RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

LONG RANGE PROGRAM PLAN

September 28, 2018

Cynthia Kelly, Director
Office of Policy and Budget
Executive Office of the Governor
1701 Capitol
Tallahassee, Florida 32399-0001

JoAnne Leznoff, Staff Director
House Appropriations Committee
221 Capitol
Tallahassee, Florida 32399-1300

Cindy Kynoch, Staff Director
Senate Appropriations Committee
201 Capitol
Tallahassee, FL 32399-1300

Dear Directors:

Pursuant to chapter 216, F.S., our Long Range Program Plan (LRPP) for the Agency for Health Care Administration is submitted in the format prescribed in the budget instructions. The information provided electronically and contained herein is a true and accurate presentation of our mission, goals, objectives, and measures for the Fiscal Year 2019-20 through Fiscal Year 2023-24. 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,

Tony Guzzo
Deputy Chief of Staff

Florida Agency for Health Care Administration

Long Range Program Plan

Fiscal Years 2019-2020 through 2023-2024

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 (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 10 percent through Fiscal Year 2022 – 2023.

Goal 3: To ensure a stronger health care delivery system by getting the incentives in Medicaid right: allowing Florida Medicaid enrollees to choose a health plan based on quality and customer service to ensure Florida enrollees receive the care they need and deserve.

Health Care Services (Division of Medicaid)

Objective 3.A: Transition 3 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:

Baseline Year FY 2017-2018	FY 2019-2020	FY 2020-2021	FY 2021-2022	FY 2022-2023	FY 2023-2024
3,974	5,600	7,000	7,000	7,000	7,000
Percent of Renewal Applications Received via Internet	80.00%	100.00%	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:

Baseline Year FY 2017-2018	FY 2019-2020	FY 2020-2021	FY 2021-2022	FY 2022-2023	FY 2023-2024
3,159	2,753	2,685	2,527	2,211	2,211
Percent of Reduction in the Annual Number of Public Record Requests Processed by HQA	10.00%	15.00%	20.00%	30.00%	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:

Baseline Year FY 2013-2014	FY 2019-2020	FY 2020-2021	FY 2021-2022	FY 2022-2023	FY 2023-2024
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.

Medicaid Program Integrity (Division of Health Quality Assurance)

Service Outcome Measure 2.A: Amount of overpayments to Medicaid providers in millions identified due to MPI oversight.

Performance Projection Table 2.A:

Baseline Year FY 2013-2014	FY 2019-2020	FY 2020-2021	FY 2021-2022	FY 2022-2023	FY 2023-2024
$27,450,000*	$36,785,624	$38,624,905	$40,556,150	$42,583,958	$44,713,155
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:

Baseline Year FY 2013-2014	FY 2019-2020	FY 2020-2021	FY 2021-2022	FY 2022-2023	FY 2023-2024
$25,320,000*	$44,855,924	$49,341,516	$54,275,668	$59,703,235	$65,673,556
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 ensure a stronger health care delivery system by getting the incentives in Medicaid right: allowing Florida Medicaid enrollees to choose a health plan based on quality and customer service to ensure Florida consumers receive the care they need and deserve.

Health Care Services (**Division of Medicaid)**

Service Outcome Measure 3.A: Transition 3 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:

Service Outcome Measures	Baseline Year FY 2013-14	FY 2019-2020	FY 2020-2021	FY 2021-2022	FY 2022-2023	FY 2023-2024
Number of Long-Term Care Recipients*	83,446	102,168	103,109	104,222	105,264	106,316
Number in Nursing Homes	45,728	45,824	43,187	40,492	37,739	37,211
Percentage in Nursing Homes	54.80%	44.85%	41.85%	38.85%	35.85%	35.00%

*Source: January 2018 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:

Service Outcome Measure	Baseline Year FY 2011	FY 2019-2020	FY 2020-2021	FY 2021-2022	FY 2022-2023	FY 2023-2024
Percentage of HEDIS measures >= 75th National Percentile	32.00%	75.00%	75.00%	75.00%	75.00%	75.00%

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

Performance Projection Table 3.C:

Service Outcome Measures	Baseline Year FY 2014-15	FY 2019-2020	FY 2020-2021	FY 2021-2022	FY 2022-2023	FY 2023-2024
Total Medicaid Member Months	41,504,316	48,251,712	48,756,792	49,260,456	49,763,220	50,265,240
Target Recipient Member Months in SMMC	35,278,669	41,013,955	41,443,273	41,871,388	42,298,737	42,725,454
Projected Recipient Member Months in SMMC	31,199,904	38,007,600	38,274,660	38,540,280	38,805,048	39,069,144
Target Percentage of Medicaid Recipient Member Months in SMMC	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%

*Source: January 2018 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 5 percent as measured by 1115 Waiver Budget Neutrality.

Performance Projection Table 3.D:

Service Outcome Measures	Baseline Year FY 2014-2015	FY 2019-2020	FY 2020-2021	FY 2021-2022	FY 2022-2023	FY 2023-2024
Projected PMPM Costs for SMMC Enrollees	$318.69	$323.40	$335.52	$348.44	$362.03	$376.15
Estimated Growth Percentage from Previous Year	--	1.00%	4.00%	4.00%	4.00%	4.00%

*Source: January 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 ensure a stronger health care delivery system by getting the incentives right: allowing Florida Medicaid enrollees to choose a health plan based on quality and customer service to ensure Florida consumers receive the care they need and deserve.
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. Goal 3: To ensure a stronger health care delivery system by getting the incentives right: allowing Florida Medicaid enrollees to choose a health plan based on quality and customer service to ensure Florida consumers receive the care they need and deserve.

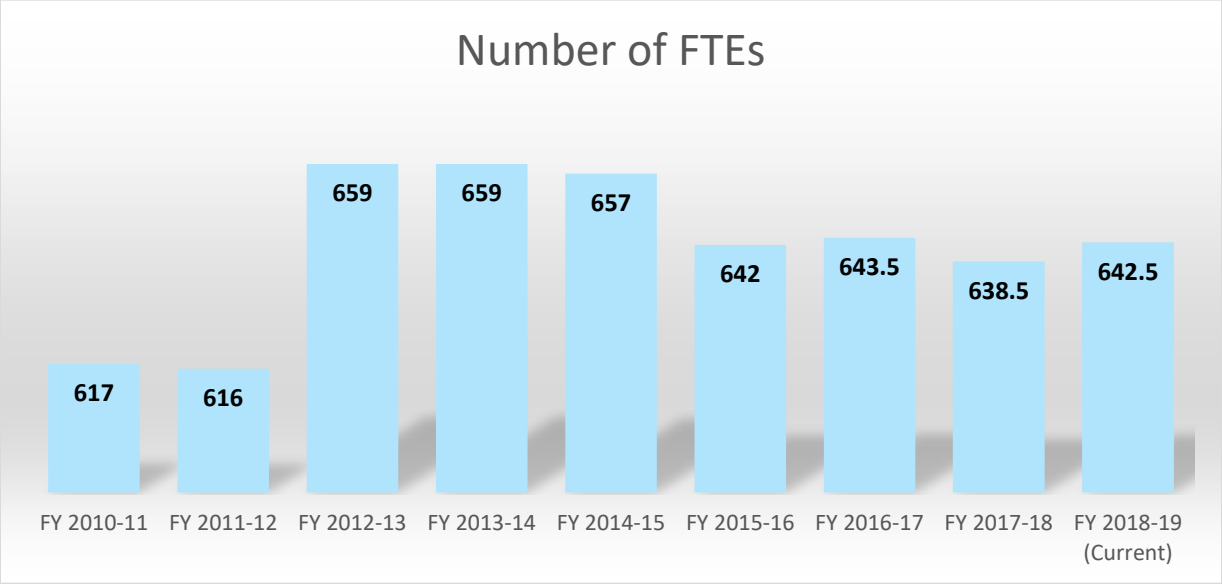
Trends and Conditions Statements

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 resources for consumers that allows families to have more information when making health care decisions. 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, increasing health care transparency, 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 organization provider network agreements, responding to consumer complaints against facilities, determining the need for select new health care facilities and services and promoting access to health information through FloridaHealthFinder.gov. During Fiscal Year 2017-18, the Division expanded when an Agency organizational change transferred the Bureau of Medicaid Program Integrity from the Office of the Inspector General to HQA. Medicaid Program Integrity, governed by Chapter 409, Part I, F. S., fulfills federal and state laws by operating as a fraud, abuse, and waste prevention and detection program that oversees Medicaid provider activities to ensure that fraudulent and abusive behavior occurs to the minimum extent possible.

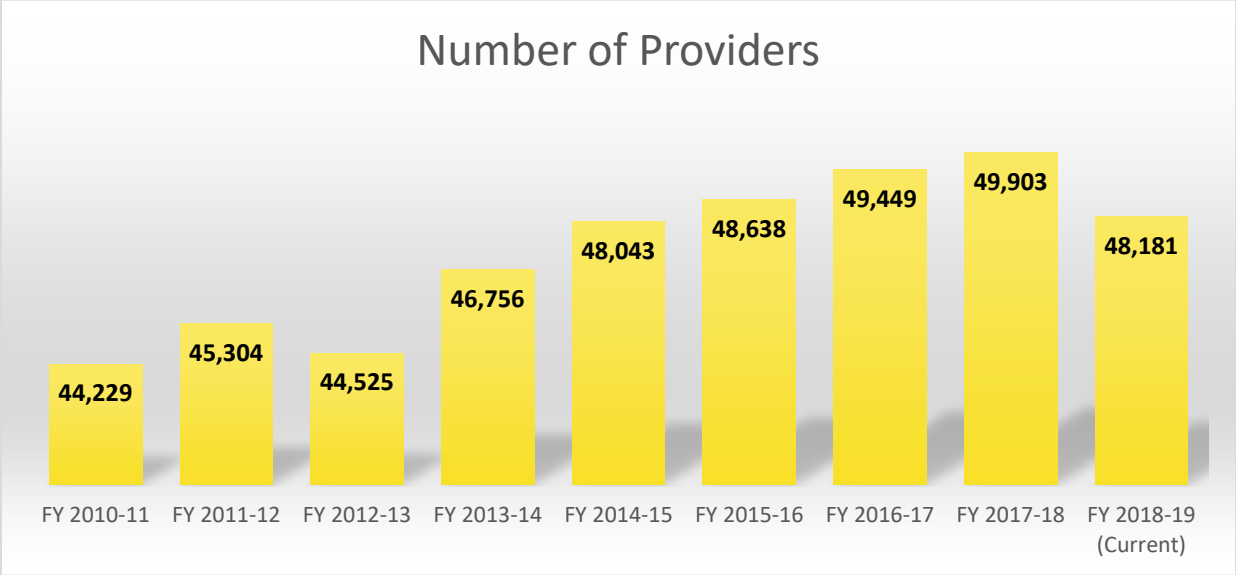
The following chart illustrates the changes in the number of HQA's FTE positions from Fiscal Year 2010-11 to present. The Florida Center became part of HQA in Fiscal Year 2012-13, explaining the increase in FTEs for that year. The division recently received 4 positions from the Division of Medicaid, which accounts for the increase in FTEs in Fiscal Year 2018-19.



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 multiphasic health testing centers. 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 or receiving services from 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.

The Agency's regulatory reform package, CS/CS/SB 622, Health Care Facility Regulation, passed during the 2018 Legislative Session, became law on July 1, 2018. The reform package aimed to clarify statutory requirements and allow the Agency and regulated providers to operate more efficiently. The new law removes regulations that are either out-of-date or duplicative, while also adding some regulations to keep pace with changing industry standards.

While there are many changes encompassed in the bill, the deregulation of two licensure programs is one of the major highlights of the bill. State licensure requirements were removed for clinical laboratories and health care risk managers. The Agency will continue to inspect and certify clinical laboratories under the Clinical Laboratory Improvement Amendment's standards, therefore the provider type will remain in the Agency's provider count as a "certified-only" provider. Health care risk managers will no longer be included in the Agency's provider count, but the requirement maintains that hospitals and ambulatory surgical centers have to hire qualified staff to oversee risk management programs. The chart below illustrates how the Agency's provider count is affected by the changes.



Despite the deregulation changes, from Fiscal Year 2010-11 to the start of Fiscal Year 2018-19, HQA's number of licensed, registered, certified, and regulated service providers and facilities increased from 44,229 to 48,181. Overall, this represents a 9 percent increase in regulated providers. Growth in licensed facilities requires additional work in licensure application processing, inspections, complaints, financial feasibility, background screening, plans and construction review and legal casework. Although workload has increased, the number of FTE positions that work on licensure and regulation has decreased as a result of program efficiencies.

