved Prior Year Standards FY 2016-2017 (Numbers)	Prior Year Actual FY 2016-2017 (Numbers)	Approved Standards for FY 2017-2018 (Numbers)	Requested FY 2018-2019 Standard (Numbers)
24	Number of prescribed drugs provided to children	4,444,636	1,154,876	4,444,636	Per Appropriations Estimate
25	Number of hospital inpatient services provided to elders	100,808	11,011	100,808	Per Appropriations Estimate
26	Number of physician services provided to elders	1,436,160	823,910	1,436,160	Per Appropriations Estimate
27	Number of prescribed drugs provided to elders	15,214,293	153,088	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 2017-2018 (Words)	Approved Prior Year Standards FY 2016-2017 (Numbers)	Prior Year Actual FY 2016-2017 (Numbers)	Approved Standards for FY 2017-2018 (Numbers)	Requested FY 2018-2019 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	46,074	550,436	Per Appropriations Estimate
31	Number of case months services purchased (Nursing Home)	619,387	46,712	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]
33A	New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions	N/A	3.71%	25.00%	20.00%

Approved Performance Measures for FY 2017-2018 (Words)		Approved Prior Year Standards FY 2016-2017 (Numbers)	Prior Year Actual FY 2016-2017 (Numbers)	Approved Standards for FY 2017-2018 (Numbers)	Requested FY 2018-2019 Standard (Numbers)
	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	N/A	6.46%	20.00%	20.00%
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**		
36	Percent of nursing home facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0.00%	3.07%	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%	33.78%	4.00%	DELETE[4]
38A	New Measure - Percent of Priority I consumer complaints about licensed facilities and programs that are investigated within two business days	100.00%	100.00%	100.00%	100.0%

Approved Performance Measures for FY 2017-2018 (Words)		Approved Prior Year Standards FY 2016-2017 (Numbers)	Prior Year Actual FY 2016-2017 (Numbers)	Approved Standards for FY 2017-2018 (Numbers)	Requested FY 2018-2019 Standard (Numbers)
39	Percent of accredited hospitals and ambulatory surgical centers cited for not complying with life safety, licensure, or emergency access standards	25.00%	52.63%	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%	0.68%	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%	0.82%	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%	1.82%	0.00%	DELETE[4]
45	Percent of hospitals with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0.00%	2.26%	0.00%	DELETE[4]
46	Percent of hospitals that fail to report serious incidents (agency identified)	6.00%	3.22%	6.00%	DELETE[4]

Approved Performance Measures for FY 2017-2018 (Words)		Approved Prior Year Standards FY 2016-2017 (Numbers)	Prior Year Actual FY 2016-2017 (Numbers)	Approved Standards for FY 2017-2018 (Numbers)	Requested FY 2018-2019 Standard (Numbers)
47	Percent of new Medicaid recipients voluntarily selecting managed care plan	50.00%	Medicaid to provide	50.00%	TRANSFER[4,5] (This is a Medicaid program – should be in Executive Direction and Support Services
48	Percent of complaints of HMO patient dumping received that are investigated2	100.00%	100.00%	100.00%	DELETE[4]
48A	New Measure - Percent of complaints of HMO access to care received that are investigated	100.00%	100.00%	100.00%	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	6,384	7,550	DELETE[4]
52	Average processing time (in days) for Subscriber Assistance Program cases.	53	14	53	20

Approved Performance Measures for FY 2017-2018 (Words)		Approved Prior Year Standards FY 2016-2017 (Numbers)	Prior Year Actual FY 2016-2017 (Numbers)	Approved Standards for FY 2017-2018 (Numbers)	Requested FY 2018-2019 Standard (Numbers)
52A	New Measure - Average processing time (in days) for Subscriber Assistance Program and Beneficiary Assistance Program cases	53	14	53	DELETE[4]
53	Number of construction reviews performed (plans and construction)	4,500	4,792	4,500	4,500
54	Number of new enrollees provided with choice counseling	520,000	Medicaid to provide	520,000	Per Estimates[1] TRANSFER[4,5] (This is a Medicaid program - should be moved to Executive Direction and Support Services
55	New Measure - Percent of renewal applications received electronically via the Online Licensing Application	30.00%	54.80%	N/A	60.00%
56	New Measure - Average processing time (in days) for financial reviews	3	1.26	N/A	3
57	New Measure - Number of FloridaHealthFinder.gov website hits	NA	3,376,751	N/A	4,000,000