The Agency has also experienced significant workload growth in background screening duties and this is continuing to grow as individuals working in health care facilities began to renew their background screenings for the first time in January 2018 (based on a 5 year anniversary period); this new workload should increase screenings processed by 7,000 – 30,000 monthly (84,000-360,000 annually). Background screening requires manual review of records with findings, processing exemption hearing requests, and increased calls from individuals screened. The Agency works diligently to process requests timely since individuals cannot work with patients until screenings are processed and cleared. Turnaround times for screening results have risen from an average of 4.16 days in 2016-17 to 5.61 days in 2017-18. Over a 5-year period, the number of criminal background screenings increased 65.1 percent, the number of exemption applications increased 49.3 percent and the number of background screening phone calls increased 28.7 percent.

The Care Provider Background Screening Clearinghouse remains a vital service as health care and human service employers have now saved over $38 million for selected agencies and persons subject to background screenings through the elimination of duplicative screenings for employees working in long-term care and other health care related provider types. During Fiscal Year 2017-18 alone, 169,368 background screening results were shared among participating agencies and Medicaid health plans resulting in an overall cost savings of $12,702,600 to

Agency providers, Department of Health (DOH) licensees, Medicaid health plans, Medicaid providers, Department of Children and Families, Department of Elder Affairs (DOEA), Department of Education Vocational Rehabilitation, and Agency for Persons with Disabilities providers.

The Clearinghouse also includes a state Rap Back requirement, also known as "retained prints," which enables immediate notification to the Agency of a Florida arrest of an employee to determine if the arrest affects access to vulnerable clients. The Clearinghouse also notifies providers of an arrest and prompts the provider to check eligibility. During Fiscal Year 2017-18, the Background Screening Unit processed 24,987 Rap Backs. Of these, 30.8 percent were found to be for a criminal charge that resulted in an ineligible status.

The next step for the Clearinghouse is to implement the Federal Rap Back process. The implementation of the Federal Rap Back would allow for the Clearinghouse to be notified of all arrests from all states, not just Florida. This process 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 continues efforts to enhance the health care provider experience through a comprehensive, integrated, online licensure system to improve access and reduce administrative burden for licensure and Medicaid enrollment. The online licensing system is now completely operational allowing providers to file license renewals and updates (changes during the licensure period). From July 2015 through June 2018, the percentage of renewal applications submitted online rose from 37.4 percent to 56.8 percent as more providers opted to go paperless.

In Fiscal Year 2018-19, the Agency plans to implement "stand-alone payments," which will allow facility personnel to log onto the online licensing system and make payments for any monies owed to the Agency; currently payments can only be made at the time of licensure application. In the future, the Agency also 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.

VISA was recently added as a payment method option in the Clearinghouse and the online licensing system. With this enhancement, VISA, MasterCard, American Express, Discover, and e-check are available for all transactions through the Clearinghouse and the online licensing system.

The following charts illustrate the workload volume HQA handles on an annual basis. The licensure and regulation of a provider type involves the efforts of multiple bureaus within the Division. Some facility types and services must apply for and receive a Certificate of Need before seeking a license. The process of obtaining a license requires application review, and in many cases proof of financial ability to operate and construction plan review, and background screening and survey clearances. The Florida Center for Health Information and Transparency works diligently to continue to push health care information to the public while Medicaid

Program Integrity combats fraud and abuse in the Medicaid program to ensure program funds are spent appropriately.

State Licensure and Federal Certification	Fiscal Year 2017-18 Volume
Certificate of Need Applications, Exemptions, and Notifications	137
Certificate of Need Condition Compliance Reviews	732
Plans and Construction Reviews	4,630
Licensure and Renewal Applications Processed – Facilities and Providers	21,637
Financial Reviews	2,700
Criminal Background Screening Checks	392,244
Criminal Background Exemption Applications	2,437
Savings to Providers Resulting from the Avoidance of Paying for a Duplicative Background Screening	$12,702,600
Facility Inspections	20,999
Complaints Reviewed	13,056

Managed Care Regulation	Fiscal Year 2017-18 Volume
Managed Care Plan Health Care Provider Certificate Applications	44
Workers Compensation Plan Health Care Provider Certificate Applications	16
Managed Care Plan Risk Assessment Surveys	36
Subscriber Assistance Program Panel Cases	22
Balance Billing Complaints	197

Consumer and Public Information	Fiscal Year 2017-18 Volume
Florida Health Finder Views	2,707,537
Consumer Calls to Call Center	49,138
Public Record Requests	3,159
Background Screening Unit Calls	120,000
Adverse Incidents Received	5,582
Electronic Health Record Incentive Payments to Hospitals	4 Payments Totaling $2,421,887
Electronic Health Record Incentive Payments to Providers	1,851 Payments Totaling $20,364,588
Encounter Notification Service Patient Lives in System	7.3 Million Lives Subscribed
Encounter Notification Service Alerts	6,335,488

Medicaid Program Integrity	Fiscal Year 2017-18 Volume
Medicaid Program Integrity Complaints	1,878
Referrals to Medicaid Stakeholders, Program Integrity/Anti-Fraud Professionals, and Other Related Agencies on Common Issues	700
Prevention of Overpayments to Medicaid Providers by Conducting On-Site Visits	211

Pre-Payment Reviews	15,577 Claims Reviewed
Payment Restrictions Imposed	180
Prevention of Overpayments	$14.9 Million
Sanctions and Managed Care Organization Assessments	389
Recovery Totals	$55.8 Million
Overpayments Identified	$34 Million

More detail regarding Medicaid Program Integrity efforts will be published in the Annual Fraud and Abuse Report in December (find annual reports at: http://ahca.myflorida.com/MCHQ/MPI/).

Licensure Actions by Final/Emergency Order	Fiscal Year 2017-18 Volume
Immediate Moratorium on Admissions	8
Emergency Suspension Orders	8
License Surrenders	9
Denied Renewals	57
Revocations	24
Renewal Applications Withdrawn from Review	13
Denied Change of Ownership Applications	35
Fines and Fees Imposed	1,597 Totaling $2,247,434
Initial Applications Denied	98

Facility Closures	Fiscal Year 2017-18 Volume
Failed to Renew	793
Closed	757
License Surrenders	32

New Long-Term Care Survey Process

The Agency certifies and investigates long-term care providers for the Centers for Medicare and Medicaid Services (CMS). CMS issued new requirements for federal long-term care providers that became effective on November 28, 2017. The goals for the New Long-Term Care Survey Process include:

- Having the same survey for the entire country;
- Using strengths from traditional survey process;
- Promoting new innovative approaches;
- Focusing on effectiveness and efficiency;
- Pushing for a resident-centered approach; and
- Allowing a balance between structure and surveyor autonomy.

There are three parts to the New Long-Term Care Survey Process: initial pool process, sample selection, and investigation. The sample size for the initial pool process is based on census, with 70 percent of the pool selected offsite and 30 percent selected onsite by the surveyor team. The process involves screening all residents by identifying 8 facility residents per surveyor to include in the initial pool. Surveyors observe, interview, and complete a limited record review for initial pool residents and use a facility matrix to identify other specific concerns such as dialysis, smoking, infection, and more.

The sample selection process allows for in-depth investigation for areas of concern marked for further investigation and is only completed on active residents. The sample of residents must include at least one resident for certain conditions/treatments, including, hospice, dialysis, ventilator, and transmission-based precautions.

The third part of the process, investigations, allows surveyors to conduct investigations for sampled residents. Surveyors observe and interview staff to determine whether they consistently implement the residents' care plans over time and across various shifts. During observations of the interventions, surveyors note and follow up on deviations from the care plan as well as potential negative outcomes.

To give an idea of the most common problems surveyors see in nursing homes, the following chart illustrates the top 10 nursing home federal deficiencies from December 1, 2017 to April 30, 2018:

Rank	Federal Nursing Home Tag
1	Infection Prevention and Control
2	Develop, Implement Comprehensive Care Plan
3	Food Procure, Store/Prepare/Serve – Sanitary
4	Label/Store Drugs and Biologicals
5	Quality of Care
6	Resident Rights
7	Free of Accident Hazards/Supervision/Devices
8	Resident-Identifiable Information/Medical Records
9	Safe/Clean/Comfortable/Homelike Environment
10	Accuracy of Assessments

Federal Emergency Preparedness

On September 8, 2016, the Federal Register posted the final rule Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers. The regulation went into effect on November 16, 2016. Health care providers and suppliers affected by this rule must have complied and implemented all regulations one year after the effective date, on November 15, 2017.

The purpose is to establish national emergency preparedness requirements to ensure adequate planning for both natural and man-made disasters, and coordination with federal, state, tribal, regional and local emergency preparedness systems. The following information will apply upon publication of the final rule:

Requirements will apply to all 17 provider and supplier types.

Each provider and supplier will have its own set of emergency preparedness regulations incorporated into its set of conditions or requirements for certification.

Providers must be in compliance with emergency preparedness regulations to participate in the Medicare or Medicaid program.

There are four provisions for all provider types, including:

- Risk assessment and planning;
- Communication plan;
- Training and testing; and
- Policies and procedures.

Nursing Home Quality in Florida

Recent national data shows that Florida nursing homes are delivering higher and higher quality during the course of this decade. Since 2011, Florida nursing homes have shown strong results and/or improvement in a host of quality measures, including those related to infections, falls, pressure ulcers, wandering, physical restraints and the use of antipsychotic medicines. The data published by CMS shows Florida nursing homes are either outperforming national averages, showing significant improvement over the last 10 years, or both, on the vast majority of core quality measures.

Florida also outranked peer states in nursing home quality in a recent study published by U.S. News & World Report. The state ranked 13th while peer states ranked: California – 14, New York – 22, Ohio – 34, Pennsylvania – 39, Illinois – 42 and Texas – 50. The ranking is based on the percentage of a state's residents in nursing homes rated 4 or 5 star by the federal government. The complete study can be viewed here: https://www.usnews.com/news/best-states/rankings/health-care/healthcare-quality.

Hurricane Response

A state of emergency was declared in all 67 of Florida's counties on September 5, 2017 in anticipation for the arrival of a massive storm, Hurricane Irma. The Agency immediately began pre-storm contact and information gathering with its providers while health care facilities in the Florida Keys initiated evacuation plans. Provider outreach calls began as well as daily statewide calls with the Governor, the Agency Secretary, the DOH Surgeon General, hospital CEOs, nursing home and assisted living facility administrators and health care associations. The Agency converted its Consumer Hotline to 24 hours and launched a website that was continually updated as more information became available about Hurricane Irma.

The Agency provided technical support to Emergency Support Function 8 (Health and Medical), opened events in FLHealthSTAT, and monitored evacuations and information provided through the system. The substantial storm made landfall in Florida on the morning of September 10, 2017 as a Category 4 storm. Hurricane Irma caused extreme power outages, with 6.7 million homes and businesses without power at the height of the storm on September 11, 2017. Pre-landfall evacuations for health care facilities were ordered in some areas and many facilities evacuated post-impact due to damages or power failures. The hurricane caused secondary issues like flooding, sewage problems, and tornados in some areas. Agency staff worked around the clock in conjunction with health care associations to reach out to facilities in impacted areas. See the chart below for facility statistics on Hurricane Irma.

Hurricane Irma Statistics	
Calls Made to Facilities to Check on Status	8,591
Statewide Executive Stakeholder Conference Calls	20 Conference Calls with over 8,000 Attendees
Evacuations* – Nursing Homes	88 out of 685
Power Loss* – Nursing Homes	350 out of 685
Evacuations* – Assisted Living Facilities	635 out of 3,109
Power Loss* – Assisted Living Facilities	1,677 out of 3,109
Evacuations* – All Residential Facilities (Includes NHs and ALFs)	862
Power Loss* – All Residential Facilities (Includes NHs and ALFs)	2,282
Post-Storm Visits by Agency Surveyors**	1,778

*These numbers represent only those reported to the Agency and may underrepresent the actual number of impacted facilities.
**Visits took place over a 2.5-week period

Emergency Power Plan Rules

In response to the tragic deaths of residents at a Broward County nursing home following Hurricane Irma, the Agency and the DOEA implemented emergency rules to address an immediate danger to the public health, safety and welfare of residents. Nursing Home Emergency Power Plan Rule 59AER17-1, F.A.C., and Procedures Regarding Emergency Environmental Control for Assisted Living Facilities Rule 58AER17-1, F.A.C., became effective on September 16, 2017. The rules addressed the need for nursing homes and assisted living facilities to have a plan in place to keep internal temperatures at a comfortable level for residents in the event of power loss.