Approved Performance Measures for FY 2017-2018 (Words)	Approved Prior Year Standards FY 2016-2017 (Numbers)	Prior Year Actual FY 2016-2017 (Numbers)	Approved Standards for FY 2017-2018 (Numbers)	Requested FY 2018-2019 Standard (Numbers)
[1] These estimates are established by Estimating Conference and represent anticipated counts and are not performance measures. [2] There have been no complaints of HMO patient dumping received by this agency for several years. If any such complaints were to be received, they would be investigated. [3] The Department of Health now takes its own practitioner calls. These are no longer done by the Agency. [4] The Agency proposes to modify this measure through a budget amendment in accordance with section 216.1827, F.S. [5] This measure is being transferred to correct BE.				

LRPP Exhibit III Performance Measure Assessment

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 Legislative Affairs – July 2017

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 who 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 Legislative Affairs – July 2017

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%	74.9%	(15.1%)	-16.78%

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.

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

Explanation: Families of children in KidCare that receive Title XXI premium assistance must participate in a coverage renewal process every 12 months, which includes confirmation of the child's continued eligibility for the program. As each family's renewal anniversary approaches, the KidCare program sends parents detailed information about the renewal process and required documentation. If families do not respond or they are unable to confirm their child's continued eligibility, the child is unenrolled from KidCare health insurance coverage. Successful completion of the coverage renewal process is an important step in retaining KidCare coverage.

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

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

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

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

Explanation: 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, SHOTS records are not robust enough to capture all of a 2-year old's immunizations and 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
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix the Problem
☐ Current Laws Are Working Against the Agency Mission
☒ Technological Problems
☐ Natural Disaster
☐ Other (Identify)

Explanation: Inconsistent data is collected.

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

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

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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 #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.

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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 #7: Percent of Families Satisfied with Care Provided 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
95.00%	93.8%	1.2%	1.26%

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 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
☐ 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 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
☐ Personnel
☐ Technology
☒ 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	195,641	(32,518)	14.25%

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: 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	160,564	(35,303)	18.02%

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	24,045	21,945	1045.00%

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

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☒ Target Population Change
☐ This Program/Service Cannot Fix the Problem
☐ Current Laws Are Working Against the Agency Mission
☐ Technological Problems
☐ Natural Disaster
☒ Other (Identify)
Explanation: 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
☒ Performance Assessment of Output Measure
☒ Adjustment of GAA Performance Standards
☒ Revision of Measure
☐ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
111,292	11,032	(100,260)	90.09%

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

External Factors (check all that apply):
☐ Resources Unavailable
☐ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix the Problem
☐ Current Laws Are Working Against the Agency Mission
☐ Technological Problems
☐ Natural Disaster
☒ Other (Identify)
Explanation: 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. CMSN is a health plan in the Medicaid Managed Medical Assistance program and enrollees are counted there where appropriate. The measure should be changed to clarify that this applies only to Title XXI enrollees receiving care on a fee-for-service basis.

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

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

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

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect ☒ Other (Identify)
Explanation: 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 ☒ Technological Problems
☐ Legal/Legislative Change ☐ Natural Disaster
☐ Target Population Change ☐ Other (Identify)
☐ This Program/Service Cannot Fix the Problem
☐ Current Laws Are Working Against the Agency Mission
Explanation: Existing measure does not sufficiently reflect the Medicaid populations.

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

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

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #16: Percent of Women Receiving Adequate Prenatal Care

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
86.00%	84.0%	2.0%	2.33%

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 have at least 24-28 months between pregnancies (a minimum of 24 months being one of the program goals of the Family Planning Waiver).

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

☐ Training
☐ Technology
☐ Personnel
☒ Other (Identify)

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

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #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	153,088	(15,061,205)	98.99%

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

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

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

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

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

Explanation: Current measure is not reflective of the population.

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

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

Recommendations: 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.

Office of Legislative Affairs – July 2017

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.

Office of Legislative Affairs – July 2017

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Prepaid Health Plan/68501600
Measure #34: Number of Case Months Services Purchased (Elderly and Disabled)

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
1,877,040	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: 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
☐ Personnel
☐ Technology
☒ 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.

Office of Legislative Affairs – July 2017

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Prepaid Health Plan/68501600
Measure #35: Number of Case Months Services Purchased (Families)

Action:

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
9,850,224	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: 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
- ☐ Personnel
- ☐ Technology
- ☒ 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.

Office of Legislative Affairs – July 2017

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0%	3.07%	3.07% (Over)	3.0%

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

Explanation: This measure is not a standard over which the Agency has control. The Agency requires corrective action for deficiencies when such problems are identified.

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

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

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

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

Office of Legislative Affairs – July 2017

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%	33.78%	29.78% (Over)	29.78%

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: Outreach and education efforts contribute to the identification of unlicensed activity. The Agency is committed to protecting its customers through the investigation of all reports of unlicensed activity. However, it is not a measure the Agency can 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 of Agency performance.

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

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

Office of Legislative Affairs – July 2017

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%	52.63%	27.63% (Over)	27.63%

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: The Agency requires correction of deficiencies when such problems are identified. This measure is not a standard over which the Agency has control.

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

Explanation: This is not a measure of Agency performance.

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

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

Office of Legislative Affairs – July 2017

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%	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 Services (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. This measure reflects the performance of accrediting agencies, not the Agency.

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 of Agency performance.

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

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

Office of Legislative Affairs – July 2017

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%	0.68%	0.68% (Over)	0.68%

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 is not a standard over which the Agency has control. The Agency requires corrective action for deficiencies when such problems are identified.

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

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

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

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

Office of Legislative Affairs – July 2017

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%

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 is not a standard over which the Agency has control. The Agency requires corrective action for deficiencies when such problems are identified.

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

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

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

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

Office of Legislative Affairs – July 2017

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%	0.82%	0.82% (Over)	0.82%

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 is not a standard over which the Agency has control. The Agency requires corrective action for deficiencies when such problems are identified.

External Factors (check all that apply):

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

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

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

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

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

Office of Legislative Affairs – July 2017

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%	1.82%	1.82% (Over)	1.82%

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 is not a standard over which the Agency has control. The Agency requires corrective action for deficiencies when such problems are identified

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

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

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

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

Office of Legislative Affairs – July 2017

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

Action:

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0.00%	2.26%	2.26% (Over)	2.26%

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 is not a standard over which the Agency has control. The Agency requires corrective action for deficiencies when such problems are identified

External Factors (check all that apply):

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

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

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

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

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

Office of Legislative Affairs – July 2017

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%	3.22%	2.78% (Under)	-2.78%

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: This measure is dependent upon the ability of hospitals to identify a "serious incident" and report that incident as required by Florida law. This measure is not a standard over which the Agency has control. The Agency requires corrective action for deficiencies when such problems are identified.

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: 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
☐ 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% (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 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
☐ 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 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
☐ Personnel
☐ Technology
☒ Other (Identify)

Recommendations: The Agency is requesting that this measure be deleted due to becoming obsolete. Law changes have limited the ability for HMOs to deny coverage based on pre-existing conditions, reducing HMO patient dumping complaints.

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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%	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: The Agency has not received any complaints of HMO access to care. 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%	100%	None	0%

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

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

Explanation: 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 requesting that this measure be deleted.

Office of Legislative Affairs – July 2017

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	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 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. An agreement was made with DOH that the AHCA Call Center would discontinue these services for DOH and that callers would be referred to the DOH hotline.

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

Recommendations: The Agency is requesting the deletion of this measure.

Office of Legislative Affairs – July 2017

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	6,384	1,166 (Under)	-15.44%

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 and biennial renewal.

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

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

Office of Legislative Affairs – July 2017

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	14	39 (Under)	73.58%

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: 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 20 days.

Office of Legislative Affairs – July 2017

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	14	39 (Under)	73.58%

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 met its goals for this measure. Goal #52 reflects SAP cases. The Division of Health Quality Assurance no longer handles BAP cases.

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 Legislative Affairs – July 2017

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	4,792	292 (Over)	6.49%

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 reviews architectural plans for new construction and renovation in health care facilities.

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 plan reviews is dependent upon the number of reviews requested by facilities.