Emergency rules are only valid for a short-term period, so the Agency and the DOEA worked to propose permanent emergency power plan rules. Pursuant to s. 120.542, F.S., if a proposed rule will have an adverse impact on small businesses or if the proposed rule is likely to directly or indirectly increase regulatory costs in excess of $200,000 in the aggregate within one year after implementation of the rule, the Agency is required to prepare a statement of estimated regulatory costs (SERC). Section 120.541, F.S., also requires any rule that is determined to have an adverse economic impact exceeding $1 million over the first five years, to be ratified by the legislature to be effective. The SERC developed for Rule 59A-1.1265, F.A.C., Environmental Control for Nursing Homes showed that the rule would create an adverse economic impact of $121,380,545 over the first five years. The SERC developed for Rule 58A-5.036, F.A.C., Emergency Environmental Control for Assisted Living Facilities showed that the rule would create an adverse economic impact of $243,912,720 over the first five years. Because both of these rules were determined to have an adverse economic impact on their respective industries exceeding $1 million over the first five years, they were required to be ratified by the legislature. Rule 59A-4.1265, F.A.C., Emergency Environmental Control for Nursing Homes and Rule 58A-5.036, F.A.C., Emergency Environmental Control for Assisted Living Facilities were ratified by the Legislature during the 2018 Legislative Session and became effective upon the Governor's signature on March 26, 2018. The rules require facilities to implement an emergency power plan to support internal temperatures of 81 degrees or less for 96 hours in the event of a power loss.

Facilities needed to implement their emergency power plan by June 1, 2018. The rules allowed for extensions under certain circumstances until January 1, 2019. To receive an extension, the facilities had to demonstrate how they would keep temperatures cool in the event of a power loss during the extension. As of August 2018, 100 percent of licensed nursing homes and more than 92 percent of licensed assisted living facilities are in compliance with the rule. Over 95 percent of the licensed assisted living facility beds are in facilities that are in compliance with the rule, as of September 17, 2018. Learn more about the emergency power plan rules here: http://ahca.myflorida.com/MCHQ/Emergency_Activities/EPP.shtml.

Emergency Status System

During Fiscal Year 2017-18, the Agency began building an updated online tracking and availability tool called the Emergency Status System (ESS) to replace FLHealthSTAT for reporting information regarding licensed health care facility emergency status, beds, planning or operations as required by s. 408.821(4), F.S.

Licensees providing residential or inpatient services must utilize ESS to report information to the Agency regarding the provider's emergency status, planning, or operations. Facilities will have the ability to maintain their own user accounts, enter and save preseason planning information and report status information during events.

Facilities will report a variety of information and impact on their facility as a result of an event including but not limited to: emergency contacts, operational status, power and utility status, evacuation details, damage and needs, census and the ability to accept evacuees and patients.

Transparency

Eliminating the information gap between the patient and their health care provider informs and empowers Florida consumers about the variations in costs and quality of health care services. Transparency tools provide Floridians expanded information vital to making informed medical care decisions. The Agency has enhanced the health care transparency information available to be public by expanding the nationally recognized FloridaHealthFindger.gov consumer website and implementing the new complementary website, FloridaHealthPriceFinder.com in November 2017. The new website, which has been visited approximately 29,500 times by 25,367 unique visitors since its launch, provides the average amount paid by commercial health insurers for common procedures and conditions. This information allows consumers to compare costs and offers a better starting point from which to figure their own out of pocket costs.

The Florida Center for Health Information and Transparency is overseeing the implementation of the underlying multi-payer claims database, which houses the health care claims and payment information from health insurance plans, as well as the development and roll-out of the new website. The existing FloridaHealthFinder.gov was also enhanced and expanded to better serve consumer and stakeholders, including the integration of the new pricing information, the addition of emergency power plan information for Nursing Homes and Assisted Living Facilities, and indicators for provider types. Together, the sites serve to improve health care transparency by providing Floridians pricing information, quality ratings, and regulatory information about providers through a single integrated portal.

Additionally, a legislative budget request was approved in 2018 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 one example of the value that health care claims data can provide to the state. The Florida health care claims dataset includes millions of lines of information, compiled from thousands of consumers and providers. A claims analytic tool will allow authorized Agency users to easily convert the vast amounts of data into usable information for stakeholders, policy makers, and the public.

Telehealth

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, composed of 13 appointed members, the state Surgeon General, and the Secretary of AHCA who served as the chair, concluded their work in October of 2017, by completing their legislatively mandated report of their recommendations for the Governor, the President of the Senate, and the Speaker of the House of Representatives. The report and recommendations focused on increasing telehealth services and addressing existing barriers. Learn more about the Council, including its final report, at http://www.ahca.myflorida.com/SCHS/telehealth/index.shtml.

Pediatric Cardiology Technical Advisory Panel

Legislation passed in 2017, requiring the Agency to create a Pediatric Cardiology Technical Advisory Panel to develop procedures and standards for measuring outcomes of pediatric cardiac catheterization programs and pediatric open-heart surgery programs. The law specified that the Panel members would be cardiac specialists and surgeons from the state's ten currently licensed hospital-based pediatric cardiac surgery programs, along with three "at-large" cardiac specialists/surgeons who are not affiliated with any of the currently licensed programs.

The Agency is required to develop and adopt rules concerning pediatric cardiology based on the recommendations of the panel. The panel began meeting in November 2017 and meetings are currently ongoing. The subsection of statue requiring the panel is set to expire on July 1, 2022.

Medicaid Behavior Analysis

The Bureau of Medicaid Program Integrity has been investigating a significant number of Behavior Analysts and group Medicaid providers believed to be engaged in suspected fraud and abuse. Behavioral Analysis (BA) is a service provided to children enrolled in Medicaid with significant behavioral issues (e.g., children with autism who are injuring themselves or others). BA services are usually provided in the child's home. It is critical that the Agency ensure the health, safety, and welfare of the children receiving this service. Under the Florida Medicaid program children have access to all medically necessary services, including applied behavioral analysis services.

A preliminary investigation into the provider type identified extraordinary overbilling.

Examples of the fraudulent behavior discovered include:

- Widespread problems with providers attempting to bill impossible hours, such as more than 24 hours per day, more than 40 hours per week, and billing in excess of 31 days in a row. In one instance, a provider tried to bill for services needed for more than 250 consecutive days.
- Some Medicaid recipients were also enrolled as BA providers, which proved fraudulent upon further investigation.
- Some providers appeared to have falsified their qualifications, meaning that patients could have been receiving BA services from unqualified providers.

As of August 2018, 51 BA providers (both rendering and group/billing) or other individuals or entities have been referred to the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU) due to suspected criminal activity related to the Medicaid program, specific to BA. Medicaid Program Integrity has completed or is in the process of overpayment recovery audits for 189 BA (group/billing) providers. Of those cases, 69 cases have reached the point in an audit where a potential dollar value can be reported on, with $1,159,200.21 identified in overpayments (closed cases) and approximately $15.5 million in potential overpayments (cases still pending). Sanctions, not inclusive of any sanctions coupled with overpayment audits, have been imposed (final orders issued) or are in the process of being imposed for 21 BA providers.

As a result of the fraudulent and abusive behavior, the Agency imposed a temporary moratorium on enrollment of new BA providers in Miami-Dade and Broward counties with the approval of the CMS on May 14, 2018. The moratorium will initially be implemented for a six-month period.

Division of Information Technology

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. The Division of 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.

Collaboration with 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 Rules 74-1 and 74-2, F.A.C., to establish and refine project management and cybersecurity definitions and standards. In Fiscal Year 2017-18, AST promulgated Rule 74-5, F.A.C., 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 Chapter 282, 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;
- Working with the other divisions to improve the governance processes for better project and portfolio management to ensure strategic business alignment; and
- Consolidating and integrating all information technology systems while remaining compliant with IT Cyber security Statutes, Florida Administrative Code Rules and industry standards.

Health Care Services (Division of Medicaid)

Authority for the Florida Medicaid program is established in Chapter 409, F.S., (Social and Economic Assistance) and Rule 59G, F.A.C., (Medicaid). Other relevant statutes that mandate the management and administration of state and federal Medicaid programs and child health insurance programs as well as the development of plans and policies for Florida's health care industry include Chapters 20, 216, 393, 395, 400, 408, 409, 440, 626, and 641, F.S. Medicaid must meet federal standards, or obtain a federal waiver of such, to receive federal financial participation in the program. Although rates of federal participation vary each year and by activity, 61.79 percent of the expenditures for most Medicaid services were reimbursed with federal funds in Fiscal Year 2017-18. 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 is estimated to be more than 20.9 million as of July 1, 2017, making it the third most populous state in the nation. Florida's population growth rate has been among the fastest in the nation for decades.

According to U.S. Census estimates for 2017, Florida had the highest percentage of population age 65 and older accounting for more than 20 percent of the state's total population. The demand for health care and long-term care services will continue to grow as the baby boom generation, those born between 1946 and 1964, has begun reaching retirement age and substantial numbers of retirees relocate to Florida. 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.

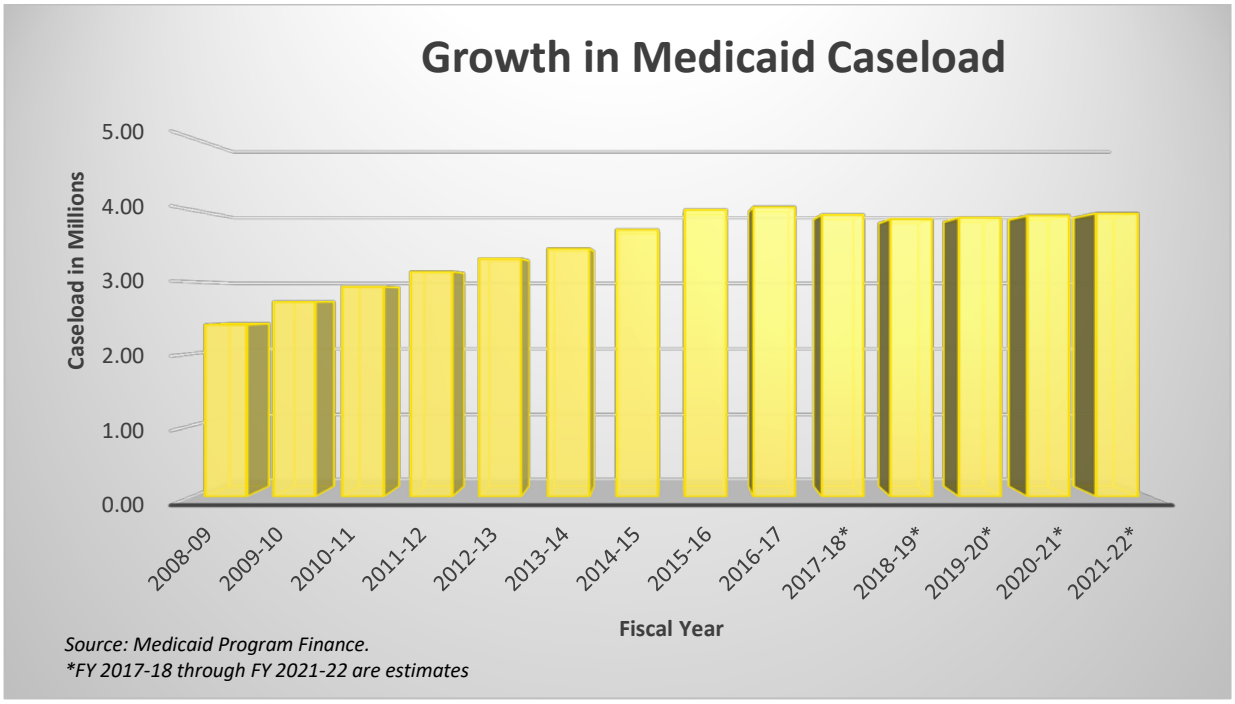
In order to help manage the growth in demand for Medicaid services and to provide greater predictability of cost increases, Florida implemented the Statewide Medicaid Managed Care program (SMMC). The SMMC program has two key program components: Long-Term Care (LTC) and Managed Medical Assistance (MMA).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

The Agency began re-procurement for a new 5-year SMMC contract period in June 2017. Rather than having two different health plan components, in the new contract period, the Agency integrated MMA and LTC plans and procured stand-alone Dental plans.

Medicaid Caseload

At the end of Fiscal Year 2017-18, Medicaid had almost 4 million recipients. These individuals receive health care services from 109,727 providers that offer services to recipients in both Fee-for-Service (FFS) and MMA health plans. Medicaid caseloads in Fiscal Year 2017-18 were more than 63 percent higher than in fiscal year 2008-09 (Figure 3-1). Total caseload decreased by about one percent in Fiscal Year 2017-18 over the prior Fiscal Year. Caseload is projected to decrease in Fiscal Year 2018-19, by approximately 3 percent or just over 116,000 recipients.