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

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

Office of Legislative Affairs – July 2017

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	3,376,751	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 reflects growth in website use year over year. 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.

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 second year that the Agency is reporting this measure and does not yet have an approved measure. However utilization continues to grow.

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

Recommendations: The Agency recommends formalizing this measure with an approved standard of 4,000,000 for Fiscal Year 2017-18.

Office of Legislative Affairs – July 2017

LRPP Exhibit IV: Performance Measure Validity and Reliability

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: N/A

Validity: N/A

Reliability: N/A

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 Legislative Affairs – July 2017

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 enrolled 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:
20.00 percent, based on baseline calculations utilizing the updated AHRQ methodology.

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

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

Reliability:
The reliability of the diagnoses data is high. Hospitals provide the information to the Agency and must certify that it is accurate. The ICD-9 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 Legislative Affairs – July 2017

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: N/A

Validity: N/A

Reliability: N/A

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 who have enrolled and are receiving benefits.

Office of Legislative Affairs – July 2017

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.

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 an historically high, but desirable outcome.

Office of Legislative Affairs – July 2017

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: N/A

Validity: N/A

Reliability: N/A

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.

Office of Legislative Affairs – July 2017

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:

Since the data are unobtainable, the measure should be deleted.

Office of Legislative Affairs – July 2017

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 FFS 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.

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

Office of Legislative Affairs – July 2017

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:
Data reflect enrollment data provided by Florida Healthy Kids (FHK). These data are a count of who is enrolled in the program and eligible to receive services. Counts shown in the LRPP represent program enrollment at the end of the current fiscal year (i.e., as of July 31).

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 Legislative Affairs – July 2017

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:
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. Counts shown in the LRPP represent program enrollment at the end of the current fiscal year (i.e., as of July 31).

Proposed Standard/Target: Based on SSEC appropriations estimates.

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

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

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

Office of Legislative Affairs – July 2017

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:
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. Counts shown in the LRPP represent program enrollment at the end of the current fiscal year (i.e., as of July 31).

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 Legislative Affairs – July 2017

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:
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. Counts shown in the LRPP represent program enrollment at the end of the current fiscal year (i.e., as of July 31).

Proposed Standard/Target: Based on SSEC appropriations estimates.

Validity:
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 Legislative Affairs – July 2017

LRPP Exhibit IV: Performance Measure Validity and Reliability

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

Action (check one):

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

Data Sources and Methodology:
The Agency's financial data is maintained in the Florida Accounting Information Resource (FLAIR) system. The programs administrative costs are first identified and then segregated from the program's total costs. The administrative costs are divided by the entire program's costs to arrive at the measurement. Actual budget are 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 Legislative Affairs – July 2017

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**.**

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 Legislative Affairs – July 2017

LRPP Ehibit 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:
This is a valid measure of the size and scope of the Medicaid FFS program and can be used to track changes in enrollment and services provided to the FFS population over time. This is not a valid measure of program performance as enrollment is determined by factors outside the Agency's control.

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 an annual SAS 70 audit.

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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

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LRPP Exhibit IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #15A: Percent of All Hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (Conditions Preventable by Good Ambulatory Care): Ages 1 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);

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:
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.

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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 #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);

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.

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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 #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. 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.

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.

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.

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

Action (check one):

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

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 FMMIS and health plan reporting. Some variation in number could occur as a result of the time that the extract from FMMIS 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 annual volume of hospital inpatient services for the elder population in the Medicaid program.

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 annual volume of hospital inpatient services for the elder population in the Medicaid program.

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: Measure should be deleted.

Validity: N/A

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 recipients receiving long-term care services are now enrolled in a health plan. This measure no longer applies and should be deleted.

Office of Legislative Affairs – July 2017

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.

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.

Office of Legislative Affairs – July 2017

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

Office of Policy and Budget – July 2017

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

Office of Policy and Budget – July 2017

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:
N/A

Validity:
N/A

Reliability:
N/A

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.

Office of Legislative Affairs – July 2017

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: N/A

Validity: N/A

Reliability: N/A

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.

Office of Legislative Affairs – July 2017

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);

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.

Office of Legislative Affairs – July 2017

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);

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.

Office of Legislative Affairs – July 2017

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 [Budget Entity No Longer Valid]
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

Office of Legislative Affairs – July 2017

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

Office of Legislative Affairs – July 2017

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 Agency performance. 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 Legislative Affairs – July 2017

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.

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 the Agency's regulatory system (VR). Data collected for this outcome enable the Agency to determine how well facilities are performing, but is not a realistic measure of Agency performance.

Reliability:
Centralized collection of data combined with management review of supporting data ensures accurate and consistent reporting, resulting in reliability for the measure. However, unlicensed facilities may emerge under different names and ownership and not be identifiable as repeated unlicensed activity. Unlicensed activity is a crime and should be reported to law enforcement authorities. The Agency conducts outreach activities to encourage the reporting of unlicensed activity which is most commonly found in the assisted living area. Recent updates to the unlicensed information website are available at: http://www.ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Assisted_Living/Unlicensed_Activity.shtml.

Office of Legislative Affairs – July 2017

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.
☒ 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.

Office of Legislative Affairs – July 2017

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

Data Sources and Methodology:
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. VR also identifies which complaints have been investigated and whether 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. 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 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 VR to be investigated. Complaints received by the call center are entered into VR by the call center staff at the time of the call.

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

Office of Legislative Affairs – July 2017

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 ASPEN and centrally collected.

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 Agency performance. The facilities have ultimate control over reducing citations 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 ensure accurate and consistent reporting.

Office of Legislative Affairs – July 2017

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 and ambulatory surgical centers 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 facilities that have received their accreditation survey during the fiscal year. This measure does not include federal accreditation validation surveys, although facilities randomly selected by the Centers for Medicare and Medicaid Services (CMS) for validation are also selected for state validation. Additional validation inspections will be selected by the Hospital and Outpatient Services 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 ASPEN. Notations are entered in VR's comment field noting "consistent with accreditation findings" or "not consistent with accreditation findings." Data collection for this measure is reflective of the performance of the accrediting organization, not the Agency.

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 Legislative Affairs – July 2017

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 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 Agency performance. 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 ensure accurate and consistent reporting.

Office of Legislative Affairs – July 2017

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 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 Agency performance. 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 ensure accurate and consistent reporting.

Office of Legislative Affairs – July 2017

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 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 Agency performance. 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 ensure accurate and consistent reporting.

Office of Legislative Affairs – July 2017

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 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 Legislative Affairs – July 2017

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 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 Agency performance. 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 ensure accurate and consistent reporting.

Office of Legislative Affairs – July 2017

LRPP Exhibit IV: Performance Measure Validity and Reliability

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

Action (check one):

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

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

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

Validity:
The Agency's ability to meet this standard is entirely dependent upon external factors that are out of Agency control. This measure is dependent upon the ability of hospitals to identify a "serious incident" and report that incident as required by Florida law.

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

Office of Legislative Affairs – July 2017

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:
Complaints regarding Medicaid or commercial HMO patient dumping would be directed to the Commercial Managed Care Unit (CMCU) within the Bureau of Health Facility Regulation if received. Medicaid HMO complaints would be directed to the Medicaid Complaint Hub. CMCU would receive and investigate the commercial HMO patient dumping complaints.

Validity: There have been no HMO patient dumping complaints received for several years. Law changes have limited the ability for HMOs to deny coverage based on pre-existing conditions, reducing HMO patient dumping complaints.

Reliability: Complaints regarding HMO patient dumping received would be investigated.

Office of Legislative Affairs – July 2017

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 Medicaid or commercial HMO access to care are directed to the Commercial Managed Care Unit (CMCU) within the Bureau of Health Facility Regulation. Medicaid HMO complaints are directed to the Medicaid Complaint Hub. CMCU receives and investigates commercial HMO access to care complaints.

Validity: This information is currently tracked on Excel spreadsheets. Details are entered by staff.

Reliability: Complaints regarding HMO access to care received would be investigated.

Office of Legislative Affairs – July 2017

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:
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. 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 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 VR to be investigated. Complaints received by the call center are entered into VR by the call center staff at the time of the call. They are entered into the 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:
Data maintained in ASPEN and VR are centrally collected. Centralized collection of data and management review of supporting data ensure accurate and consistent reporting.