Figure 3-1



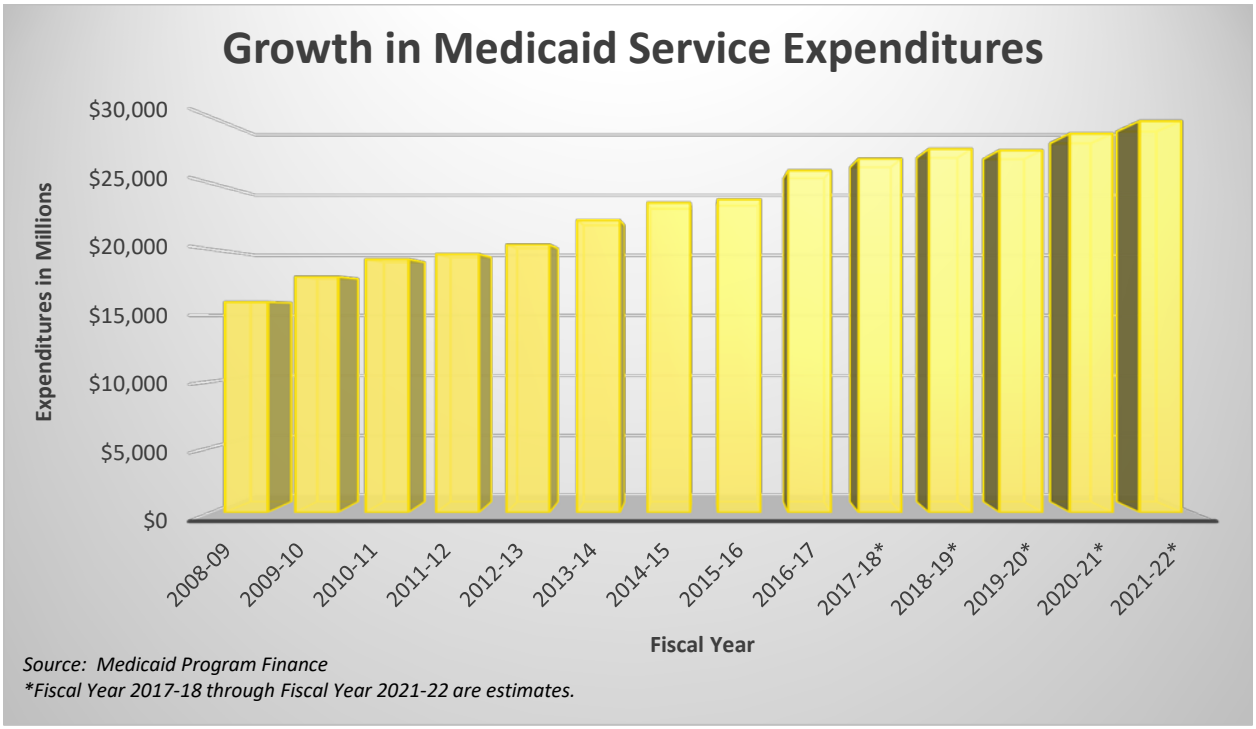
The caseload decreases in recent years reflect factors such as system enhancements, which automatically-close the assistance group if the recipient fails to recertify, the improving economy, and the use of additional tools for income verification.

Medicaid Expenditures

With expenditures of an estimated $27.6 billion in Fiscal Year 2018-19, 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. From Fiscal Year 2008-09 to Fiscal Year 2018-19, expenditures in the Medicaid program grew 72.4 percent, from about $16 billion to $27.6 billion, (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. Implementation of the Statewide Medicaid Managed Care program in 2014 helped constrain the growth in medical costs and kept per member, per month costs below what they would have been without the program. The largest expenditure categories for Fiscal Year 2018-19, were:

- Prepaid Health Plans ($13.2 billion);
- Prepaid Health Plan/Long-Term Care ($4.5 billion);
- Supplemental Medical Insurance ($1.8 billion);
- Low Income Pool ($1.5 billion);
- Home and Community-Based Services ($1.1 billion); and
- Hospital Inpatient Services ($958 million).

Figure 3-2



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. 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

Statewide Medicaid Managed Care

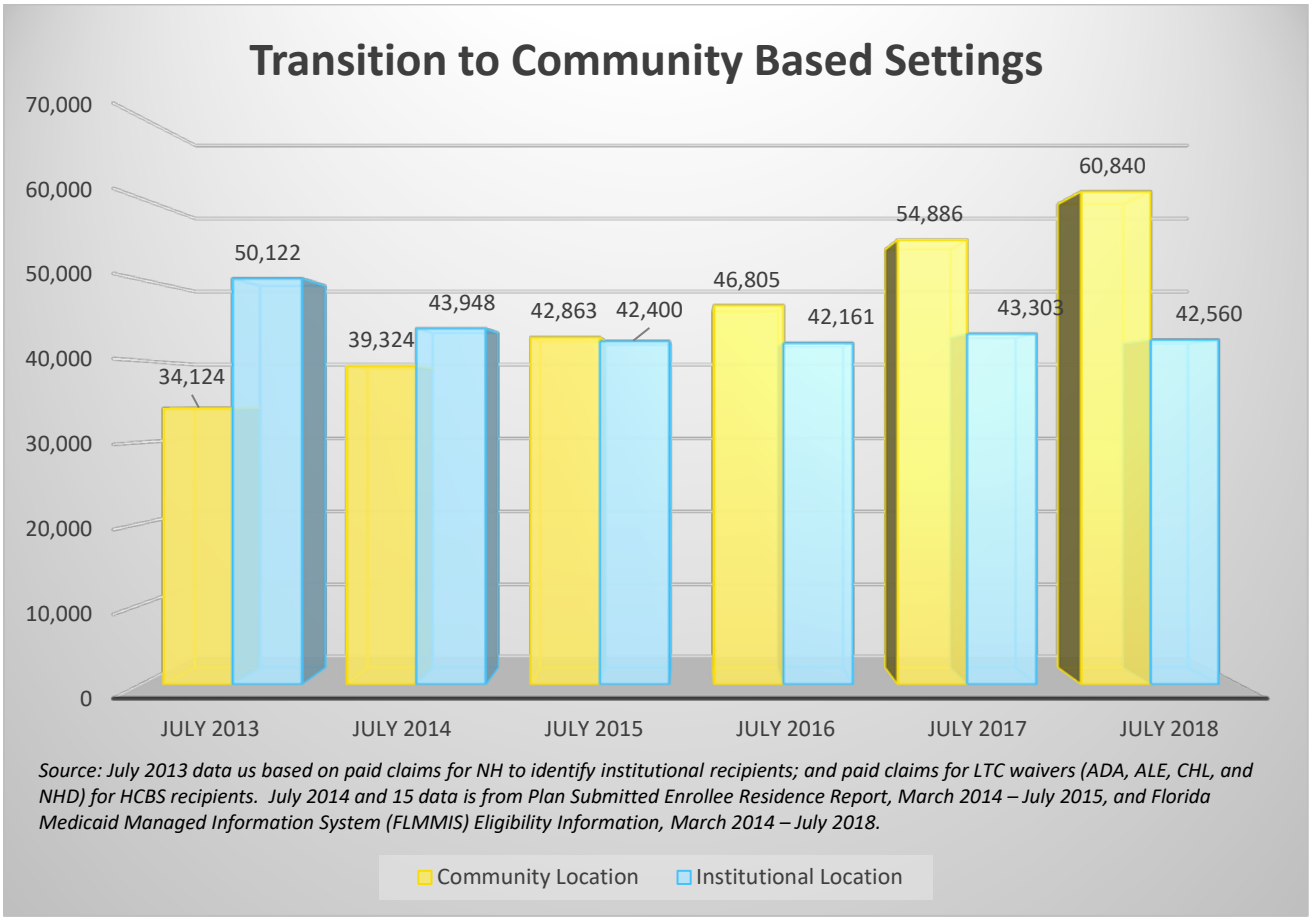
When the SMMC program launched in 2014, it had two primary components, Managed Medical Assistance and Long-Term Care. During Fiscal Year 2017-18, Medicaid began re-procurement of the health plans for the next five-year period as well as procuring dental plans as required by the Florida Legislature.

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.

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 there are more individuals being served in home and community-based settings than in nursing facilities. As of July 2018, 42,560 LTC enrollees received services in a nursing facility or institutional setting and 60,840 received services in a community setting. That means the percentage of long-term care enrollees receiving services was 58.8 percent, almost three percent higher than the previous year. In the new SMMC contracts, plans committed to continuing transitions until they reached a percentage of no more than 25 percent of enrollees receiving LTC services in a nursing facility.

Figure 3-3



SMMC Managed Medical Assistance

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

The objectives for SMMC MMA include:

- Improving outcomes through care coordination, patient engagement in their own health care, and maintaining fiscal responsibility;
- Improving program performance by increasing patient satisfaction;
- Improving access to coordinated care by enrolling all non-exempt, eligible Medicaid participants in managed care; and

- Enhancing fiscal predictability and financial management by converting the purchase of Medicaid services to capitated, risk-adjusted payment systems, with strict financial oversight requirements for health plans to improve fiscal integrity.

Implementation of SMMC MMA began in May 2014, and was complete in all regions of the state by August 1, 2014. As of June 30, 2018, there were 3,075,778 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 beginning in 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. The agency negotiated with both MMA and Dental plans to ensure continuous coordination of care so that the significant increases in quality of care would continue. Particularly important was ensuring that the large improvement in dental services under the Medicaid program would continue its upward trajectory

In addition to the comprehensive array of Medicaid services that MMA plans offer, as well as Dental plans beginning in 2019, 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 additional 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. In the new contract period, Dental plans agreed to provide a rich adult dental benefit under expanded benefits.

SMMC 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.

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 2017-18:

Marketing	7
Enrollee Services and Grievances	24
Medicaid Fair Hearing	3
Covered Services	35
Provider Network	B
Quality and Utilization Management	46
Administration and Management	63
Finance	7
Reporting	48

In all, there were 329 final actions in Fiscal Year 2017-18, resulting in $26.43 million in liquidated damages and $160,000 in sanctions.

SMMC Extension and Health Plan Re-procurement

The Agency sought and received a five-year extension of the federal waiver for the SMMC program through June 2022. In addition, the Agency has completed re-procurement of SMMC contracts for health and dental plans for a new five-year period. Contracts were awarded in April 2018 for SMMC health plans and in June 2018 for SMMC dental plans. Where the original SMMC program had both MMA and LTC plans (with dental services provided through the MMA plans), under the new contract period, all plans will provide MMA services to their enrollees and any enrollee with both LTC and MMA services needs will receive all of their services from one plan. The following shows the types of plans in the new contract period and the populations they serve.

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 LTC Members
MMA	MMA Only
Specialty	MMA Only; Targeted Populations
Dental Plans	Dental Services to All Members

The agency negotiated with both MMA and Dental plans to ensure continuous coordination of care so that the increases in quality of care seen in the initial contract period would continue. This is particularly important for Dental plans so that the large, recent improvements in dental services under the Medicaid program will continue to have a significant upward trajectory. In the new contract period, Dental plans agreed to provide a rich adult dental benefit under expanded benefits.

Health plan contracts in the new 5-year period are structured to require plans to help the Agency reach the following Medicaid goals:

- Reduce potentially preventable hospital admissions, readmissions, emergency department use and use of unnecessary ancillary services;

- Improve birth outcomes; and
- Rebalance long-term care 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 new dental plans are responsible for providing dental services to all eligible members. The Agency has established the following goals for the new dental plans:

- A reduction in potentially preventable dental related emergency department visits; and
- Improved child access to dental care.

The new SMMC program will benefit both providers and recipients. High performing providers can bypass prior authorization and plans will be able to complete credentialing of providers that wish to provide services to the plan’s members more quickly. Recipients will have better access to care when they need it, improved transportation, and the best benefits package ever with more than 55 expanded benefits offered by health plans and extensive expanded dental benefits offered by dental plans at no cost to the state.