Office of Legislative Affairs – July 2017

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:
Prior to July 1, 2009, the Agency was responsible for practitioner complaints. 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 database, 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. As of July 1, 2009, this program and responsibility was transferred to the Department of Health.

Validity:
We are unable to provide this data for the current reporting period because we discontinued handling practitioner-related calls effective July 1, 2009. If callers call the Agency Call Center requesting practitioner information, they are referred to the Department of Health for assistance.

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

Office of Legislative Affairs – July 2017

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, license renewal, 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.

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. Centralized aggregation of this data will ensure consistency among several facility types.

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

Office of Legislative Affairs – July 2017

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:
Staff enter the date the case was assigned and the date the case was closed. These number of days between the two dates are is calculated and an average of this data is taken. The revised measure is based on an average from the past three fiscal years.

Reliability:
The data is collected by a centralized unit, ensuring accurate and consistent reporting, resulting in reliability of the measure.

Office of Legislative Affairs – July 2017

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 Legislative Affairs – July 2017

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 Legislative Affairs – July 2017

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.

Data Sources and Methodology: The data source is VR. The methodology is the number of renewal applications submitted via Online Licensing divided by the total number of applications that were renewed during the specified time period equals the percent of renewal applications that were submitted online.

Proposed Standard/Target: 60%

Validity: 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. 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 the target.

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

Office of Legislative Affairs – July 2017

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.

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

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

Office of Legislative Affairs – July 2017

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.

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: 4.0 million visits

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. 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 obtained through the site (higher satisfaction leads to return visits and also increases 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 Legislative Affairs – July 2017

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

Approved Performance Measures for FY 2014-2015 (Words)		Associated Activities Title
Program: Administration and Support		**Code: 68200000**
1	Administrative costs as a percent of total agency costs	Executive Direction ACT0010; General Counsel/Legal ACT0020 External Affairs ACT0040; Inspector General ACT0060 Director of Administration ACT0080; Planning & Budgeting ACT0090 Grants Management ACT0190; Finance & Accounting ACT0100; Personnel Services/HR ACT0110; Mail Rm ACT0130; Contract Adm ACT0180; Procurement ACT0200; Gen Srvs Adm ACT2090
2	Administrative positions as a percent of total agency positions	Executive Direction ACT0010; General Counsel/Legal ACT0020 External Affairs ACT0040; Inspector General ACT0060 Director of Administration ACT0080; Planning & Budgeting ACT0090 Grants Management ACT0190; Finance & Accounting ACT0100; Personnel Services/HR ACT0110; Mail Rm ACT0130; Contract Adm ACT0180; Procurement ACT0200; Gen Srvs Adm ACT2090
Children's Special Health Care		**Code: 68500100**
3	Percent of hospitalizations for conditions preventable by good	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

Approved Performance Measures for FY 2014-2015 (Words)		Associated Activities Title
		Hospital Inpatient ACT 4710
16	Percent of women receiving adequate prenatal care	Prescribed Medicines ACT4220 Physician Services ACT4230 Early Periodic Screening Diagnosis & Treatment ACT4260 Patient Transportation ACT4270
17	Neonatal mortality rate per 1000	Hospital Inpatient ACT4210 Physician Services ACT4220 Early Periodic Screening Diagnosis & Treatment ACT4260
18	Average number of months between pregnancies for those receiving family planning services	Physician Services ACT4230 Case Management ACT4280
18A	New Measure - Percentage of women with an Interpregnancy Interval (IPI) greater than or equal to 28 months	Physician Services ACT4230 Case Management ACT4280

	Approved Performance Measures for FY 2014-2015 (Words)	Associated Activities Title
19	Percent of eligible children who received all required components of EPSDT screening	Prescribed Medicines ACT4220 Physician Services ACT4230 Early Periodic Screening Diagnosis & Treatment ACT4260 Therapeutic Services for Children ACT4310
20	Number of children ages 1-20 enrolled in Medicaid	Purchase MediKids Program Services ACT5110 Purchase Children's Medical Services Network Services ACT5120 Purchase Children's Medical Services Network Services ACT5130
21	Number of children receiving EPSDT services	Physician Services ACT4230 Early Periodic Screening Diagnosis & Treatment ACT4260 School Based Services ACT4310 Clinic Services ACT4330
22	Number of hospital inpatient services provided to children	Hospital Inpatient ACT4210 Therapeutic Services for Children ACT4310

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

Approved Performance Measures for FY 2014-2015 (Words)		Associated Activities Title
		Prescribed Medicines- Elderly and Disabled/Fee for Service ACT4020
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) -

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

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

	Approved Performance Measures for FY 2014-2015 (Words)	Associated Activities Title
47	Percent of new Medicaid recipients voluntarily selecting managed care plan	Health Facilities and Practitioner Regulation - Medicaid Choice Counseling ACT7150
48	Percent of complaints of HMO patient dumping received that are investigated	Managed Health Care ACT7090
48A	New Measure - Percent of complaints of HMO access to care received that are investigated	Managed Health Care ACT7090
49	Percent of complaints of facility patient dumping received that are investigated	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020

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

	Approved Performance Measures for FY 2014-2015 (Words)	Associated Activities Title
53	Number of construction reviews performed (plans and construction)	Plans & Construction ACT7080
54	Number of new enrollees provided with choice counseling	Health Facilities and Practitioner Regulation - Medicaid Choice Counseling ACT7150
55	Percent of Renewal Applications Received Electronically via the Online Licensing Application	Health Facility Regulation (Compliance, licensure, complaints) - Tallahassee ACT7020
56	Average processing time (in days) for review of Applicant Financial Information	CON / Financial Analysis ACT7010

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

Exhibit VI: Unit Cost Summary

AGENCY FOR HEALTH CARE ADMINISTRATION	FISCAL YEAR			
SECTION I: BUDGET	OPERATING			FIXED CAPITAL
TOTAL ALL FUNDS GENERAL APPROPRIATIONS ACT			26,599,695,816	0
ADJUSTMENTS TO GENERAL APPROPRIATIONS ACT (Supplementals, Vetoes, Budget Amendments, etc.)			-33,612,593	0
FINAL BUDGET FOR AGENCY			26,566,083,223	0
SECTION II: ACTIVITIES *	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 *	559,622	13,791.30	7,717,917,475	
Prepaid Health Plans - Families *	2,225,878	2,521.33	5,612,178,018	
Elderly And Disabled/Fee For Service/Medipass - Hospital Inpatient * **Number of case months Medicaid program services purchased**	14,178	36,368.82	515,637,200	
Elderly And Disabled/Fee For Service/Medipass - Prescribed Medicines * **Number of case months Medicaid program services purchased**	40,333	8,661.69	349,351,906	
Elderly And Disabled/Fee For Service/Medipass - Physician Services * **Number of case months Medicaid program services purchased**	72,794	3,238.36	235,733,381	
Elderly And Disabled/Fee For Service/Medipass - Hospital Outpatient * **Number of case months Medicaid program services purchased**	72,794	1,250.68	91,042,316	
Elderly And Disabled/Fee For Service/Medipass - Supplemental Medical Insurance * **Number of case months Medicaid program services**	1,575,074	877.89	1,382,749,503	
Elderly And Disabled/Fee For Service/Medipass - Case Management * **Number of case months Medicaid program services purchased**	752,633	9.22	6,937,396	
Elderly And Disabled/Fee For Service/Medipass - Hospital Insurance Benefit * **Number of case months Medicaid program services purchased**	58,616	1,001.67	58,713,714	
Elderly And Disabled/Fee For Service/Medipass - Other * **Number of case months Medicaid program services purchased**	42,534	28,065.16	1,193,723,603	
Women And Children/Fee For Service/Medipass - Hospital Inpatient * **Number of case months Medicaid program services purchased**	157,397	2,421.34	381,111,354	
Women And Children/Fee For Service/Medipass - Prescribed Medicines * **Number of case months Medicaid program services purchased**	195,065	543.73	106,061,804	
Women And Children/Fee For Service / Medipass - Hospital Outpatient * **Number of case months Medicaid program services purchased**	395,543	311.54	123,226,237	
Women And Children/Fee For Service / Medipass - Supplemental Medical Insurance * **Number of case months Medicaid program services**	6,778,321	37.28	252,679,347	
Women And Children/Fee For Service / Medipass - Case Management * **Number of case months Medicaid program services purchased**	3,271,905	0.26	844,346	