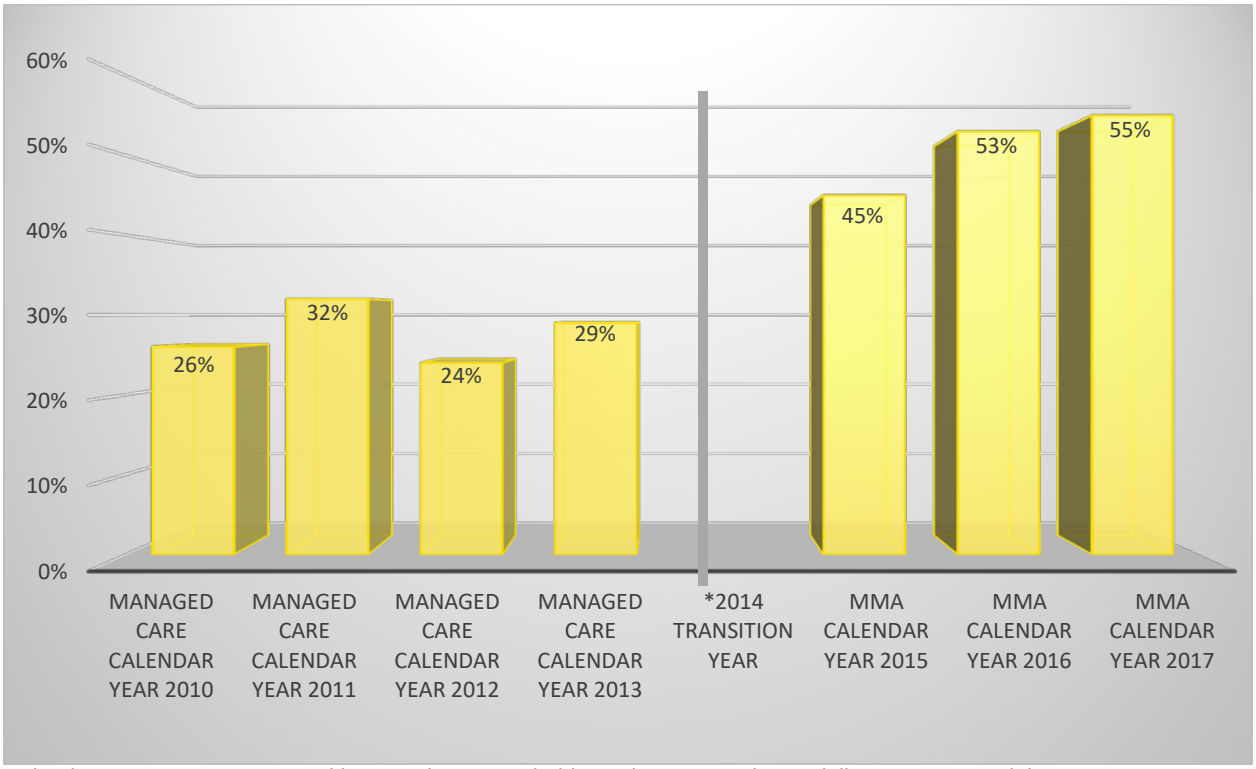
Improved Quality and High Satisfaction

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 2017. 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 the national Home and Community Based Services (HCBS) CAHPS survey instrument.

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 55 percent of HEDIS measures. Figure 3-4 shows the percentage of HEDIS measures that exceeded the national average for all Medicaid health plans in a given year.

Figure 3-4 Percentage of HEDIS 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. Below are some highlights from 2018 CAHPS results along with 2016 and 2017 results for comparison:

Adult Survey Results

CAHPS Item	Rate Description	2016	2017	2018*
Rating of Health Plan	% of Respondents Rating their Health Plan an 8, 9, or 10 on a scale of 0-10	73%	76%	76%
Getting Needed Care	% of Respondents Reporting it is Usually or Always Easy to Get Needed Care	80%	83%	81%

Getting Care Quickly	% of Respondents Reporting it is Usually or Always Easy to Get Care Quickly	82%	84%	82%
Customer Service	% of Respondents Reporting they Usually or Always Get the Help/Info Needed from their Plan's Customer Service	88%	88%	88%
Rating of Health Care	% of Respondents Rating their Health Care an 8, 9, or 10 on a scale of 0-10	75%	77%	74%

*2018 statewide rates are preliminary and may change slightly.

Child Survey Results

CAHPS Item	Rate Description	2016	2017	2018*
Rating of Health Plan	% of Respondents Rating their Health Plan an 8, 9, or 10 on a Scale of 0-10	84%	86%	85%
Getting Needed Care	% of Respondents Reporting it is Usually or Always Easy to Get Needed Care	83%	83%	84%
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	88%	88%	90%
Rating of Health Care	% of Respondents Rating Their Health Care an 8, 9, or 10 on a Scale of 0-10	86%	89%	87%

*2018 statewide rates are preliminary and may change slightly.

LTC Surveys

Beginning in 2018, LTC plans are required to conduct the HCBS CAHPS Survey, which replaces the previous Agency-designed survey. The HCBS CAHPS Survey measures enrollee experience with the Medicaid HCBS delivered by providers. Core questions cover topics such as: getting needed services, communication with providers, case managers, choice of services, medical transportation, and personal safety, as well as community inclusion and empowerment. The first year of survey results is due to the Agency on September 1, 2018.

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 began October 1, 2017) were 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 also includes the following board certified providers:

- Pediatric Cardiologists;
- Pediatric Endocrinologists;
- Pediatric Nephrologists;
- Pediatric Neurologists; and
- Pediatric Psychiatrists.

These provider types were further expanded in April 2018 to include:

- Board Certified Adolescent Medicine Specialists
- Board Certified Maternal/Fetal Specialists
- Board Certified Pediatric Allergists
- Board Certified Pediatric Cardiovascular Surgeons
- Board Certified Pediatric Critical Care Specialists
- Board Certified Pediatric Dermatologists
- Board Certified Pediatric Gastroenterologists
- Board Certified Pediatric General Surgeons
- Board Certified Pediatric Hematologists
- Board Certified Pediatric Hospitalists
- Board Certified Pediatric Infectious Disease Specialists
- Board Certified Pediatric Internal Medicine Specialists

- Board Certified Pediatric Neurology Surgeons
- Board Certified Pediatric Oncologists
- Board Certified Pediatric Ophthalmologists
- Board Certified Pediatric Orthopedic Surgeons
- Board Certified Pediatric Otolaryngologists
- Board Certified Pediatric Physical Medicine and Rehab Specialists
- Board Certified Pediatric Plastic Surgeons
- Board Certified Pediatric Pulmonologists
- Board Certified Pediatric Rheumatologists
- Board Certified Pediatric Thoracic Surgeons

Year 3 of the program will become effective October 1, 2018 and include the same 30 provider types but they will no longer need to be Board Certified. The program will not actually begin Year 3 until all of the new SMMC plans are up and running. There has been a total of $270 million earmarked for the program in Year 3 representing an almost $100 million increase over Year 2.

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 issues, concerns, or complaints 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.

Number of MMA Services Related Complaints per 1,000 Enrollees July 1, 2017, through June 30, 2018

Month	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Total MMA Enrollment	3,181,088	3,148,693	3,132,032	3,158,464	3,114,644	3,112,207	3,102,714	3,096,655	3,076,326	3,069,224	3,019,549	3,078,279
Number of Complaints	1,167	1,575	1,106	1,402	1,293	N/A*	989	1,182	1,094	902	923	817
Complaints Per 1,000 Enrollees	0.37	0.50	0.35	0.44	0.42	N/A*	0.32	0.38	0.36	0.29	0.31	0.27

*A new complaint system was implemented in December 2017 so no complaints were reported for this period.

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 lifesaving 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 2017-18 Medicaid completed a study of PPEs for the period July 2015 to June 2016. 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.

Looking Ahead for Medicaid

Over the next year, Medicaid is focused on three main areas, Procurements, Program Implementation, and Legislative and Budget Activities. The primary emphasis for each of these areas include:

- Procurement
  - Statewide Medicaid Managed Care – Health plans (Provider Service Networks)
  - Enterprise Data Warehouse
  - Integration Services Integration Platform

- Program Implementations
  - SMMC
  - Dental
  - Behavior Analysis
  - ROPA and CURES
  - Medicaid Buy-in/Working People with Disabilities
  - Retroactive Eligibility
  - Recruitment and Onboarding

- Legislative and Budget Activities
  - Gubernatorial Transition
  - SSEC Meetings
  - 2019 Legislative Session
  - FFS and Health Plan Capitation Rate Setting

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 health and dental plans provided

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 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.

Florida Health Care Connections (FX) (formerly known as Medicaid Enterprise System (MES))

Current Florida Health Care Enterprise

The title of this procurement project was recently changed from the MES Procurement Project to the Florida Health Care Connection (FX) Procurement Project. The current Florida Health Care Enterprise consists of the Florida Medicaid Management Information System (FMMIS), a Decision Support System, a fiscal agent, as well as several separate systems that function to support the Agency in administering the Florida Medicaid program. Such Agency systems include: the enrollment broker system, third party liability, pharmacy benefits management, fraud and abuse case tracking, prior authorization, home health electronic visit verification, provider data management system, and Health Quality Assurance licensure systems. The Florida health care enterprise also includes connections with systems that reside at other agencies, including: the Department of Children and Families, Department of Health, Department of Elder Affairs, Agency for Persons with Disabilities, Florida Healthy Kids Corporation, Department of Financial Services, Department of Law Enforcement, Department of Juvenile Justice, and Vital Statistics. These point-to-point interfaces become more complex and costly as the number of systems and applications increase.

The Agency is required by the federal Centers for Medicare and Medicaid Services (CMS) to re-procure the FMMIS. On February 5, 2014, CMS approved the Agency to contract with consultants to provide research and planning, a project management office, and independent verification and validation services to assist with the procurement of a new fiscal agent contract and enhancements to, or development of, the FMMIS and Decision Support System.

In November of 2016, the Agency presented the MES Procurement Strategy to CMS and proposed a phased approach to replace the current functions of the FMMIS based on the CMS conditions and standards. CMS approved the MES Procurement Strategy in February of 2017. FX will ultimately transition the FMMIS to an interoperable and unified Health Care Enterprise

where individual processes, modules, and systems work together to support the Agency's functions. The FX program is meant to be a broad project that leverages the Medicaid infrastructure to improve overall Agency functionality and build better connections to other data sources and programs. This approach provides the most efficient and cost-effective long-term solution for the Agency while complying with federal regulations, achieving federal certification, and obtaining enhanced federal funding.

In September of 2017, the Agency completed Phase I of the FX Procurement Strategy by contracting with a Strategic Enterprise Advisory Services (SEAS) vendor to create a strong strategic plan to guide the Agency's transformation of the Health Care Enterprise to a modular environment over a five to six year period. The strategic plan identifies the FX vision, guiding principles, strategic priorities, and high-level tactics to transform the FX.

Phase II of the FX procurement project began in Fiscal Year 2018-2019. It will focus on building the infrastructure or foundation of the enterprise system. During Phase II, the Agency will procure contracted services for the following:

- An Integration Services/Integration Platform that will bring together the FX components ensuring that the modules function together to administer the FX program. This includes a modern and expandable computer application communication system to use between FX applications (often referred to as an Enterprise Service Bus); and
- Replacement of the current Decision Support System with a more robust, modern Enterprise Data Warehouse that includes other data sources to be used for FX reporting and detailed data analytics.

The Agency contracts with DXC Technology Services to act as the fiscal agent responsible for operating the FMMIS and Decision Support System. The original contract was recently extended until July 31, 2020. The Agency envisions the need for "emergency extensions" of the contract after July 31, 2020. The contract extension was vital to ensure that Florida has fully functional systems to support Medicaid operations during the interim planning and developmental periods as we transition to a new modular system. Extending the fiscal agent contract also allows for continued operations without a takeover procurement. This plan will save money for the state and federal governments and eliminate the need for intense participation of Agency subject matter experts for the takeover effort.

As the FX project progresses, the state will continue to keep CMS informed of progress and changes through regular updates and submission of required requests for continued funding at an enhanced federal match rate. The Agency anticipates that as the strategy is implemented the functions currently performed in the fiscal agent contract will be replaced with a robust, modern group of modules that will provide a greater cost benefit and the flexibility of choice of vendors, enhancing the operations of the FX.

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.	Section 627.6699(11)(b)2,F.S.	Florida Small Employer Health Reinsurance Program	Ongoing responsibilities
6.	Section 624.91, F.S.	Florida Healthy Kids Corporations Board of Directors	Ongoing responsibilities
7.	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
8.	Section 395.40, F.S.	Florida Trauma System Plan Advisory Council	Ongoing responsibilities
9.	Section 409.1451(7), F.S.	Independent Living Advisory Council	Ongoing responsibilities
10.	Section 427.013, F.S.	Commission for the Transportation Disadvantaged	Ongoing responsibilities
11.	Section 14.2019, F.S.	Florida Suicide Prevention Coordinating Council	Ongoing responsibilities

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
12.	Chapter 2012-120, Laws of Florida	Statewide Task Force on Prescription Drug Abuse and Newborns	Ongoing responsibilities
13.	Section 893.055, F.S.	Prescription Drug Monitoring Program	Ongoing responsibilities
14.	Section 893.055, F.S.	Program Implementation and Oversight Taskforce on Prescription Drug Monitoring	Ongoing responsibilities
15.	Supreme Court of Florida No. AOSC16-44	Taskforce on Substance Abuse and Mental Health Issues in the Courts	Ongoing responsibilities
16.	Chapter 2014-161, Laws of Florida	Statewide Council on Human Trafficking	Ongoing responsibilities
17.	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
18.	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
19.	Section 409.913, F.S.	Annual Medicaid Fraud and Abuse Report	Annually/January 1
Division of Health Quality Assurance			
20.	Section 408.909(9), F.S.	Annual report on Health Flex to be submitted jointly with the Office of Insurance Regulation	Annually/January 1
21.	Section 408.7057(2)(g)2., F.S.	Annual Report on the Cases of the Statewide Managed Care Dispute Resolution Program	Annually/February 1

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
22.	Section 400.191(2), F.S.	Nursing Home Guide Quarterly Report	Ongoing responsibilities
23.	Section 395.10972, F.S.	Risk Managers Advisory Group – This is a standing advisory group that has not met in several years.	Ongoing responsibilities
24.	Section 627.4236, F.S.	Bone Marrow Transplant Advisory Panel	Ongoing responsibilities
25.	Section 409.912, F.S.	Drug Utilization Review Board	Ongoing responsibilities
26.	Section 288.0656, F.S.	Rural Economic Development Initiative	Ongoing responsibilities
27.	Section 402.281, F.S.	Governor's Panel on Excellence in Long-Term Care (Gold Seal Program)	Ongoing responsibilities
28.	Section 408.7056 and Section 408.7057, F.S.	Statewide Provider and Subscriber Assistance Panel	Ongoing responsibilities
29.	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
30.	Section 429.19, F.S.	Assisted Living Facilities Annual Report on Fines	Annually/July 30
31.	Section 627.6699, F.S.	Florida Health Insurance Advisory Board (FHIAB)	Ongoing responsibilities
32.	Section 408.05(3)(c), F.S.	Internet platform to research price of health care services and perform price comparisons	Ongoing responsibilities

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
33.	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
34.	Section 408.05(6), F.S.	State Consumer Health Information and Policy Advisory Council	Ongoing responsibilities
35.	Section 408.0611(4), F.S.	Annual Electronic Prescribing Report	Annually/January 31
36.	Section 408.062(1)(e), F.S.	Health Care Expenditures Report	Annually/due date unspecified
37.	Section 408.062(1)(h), F.S.	Retail prices charged by pharmacies for the 100 most frequently prescribed medications	Quarterly (met as ongoing)
38.	Section 408.062(1)(i), F.S.	Annual Report of Emergency Department Utilization and Services	Annually/January 1
39.	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
40.	Section 395.0197(8), F.S.	Quarterly and Annual summaries and trend analyses of adverse incidents	Quarterly and Annually
41.	Section 408.05(6), F.S.	State Consumer Health Information and Policy Advisory Council	Ongoing Responsibilities

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
Division of Information Technology			
42.	None.		
Division of Medicaid			
43.	Section 409.91211, F.S.	Enhanced Benefits Panel	Ongoing responsibilities
44.	Section 409.818, F.S.	Florida KidCare Grievance Committee	Ongoing responsibilities
45.	Section 409.91213, F.S.	Low Income Pool (LIP)	Quarterly progress reports and annual reports for 1115 waivers
46.	Section 765.53, F.S.	Organ Transplant Advisory Council	Ongoing responsibilities
47.	Section 409.91195, F.S.	Pharmaceutical and Therapeutics Committee	Ongoing responsibilities
48.	Section 16.615, F.S.	Council on the Social Status of Black Men and Boys	Ongoing responsibilities
49.	Section 409.818(2)(c), F.S.	Kid Care Coordinating Council (Membership Only)	Ongoing responsibilities
50.	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
51.	Section 409.908(2)(b)5, F.S.	Nursing Care Cost Report: Annual Report on direct and indirect care costs	Ongoing responsibilities
52.	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
53.	Section 409.912(44), F.S.	HSD annual report of audit results to ensure cost effectiveness relating to Medicaid Managed Care	Ongoing responsibilities
54.	Section 409.8177(1), F.S.	Florida KidCare Evaluation Annual Report: the Agency, in consultation with the DOH, the DCF and Florida Healthy Kids contract for evaluation and report on KidCare program	Ongoing responsibilities
55.	Section 409.912(28), F.S.	EPSDT (Child Health Check-Up) Screening Rates	Ongoing responsibilities
56.	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

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
			diabetes programs implemented by each state agency.

LRPP Exhibit II: Performance Measures and Standards

Approved Performance Measures for FY 2017-2018 (Words)		Approved Base Year Standards (Numbers)	Prior Year Actual FY 2017-2018 (Numbers)	Approved Standards for FY 2018-2019 (Numbers)	Requested FY 2019-2020 Standard (Numbers)
Program: Administration and Support			**Code: 68200000**		
1	Administrative costs as a percent of total agency costs	0.11%	0.07%	0.13%	0.11%
2	Administrative positions as a percent of total agency positions	12.08%	10.88%	12.19%	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	6.87%	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	94.96%	90.00%	75.00%

	Approved Performance Measures for FY 2017-2018 (Words)	Approved Base Year Standards (Numbers)	Prior Year Actual FY 2017-2018 (Numbers)	Approved Standards for FY 2018-2019 (Numbers)	Requested FY 2019-2020 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%	93.1%	95.00%	90.00%
8	Total number of Title XXI-eligible children enrolled in KidCare	228,159	216,350	228,159	171,323
9	Number of Title XXI-eligible children enrolled in Florida Healthy Kids	195,867	176,529	195,867	139,279
10	Number of Title XXI-eligible children enrolled in MediKids	2,100	28,089	21,000	21,723
11	Number of Title XXI-eligible children enrolled in Children's Medical Services Network	111,292	11,732	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%	0.83%	1.44%	2.00%

Approved Performance Measures for FY 2017-2018 (Words)		Approved Base Year Standards (Numbers)	Prior Year Actual FY 2017-2018 (Numbers)	Approved Standards for FY 2018-2019 (Numbers)	Requested FY 2019-2020 Standard (Numbers)
13	Average number of days between receipt of clean Medicaid claim and payment	15	10.34	15	15
14	Number of Medicaid claims received	145,101,035	69,587,143	145,101,035	Per SSEC 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	1.22%	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	7.23%	20.00%	20.00%
16	Percent of women receiving adequate prenatal care	86.00%	83.70%	86.00%	86.00%
17	Neonatal mortality rate per 1000	4.70%	4.90%	4.70%	5.00%

Approved Performance Measures for FY 2017-2018 (Words)		Approved Base Year Standards (Numbers)	Prior Year Actual FY 2017-2018 (Numbers)	Approved Standards for FY 2018-2019 (Numbers)	Requested FY 2019-2020 Standard (Numbers)
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	75.10%	50.00%	Per SSEC Estimate
19	Percent of eligible children who received all required components of EPSDT screening	64.00%	73.00%	64.00%	Per SSEC Estimate
20	Number of children ages 1-20 enrolled in Medicaid	1,249,276	2,187,601	1,249,276	Per SSEC Estimate
21	Number of children receiving EPSDT services	407,052	2,293,151	407,052	Per SSEC Estimate
22	Number of hospital inpatient services provided to children	92,960	52,635	92,960	Per SSEC Estimate
23	Number of physician services provided to children	6,457,900	3,238,323	6,457,900	Per SSEC Estimate
24	Number of prescribed drugs provided to children	4,444,636	1,108,982	4,444,636	Per SSEC Estimate
25	Number of hospital inpatient services provided to elders	100,808	11,377	100,808	Per SSEC Estimate
26	Number of physician services provided to elders	1,436,160	959,316	1,436,160	Per SSEC Estimate

Approved Performance Measures for FY 2017-2018 (Words)		Approved Base Year Standards (Numbers)	Prior Year Actual FY 2017-2018 (Numbers)	Approved Standards for FY 2018-2019 (Numbers)	Requested FY 2019-2020 Standard (Numbers)
27	Number of prescribed drugs provided to elders	15,214,293	142,804	15,214,293	Per SSEC 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]
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	658,632	550,436	Per SSEC Estimate
31	Number of case months services purchased (Nursing Home)	619,387	519,636	619,387	Per SSEC Estimate
Program: Health Care Services			**Code: 68500000**		
Service/Budget Entity: Medicaid Prepaid Health Plan			**Code: 68501600**		

Approved Performance Measures for FY 2017-2018 (Words)		Approved Base Year Standards (Numbers)	Prior Year Actual FY 2017-2018 (Numbers)	Approved Standards for FY 2018-2019 (Numbers)	Requested FY 2019-2020 Standard (Numbers)
32	Percent of hospitalizations for conditions preventable by good ambulatory care	16.00%	See New Measures 33A and 33B Below	16.00%	DELETE[4]
33	Percent of women and child hospitalizations for conditions preventable with good ambulatory care	16.00%	See New Measure 33A Below	16.00%	DELETE[4]
33A	New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Ages 1-20 in full service capitated managed health care plans	N/A	2.92%	25.00%	20.00%4,5 (Budget Entity 68501600 no longer exists, standard should be in Medicaid Services - Individuals Budget Entity 68501400)
33B	New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Ages 21 and over in full service capitated managed health care plans	N/A	6.22%	20.00%	20.00%4,5 (Budget Entity 68501600 no longer exists, standard should be in Medicaid Services - Individuals

Approved Performance Measures for FY 2017-2018 (Words)		Approved Base Year Standards (Numbers)	Prior Year Actual FY 2017-2018 (Numbers)	Approved Standards for FY 2018-2019 (Numbers)	Requested FY 2019-2020 Standard (Numbers)
					Budget Entity 68501400)
34	Number of case months services purchased (elderly and disabled)	1,877,040	N/A	1,877,040	DELETE[4]
35	Number of case months services purchased (families)	9,850,224	N/A	9,850,224	DELETE[4]
Program: Program: Health Care Regulation			**Code: 68700700**		
Service/Budget Entity: Health Care Regulation			**Code: 68700700**		
36	Percent of nursing home facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0.00%	2.48%	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%	29.61%	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%
39	Percent of accredited hospitals and ambulatory surgical centers cited for not complying with life safety, licensure, or emergency access standards	25.00%	57.45%	25.00%	DELETE[4]

Approved Performance Measures for FY 2017-2018 (Words)		Approved Base Year Standards (Numbers)	Prior Year Actual FY 2017-2018 (Numbers)	Approved Standards for FY 2018-2019 (Numbers)	Requested FY 2019-2020 Standard (Numbers)
40	Percent of validation surveys that are consistent with findings noted during the accreditation survey	98.00%	100.00%	98.00%	DELETE[4]
41	Percent of assisted living facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0.00%	0.49%	0.00%	DELETE[4]
42	Percent of home health facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0.00%	0.00%	0.00%	DELETE[4]
43	Percent of clinical laboratories with deficiencies that pose a serious threat for not complying with life safety, licensure or emergency access standards	0.00%	1.36%	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%	2.21%	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%	4.19%	0.00%	DELETE[4]
46	Percent of hospitals that fail to report serious incidents (agency identified)	6.00%	4.19%	6.00%	DELETE[4]

Approved Performance Measures for FY 2017-2018 (Words)		Approved Base Year Standards (Numbers)	Prior Year Actual FY 2017-2018 (Numbers)	Approved Standards for FY 2018-2019 (Numbers)	Requested FY 2019-2020 Standard (Numbers)
47	Percent of new Medicaid recipients voluntarily selecting managed care plan	50.00%	43%	50.00%	TRANSFER[4,5] (This is a Medicaid program – should be in Executive Direction and Support Services Budget Entity 68500200) DELETE[4]
48	Percent of complaints of HMO patient dumping received that are investigated	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 information	30,000	N/A	30,000	DELETE[4]
51	Total number of full facility quality-of-care surveys conducted	7,550	10,070	7,550	DELETE[4]

Approved Performance Measures for FY 2017-2018 (Words)		Approved Base Year Standards (Numbers)	Prior Year Actual FY 2017-2018 (Numbers)	Approved Standards for FY 2018-2019 (Numbers)	Requested FY 2019-2020 Standard (Numbers)
52	Average processing time (in days) for Subscriber Assistance Program cases.	53	17	53	20
52A	New Measure - Average processing time (in days) for Subscriber Assistance Program and Beneficiary Assistance Program cases	53	17	53	DELETE[4]
53	Number of construction reviews performed (plans and construction)	4,500	4,630	4,500	4,500
54	Number of new enrollees provided with choice counseling	520,000	821,740	520,000	Per Estimates[1] TRANSFER[4,5] (This is a Medicaid program - should be moved to Executive Direction and Support Services Budget Entity 68500200)
55	New Measure - Percent of renewal applications received electronically via the Online Licensing Application	30.00%	56.77%	N/A	60.00%

Approved Performance Measures for FY 2017-2018 (Words)		Approved Base Year Standards (Numbers)	Prior Year Actual FY 2017-2018 (Numbers)	Approved Standards for FY 2018-2019 (Numbers)	Requested FY 2019-2020 Standard (Numbers)
56	New Measure - Average processing time (in days) for financial reviews	3	1.17	N/A	3
57	New Measure - Number of FloridaHealthFinder.gov website hits	NA	2,707,537	N/A	4,000,000

[1] These estimates are established by Estimating Conference and represent anticipated counts and are not performance measures.
[2] There have been no complaints of HMO patient dumping received by 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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
7.70%	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 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 ☐ 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: Not solely a Medicaid program.

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 3A 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: 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.