Women And Children/Fee For Service / Medipass - Therapeutic Services For Children * **Number of case months Medicaid program services**	265,925	4.51	1,200,000	
Women And Children/Fee For Service / Medipass - Clinic Services * **Number of case months and Medicaid program services purchased**	6,221,240	0.13	782,753	
Women And Children/Fee For Service / Medipass - Other * **Number of case months Medicaid program services purchased**	472,191	292.45	138,091,076	
Medically Needy - Hospital Inpatient * **Number of case months Medicaid program services purchased**	24,639	3,066.61	75,558,210	
Medically Needy - Prescribed Medicines * **Number of case months Medicaid program services purchased**	24,639	1,883.40	46,405,029	
Medically Needy - Hospital Outpatient * **Number of case months Medicaid program services purchased**	29,685	587.44	17,438,108	
Medically Needy - Supplemental Medical Insurance * **Number of case months Medicaid program services purchased**	59,370	143.99	8,548,683	
Medically Needy - Case Management * **Number of case months Medicaid program services purchased**	29,685	4.18	124,122	
Medically Needy - Other * **Number of case months Medicaid program services purchased**	73,916	10,525.71	778,018,326	
Refugees - Hospital Inpatient * **Number of case months Medicaid program services purchased**	3,750	344.74	1,292,791	
Refugees - Prescribed Medicines * **Number of case months Medicaid program services purchased**	3,750	146,719.36	550,197,606	
Refugees - Hospital Outpatient * **Number of case months Medicaid program services purchased**	3,750	255.03	956,371	
Refugees - Other * **Number of case months Medicaid program services purchased**	11,249	0.02	280	
Nursing Home Care * **Number of case months Medicaid program services purchased**	46,712	72,790.39	3,400,184,619	
Home And Community Based Services * **Number of case months Medicaid program services purchased**	46,074	29,184.73	1,344,657,315	
Intermediate Care Facilities For The Developmentally Disabled - Sunland Centers * **Number of case months Medicaid program services**	2,650	128,888.76	341,555,220	
Purchase Medikids Program Services * **Number of case months Medicaid Program services purchased**	29,487	1,809.66	53,361,424	
Purchase Children's Medical Services Network Services * **Number of case months**	9,150	11,378.52	104,113,418	
Purchase Florida Healthy Kids Corporation Services * **Number of case months**	152,197	1,824.95	277,752,163	
Certificate Of Need/Financial Analysis * **Number of certificate of need (CON) requests/financial reviews conducted**	3,187	653.59	2,082,976	
Health Facility Regulation (compliance, Licensure, Complaints) - Tallahassee * **Number of licensure/certification applications**	40,330	435.29	17,555,371	
Facility Field Operations (compliance, Complaints) - Field Offices Survey Staff * **Number of surveys and complaint investigations**	40,156	1,417.95	56,939,332	
Health Standards And Quality * **Number of transactions**	2,952,960	1.69	4,999,178	
Plans And Construction * **Number of reviews performed**	4,792	1,531.73	7,340,051	
Managed Health Care * **Number of Health Maintenance Organization (HMO) and workers' compensation arrangement surveys**	131	13,229.58	1,733,075	
Background Screening * **Number of requests for screenings**	330,466	2.81	927,748	
Subscriber Assistance Panel * **Number of cases**	246	2,348.34	577,691	
TOTAL			25,260,300,536	
SECTION III: RECONCILIATION				
PASS THROUGHS				
TRANSFER - STATE AGENCIES				
AID TO LOCAL GOVERNMENTS				
PAYMENT OF PENSIONS, BENEFITS AND CLAIMS				
OTHER			1,173,189,791	
REVERSIONS			132,592,921	
TOTAL BUDGET FOR AGENCY (Total Activities + Pass Throughs + Reversions) - Should equal Section I above. (4)			26,566,083,248	

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.

- **CFR** –The Code for Federal Regulations is an arrangement of the general and permanent rules published in the *Federal Register* by the executive departments and agencies of the Federal Government. The CFR presents the official and complete text of agency regulations. It is a single publication divided into 50 titles covering broad subject areas of Federal regulations.

- **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.

- **MC** - Managed Care, *see* SMMC.

- **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-preventable 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.

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