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

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

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect ☒ Other (Identify)
Explanation: This measure originally included the number of children who had all their immunizations when starting kindergarten. Since it was a requirement to have updated immunizations before enrolling in school, the measure was not meaningful. Medicaid originally attempted between 2004 and 2006 to use survey data to statistically determine the immunization percentage but the self-reported data based on parental or caregiver recall were not reliable. In 2007, Medicaid sought to replace the measure with the percentage of 2-year olds who had up to date immunizations based on 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 ☒ Technological Problems
☐ Legal/Legislative Change ☐ Natural Disaster
☐ Target Population Change ☐ Other (Identify)
☐ This Program/Service Cannot Fix the Problem
☐ Current Laws Are Working Against the Agency Mission
Explanation: Inconsistent data is collected.

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

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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 Children's Medical Services Network (CMSN) or Medicaid data (such as caregiver counseling or levels of depression among parents). Since the original standard no longer exists and data for the new standards cannot be collected by Medicaid, this measure is being requested to be deleted.

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

Explanation: Data are not available to calculate this measure.

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

Recommendations: This measure should be deleted due to unavailability of data.

Office of Legislative Affairs – July 2018

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%	93.1%	1.9%	2.0%

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 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
☒ 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
228,159	216,350	(11,809)	-5.18%

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 launch of the Affordable Care Act (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
☐ 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 Social Services Estimating Conference (SSEC).

Office of Legislative Affairs – July 2018

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
☒ 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
195,867	176,529	(19,338)	-9.87%

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 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
☐ 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 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 #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	28,089	25,989	1,237.57%

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 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 #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	11,732	(99,560)	-89.46%

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. Children's Medical Services Network (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: Children's Special Health Care/68500100
Measure #14: Number Medicaid Claims Received

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
145,101,035	69,587,143	(75,513,892)	-52.04%

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

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

Explanation: The approved standard does not reflect recent trends for the population in this program and does not account for changes in enrollment such as Express Enrollment which automatically enrolls newly eligible individuals in a health plan. 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. 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 ☐ 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: Medicaid Services to Individuals/68501400
Measure #15: Percent of Hospitalizations that are Preventable by Good Ambulatory Care

Action:

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

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

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

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

Explanation: This measure applied to all individuals regardless of age who received care in Fee-for-Service (FFS), MediPass, or a Provider Service Network (PSN). A better measurement would be to separate populations by Adults and Children. Therefore, the measure has been replaced using the national Agency for Healthcare Research and Quality's (AHRQ) standard quality assurance measures, 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 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 and Provider Service Networks.

External Factors (check all that apply):

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

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

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

- ☐ Training
- ☐ 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.
Office of Legislative Affairs – July 2018

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
86.00%	83.70%	2.30%	2.67%

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

External Factors (check all that apply):
☐ Resources Unavailable ☐ Technological Problems
☐ Legal/Legislative Change ☐ Natural Disaster
☐ Target Population Change ☒ Other (Identify)
☐ This Program/Service Cannot Fix the Problem
☐ Current Laws Are Working Against the Agency Mission
Explanation: Women are often not aware of their eligibility for public programs and do not enroll in Medicaid for prenatal and birth-related care until well into their pregnancy. Women also do not appear to be taking full advantage of the services available to them.

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

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
4.70%	4.90%	0.20%	-4.26%

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: 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: It is possible that some women are 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.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☒ Other (Identify)
Recommendations: The Agency will continue the Family Planning Waiver and will seek methods to ensure women are aware of and 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).

Measure #18: Average Number of Months between Pregnancies for those Receiving Family Planning Services– Page 2

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

☐ Training
☐ Personnel
☐ Technology
☒ Other (Identify)

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

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #20: Number of Children Ages 1-20 Enrolled in Medicaid

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
1,249,276	4,921	1,244,355	-99.61%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☐ Staff Capacity
☐ Level of Training
☒ Other (Identify)
Explanation: 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 implementation of the Statewide Medicaid Managed Care (SMMC) program in 2014 means that the majority of Medicaid recipients now receive care through a managed care health plan. The standard has not been changed to reflect changes in law. Enrollment standards 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. The measure should be changed to clarify that this applies only to enrollees receiving care on a Fee-for-Service (FFS) 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 Social Services Estimating Conference (SSEC) and to clarify that it pertains only to the FFS population.

Office of Legislative Affairs – July 2018

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 #22: Number of Hospital Inpatient Services Provided to Children

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
92,960	52,635	(40,325)	-43.38%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☐ Staff Capacity
☐ Level of Training
☒ Other (Identify)
Explanation: 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 implementation of the Statewide Medicaid Managed Care (SMMC) program in 2014 means that the majority of Medicaid recipients now receive care through a managed care health plan. The standard has not been changed to reflect changes in law. Enrollment standards 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. The measure should be changed to clarify that this applies only to enrollees receiving care on a Fee-for-Service (FFS) 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 expected utilization from actual enrollment expectations based upon the Social Services Estimating Conference (SSEC) and to clarify that it pertains only to the FFS population.

Office of Legislative Affairs – July 2018

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 #23: Number of Physician Services Provided to Children

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
6,457,900	3,238,323	(3,219,577)	-49.85%

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 implementation of the Statewide Medicaid Managed Care (SMMC) program in 2014 means that the majority of Medicaid recipients now receive care through a managed care health plan. The standard has not been changed to reflect changes in law. Enrollment standards 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. The measure should be changed to clarify that this applies only to enrollees receiving care on a Fee-for-Service (FFS) 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 expected utilization from actual enrollment expectations based upon the Social Services Estimating Conference (SSEC) and to clarify that it pertains only to the FFS population.

Office of Legislative Affairs – July 2018

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 #24: Number of Prescribed Drugs Provided to Children

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
4,444,636	1,108,982	(3,335,654)	-75.05%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☐ Staff Capacity
☐ Level of Training
☒ Other (Identify)
Explanation: 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 implementation of the Statewide Medicaid Managed Care (SMMC) program in 2014 means that the majority of Medicaid recipients now receive care through a managed care health plan. The standard has not been changed to reflect changes in law. Enrollment standards 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. The measure should be changed to clarify that this applies only to 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 expected utilization from actual enrollment expectations based upon the Social Services Estimating Conference (SSEC) and to clarify that it pertains only to the FFS population.

Office of Legislative Affairs – July 2018

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 #25: Number of Hospital Inpatient Services Provided to Elders

Action:

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
100,808	11,377	(89,431)	-88.71%

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

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

Explanation: There are no internal factors that 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 implementation of the Statewide Medicaid Managed Care (SMMC) program in 2014 means that the majority of Medicaid recipients now receive care through a managed care health plan. The standard has not been changed to reflect changes in law. Enrollment standards 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. The measure should be changed to clarify that this applies only to 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 expected utilization from actual enrollment expectations based upon the Social Services Estimating Conference (SSEC) and to clarify that it pertains only to the FFS population.

Office of Legislative Affairs – July 2018

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #26: Number of Physician Services Provided to Elders

Action:
☐ Performance Assessment of Outcome Measure
☒ 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
1,436,160	959,316	(476,844)	-33.20%

Factors Accounting for the Difference:
Internal Factors (check all that apply):
☐ Personnel Factors
☐ Competing Priorities
☐ Previous Estimate Incorrect
☐ Staff Capacity
☐ Level of Training
☒ Other (Identify)
Explanation: 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 implementation of the Statewide Medicaid Managed Care (SMMC) program in 2014 means that the majority of Medicaid recipients now receive care through a managed care health plan. The standard has not been changed to reflect changes in law. Enrollment standards 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. The measure should be changed to clarify that this applies only to enrollees receiving care on a Fee-for-Service (FFS) 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 expected utilization from actual enrollment expectations based upon the Social Services Estimating Conference (SSEC) and to clarify that it pertains only to the FFS population.

Office of Legislative Affairs – July 2018

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	142,804	(15,071,489)	-99.06%

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. It is recommended that the standard for this measure also be changed to reflect the expected utilization from actual enrollment expectations based upon the Social Services Estimating Conference (SSEC) and to clarify that it pertains only to the Fee-for-Service (FFS) population.

Office of Legislative Affairs – July 2018

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	-1,227	N/A

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

External Factors (check all that apply):
☐ Resources Unavailable
☒ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix the Problem
☐ Current Laws Are Working Against the Agency Mission
☐ Technological Problems
☐ Natural Disaster
☒ Other (Identify)
Explanation: This was an expansion group for a specific population of children. The expansion was not renewed, and all of the participating children have aged out of the program.

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training
☐ Personnel
☐ Technology
☒ Other (Identify)
Recommendations: This is an old eligibility expansion population in a category that was not renewed. All members have since aged out, and the measure should be deleted.

Office of Legislative Affairs – July 2018

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 Fee-for-Service (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.

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.

Office of Legislative Affairs – July 2018

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Long-Term Care/68501500
Measure #30: Number of Case Months (Home and Community-Based Services)

Action:
☐ Performance Assessment of Outcome Measure
☒ 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
550,436	658,632	108,196	19.66%

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: One of the Agency's goals since the implementation of the Statewide Medicaid Managed Care (SMMC) program in 2014 is to ensure that the majority of Medicaid recipients receiving long-term care benefits do so in a community setting whenever possible. One of the overarching performance goals for Medicaid is to transition 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 3A).

The standard has not been changed to reflect changes in law or policy objectives. Enrollment standards should be based on estimating conference predictions developed the previous year from anticipated economic and population indicators.

M**anagement 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 expected utilization from actual policy goals and enrollment expectations based upon the Social Services Estimating Conference (SSEC).

Office of Legislative Affairs – July 2018

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Long-Term Care/68501500
Measure #31: Number of Case Months Services Purchased (Nursing Home)

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
619,387	519,636	(99,751)	16.10%

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

External Factors (check all that apply):
☐ Resources Unavailable
☒ Legal/Legislative Change
☐ Target Population Change
☐ This Program/Service Cannot Fix the Problem
☐ Current Laws Are Working Against the Agency Mission
☐ Technological Problems
☐ Natural Disaster
☒ Other (Identify)
Explanation: One of the Agency's goals since the implementation of the Statewide Medicaid Managed Care (SMMC) program in 2014 is to ensure that the majority of Medicaid recipients receiving long-term care benefits do so in a community setting whenever possible. One of the overarching performance goals for Medicaid is to transition 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 3A).

The standard has not been changed to reflect changes in law or policy objectives. Enrollment standards should be based on estimating conference predictions developed the previous year from anticipated economic and population indicators.

M**anagement 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 expected utilization from actual policy goals and enrollment expectations based upon the Social Services Estimating Conference (SSEC).

Office of Legislative Affairs – July 2018

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Prepaid Health Plan/68501600 (Note: Budget Entity No Longer Exists)
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 (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 (conditions preventable by good ambulatory care): Ages 21 and over in full service capitated managed health care plans.

Office of Legislative Affairs – July 2018

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Prepaid Health Plan/68501600 (Note: Budget Entity No Longer Exists)
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 is 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 a Managed Medical Assistance (MMA) plan. Note also that these measures should be moved under the budget item in Medicaid Service to Individuals.

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

Management Efforts to Address Differences/Problems (check all that apply):
☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)
Recommendations: *(Note also that these measures should be moved under the budget item in Medicaid Service to Individuals.)* Medicaid is requesting that the existing measure be replaced

with the two measures noted above (33A and 33B), i.e., one for services to Children (ages 1-20) and one for Adults (ages 20+) who are enrolled in an MMA plan.

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

Action:
☐ Performance Assessment of Outcome Measure
☐ 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 2018

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 2018

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0.00%	2.48%	2.48% (Over)	2.48%

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 2018

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%	29.61%	25.61% (Over)	640.25%

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 2018

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Field Operations
Service/Budget Entity: Field Operations
Measure #38A: Percent of Priority 1 Consumer Complaints about Licensed Facilities and Programs that are Investigated within Two Business Days

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
100%	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: Adequate training and monitoring enable the Agency to investigate all P1 complaints within the two business day timeframe.

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

Explanation: Agency met the goal for this measure.

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

Recommendations: None

Office of Legislative Affairs – July 2018

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%	57.45%	32.45% (Over)	129.80%

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

Explanation: The Agency 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 2018

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 Cervices (CMS) grants authority to a selected group of accrediting organizations to determine, on CMS' behalf, whether a health care facility evaluated by the organization is in compliance with corresponding regulations. The Agency in turn accepts inspections performed by CMS approved accrediting organizations in lieu of State licensure surveys. A validation survey assesses whether the review by the accrediting organization has adequately evaluated the facility according to the minimum state standards. 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 2018

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%	0.49%	0.49% (Over)	0.49%

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: 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 2018

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 2018

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
0.00%	1.36%	1.36% (Over)	1.36%

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

Explanation: 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 2018

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%	2.21%	2.21% (Over)	2.21%

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 2018

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%	4.19%	4.19% (Over)	4.19%

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 2018

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%	4.19%	1.81% (Under)	-30.17%

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.

Office of Legislative Affairs – July 2018

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 Health Maintenance Organization (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.

Office of Legislative Affairs – July 2018

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
100.00%	100.00% (N/A)	N/A	N/A

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

Explanation: The Agency has not received any complaints of Health Maintenance Organization (HMO) access to care. Any complaints of HMO access to care received would be investigated.

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

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

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

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

Office of Legislative Affairs – July 2018

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 2018

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
- ☐ 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
30,000	N/A	30,000	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 is now handled by the Department of Health.

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

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

Office of Legislative Affairs – July 2018

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	10,070	2,520 (Over)	33.78%

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 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 2018

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	17	36 (Under)	67.92%

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

Explanation: 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 2018

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	17	36 (Under)	67.92%

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

Explanation: 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 2018

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	4,630	130 (Over)	2.89%

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 2018

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
30.00%	56.77%	26.77% (Over)	89.23%

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

Explanation: The Agency met its goals for this measure.

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

Explanation: The Agency met its goals for this measure.

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

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

Office of Legislative Affairs – July 2018

LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
3.00 Business Days	1.17 Days	1.83 Days (Under)	61.00%

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

Explanation: Staff in these positions are highly trained, and have become extremely efficient as a group, despite increasing workload.

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

Explanation: There are no external factors affecting this measure.

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

Recommendations: The Agency has no recommendations at this time.

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LRPP Exhibit III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #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	2,707,537	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 2018-19.

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

Proposed Standard/Target: N/A

Validity: Not a valid measure.

Reliability:

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

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Children's Special Health Care/68500100
Measure #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.

Measure #3A: Percent of all Hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (Conditions Preventable by Good Ambulatory Care): CMSN Enrollees (Title XIX and Title XXI) – Page 2

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

Reliability:
The reliability of the diagnoses data is high. Hospitals provide the information to the Agency and must certify that it is accurate. The ICD-9 and ICD-10 codes are used for billing and hospital report cards. Therefore, hospitals have incentives to be accurate in their use of the codes. Similarly, the eligibility information provided by the Department of Children and Families through Medicaid Contract Management is reliable for identification of eligibility group. Eligibility information is used to approve and pay for benefits and must be accurate.

Office of Legislative Affairs – July 2018

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

Proposed Standard/Target: N/A

Validity: Not a valid measure.

Reliability: Data are not available.

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 2018

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Children's Special Health Care/68500100
Measure #4A: Percentage of all Title XXI KidCare Enrollees Eligible for Renewal Who Renew KidCare Coverage

Action (check one):

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

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

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

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

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

Proposed Standard/Target:
75.00 percent

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

Reliability:
Data is provided by FHK from their program administrative files. FHK is responsible for the reliability and validity of their data, and the data provided to ICHP is assumed to be reliable.

Measure #4A: Percentage of all Title XXI KidCare Enrollees Eligible for Renewal Who Either Renew KidCare Coverage – Page 2

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

While this measure should be as close to 100.00 percent as possible, there will always be some people who choose not to maintain insurance coverage through KidCare or who do not complete the re-enrollment process for reasons outside the control of the KidCare program. While 100.00 percent is ideal, it is not a realistic goal and a standard of 75 percent would reflect an historically high, but desirable outcome.

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Action (check one):

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

Proposed Change to Measure: Deletion of measure.

Data Sources and Methodology:

Proposed Standard/Target: N/A

Validity: Not a valid measure.

Reliability: Data are not reliable as noted below.

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, 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.

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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: Data is unobtainable.

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

Office of Legislative Affairs – July 2018

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 KidCare health plan/provider at least a seven out of ten on the annual satisfaction surveys". This will bring the measure in line with national standards. 90% is the national standard for the proposed change and the Agency is requesting that the standard reflect this change as well.

Data Sources and Methodology:
To assess KidCare program satisfaction, the University of Florida Institute for Child Health Policy (ICHP) conducts a telephone interview survey, as part of the annual KidCare Evaluation, with caregivers whose children have been receiving health care coverage through one of the KidCare program components for at least 12 consecutive months. The survey population includes children receiving the following coverage: Medicaid enrolled with an HMO, Medicaid enrolled with a 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.

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Action (check one):

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

Proposed Change to Measure: The target standard should be the estimates established by the Social Services Estimating Conference (SSEC).

Data Sources and Methodology: 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 June 30).

Proposed Standard/Target: Based on SSEC 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.

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Children's Special Health Care/68500100
Measure #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 (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 June 30).

Proposed Standard/Target: Based on SSEC estimates.

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

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

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

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Action (check one):

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

Proposed Change to Measure: The target standard should be the estimates established by the Social Services Estimating Conference (SSEC).

Data Sources and Methodology: 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 June 30).

Proposed Standard/Target: Based on SSEC 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.

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Children's Special Health Care/68500100
Measure #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 (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 June 30).

Proposed Standard/Target: Based on SSEC estimates.

Validity: 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. Children's Medical Services Network (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.

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

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

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: 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 is used to calculate the measure.

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

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

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Executive Direction and Support Services/68500200
Measure #13: Average Number of Days between Receipt of Clean Medicaid Claim and Payment

Action (check one):

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

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

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

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

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

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Executive Direction and Support Services/68500200
Measure #14: Number of Medicaid Claims Received

Action (check one):

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

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

Validity:
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 Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to individuals/68501400
Measure #15: Percent of hospitalizations that are preventable by good ambulatory Care

Action (check one):

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

Proposed Changes to Measure:
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 Networks.

Data Sources and Methodology: N/A

Proposed Standard/Target: N/A

Validity: Not a valid measure.

Reliability:

Discussion:
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 IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #15A: Percent of All Hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (Conditions Preventable by Good Ambulatory Care): Ages 1 through 20 Enrolled in Fee-for-Service

Action (check one):

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

Proposed Change to Measure:
This represents a replacement to the existing categories currently measured for ambulatory sensitive hospitalizations.

Data Sources and Methodology:
Hospitalizations are extracted from Medicaid encounter data and Medicaid claims data. Hospital data is then matched against Medicaid eligibility files to determine eligibility groups. Ambulatory sensitive conditions are identified by ICD-9 and/or ICD-10 diagnosis codes, using the algorithm and methodology outlined by the federal Department of Health and Human Services, Agency for Healthcare Research and Quality. The percentage of hospitalizations that occur for Ambulatory Sensitive Conditions within the measure target group are divided by the total hospitalizations for that group to arrive at a percentage. This measure is calculated annually for the LRPP based on prior calendar year encounters/claims (e.g., Calendar Year 2013 for the LRPP published in 2014).

Enrollees/beneficiaries are divided into “ages 1 through 20” and “21 and older” age groups because the Medicaid benefit package varies for adults and children. Children under one year of age have almost no hospitalizations that fit these criteria. Further, many do not have established Medicaid identifications at the time of hospitalization and cannot be matched to Medicaid eligibility files. These measures, therefore, concentrate on the children ages one through 20 where appropriate. The following groups would be excluded from this measure:

a. Sixth Omnibus Budget Reconciliation Act (SOBRA) for pregnant women;
b. Women eligible for Medicaid through the Family Planning Waiver;
c. Medicaid recipients domiciled or residing in an institution, including nursing facilities, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an Intermediate Care Facility/Developmentally Disabled (ICF/DD);
d. Medicaid recipients whose eligibility was determined through the medically needy program;
e. Qualified Medicare Beneficiaries (QMBs);

Measure #15A: Percent of all Hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (Conditions Preventable by Good Ambulatory Care): Ages 1 through 20 Enrolled in Fee-for-Service – Page 2

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

Proposed Standard/Target:
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);

Measure #15B: Percent of all Hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (Conditions Preventable by Good Ambulatory Care): Ages 21 and Older Enrolled in Fee-for-Service – Page 2

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

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

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

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

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

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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. 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 Healthcare 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.
☒ Requesting Deletion

Proposed Change to Measure:
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).

Data Sources and Methodology: N/A

Proposed Standard/Target: N/A

Validity: Not a valid measure.

Reliability:

Discussion:
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 IV: Performance Measure Validity and Reliability

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

Action (check one):

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

Proposed Change to Measure:
This is a new measure. Healthy Start and the Family Planning Waiver program both advocate optimal spacing between pregnancies in order to ensure the best health and environment for children and mothers. An inter-pregnancy interval of at least 18 months ensures 24 or more months between births.

Data Sources and Methodology:
The data source is the Medicaid claims data from the Florida Medicaid Management Information System (FMMIS) that has been merged with a data set maintained by the University of Florida, Family Data Center, which contain Medicaid eligibility, birth certificate, death certificate, and Healthy Start data related to women giving birth in Florida for each year since 1991. Medicaid extracts claims each year which contain the social security number of the person. UF compares this information to the number of women giving birth in the following year and identifies those who had a birth. The inter-pregnancy interval (IPI) is the total number of months between pregnancies measured from the end of the first pregnancy to the beginning of the subsequent pregnancy. The IPI for each of the women identified with a subsequent birth is calculated. The total number of those with an inter-pregnancy interval of 18 months or more are then divided by the total number of women with a subsequent birth to arrive at a percentage.

Proposed Standard/Target:
75.00 percent

Validity:
This is a valid measure for the effectiveness of family planning services. Lengths between children's' births of at least 24 months are encouraged by the Healthy Start and Family Planning Waiver program and are preferable due to the demonstrated benefits for growth and healthy development of young children.

Reliability:
The reliability is considered high for women who have maintained Medicaid coverage between pregnancies since it is based on claims data and birth records. Although the potential for inaccuracies on the birth certificate exist, they are not serious enough to jeopardize comparisons between programs or over time.

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #19: Percent of Eligible Children who Received all Required Components of EPSDT 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. 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:
The unduplicated population can be reliably calculated. 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 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. Data is compiled from the CMS-416 report, which is used to report EPSDT data to the federal Centers for Medicare and Medicaid Services using federal reporting criteria.

Reliability:
The unduplicated population can be reliably calculated and replicated since it follows federal guidelines and procedures for reporting.

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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 non-adult Medicaid population receives in a year. This is a valid measure of the size and scope of one aspect of the Medicaid FFS program and can be used to track changes in 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:
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. The unduplicated population can be reliably calculated. Claims are received and processed by the Medicaid fiscal agent in a highly controlled and monitored process. Processing is under the control of the 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 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. This is a valid measure of the size and scope of one aspect of the Medicaid FFS program and can be used to track changes in 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:
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. The unduplicated population can be reliably calculated. Claims are received and processed by the Medicaid fiscal agent in a highly controlled and monitored process. Processing is under the control of the 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 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. This is a valid measure of the size and scope of one aspect of the Medicaid FFS program and can be used to track changes in 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:
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. The unduplicated population can be reliably calculated. Claims are received and processed by the Medicaid fiscal agent in a highly controlled and monitored process. Processing is under the control of the 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 Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #25: Number of Hospital Inpatient Services Provided to Elders

Action (check one):

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

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

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

Validity:
This measure helps to identify the volume of hospital inpatient services the Medicaid population ages 65 and older receives in a year. This is a valid measure of the size and scope of one aspect of the Medicaid FFS program and can be used to track changes in 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:
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. Claims are received and processed by the Medicaid fiscal agent in a highly controlled and monitored process. Processing is under the control of the 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 Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #26: Number of Physician Services Provided to Elders

Action (check one):

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

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

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

Validity:
This measure helps to identify the volume of physician services the Medicaid elderly population receives in a year. This is a valid measure of the size and scope of one aspect of the Medicaid Fee-for-Service program and can be used to track changes in 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:
The number of physician services can be reliably calculated for Fee-for-Service settings. These figures do not include 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. Claims are received and processed by the Medicaid fiscal agent in a highly controlled and monitored process. Processing is under the control of the 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 #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.

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 Florida Medicaid Management Information System (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 Social Services Estimating Conference (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 Fiscal Year 1998 to allow the state to use Medicaid funding and receive federal match for enrolling children in KidCare whose household incomes fell between 185 percent but no more than 200 percent of the federal poverty level. The statute did not apply to future populations subsequent to CHIP re-authorization and all children initially covered during the expansion have aged out of the program.

Validity:
N/A

Reliability:
N/A

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Action (check one):

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

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

Validity: Not a valid measure.

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 Fee-for-Service 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.

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Long-Term Care/68501500
Measure #30: Number of Case Months (Home and Community-Based Services)

Action (check one):

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

Proposed Change to Measure:
One of the Agency's goals since the implementation of the Statewide Medicaid Managed Care (SMMC) program in 2014 is to ensure that the majority of Medicaid recipients receiving long-term care (LTC) benefits do so in a community setting whenever possible. One of the overarching performance goals for Medicaid is to transition LTC recipients receiving care in nursing homes to community-based care until no more than 35 percent of all Medicaid LTC recipients receive care in nursing homes (Objective 3A).

The standard has not been changed to reflect changes in law or policy objectives. Enrollment standards should be based on estimating conference predictions developed the previous year from anticipated economic and population indicators

Data Sources and Methodology:
LTC services data are extracted from Medicaid encounter data and Medicaid eligibility files. Services data is then matched against Medicaid eligibility files to determine eligibility groups. LTC services are covered on a capitated basis for LTC recipients through a specialized LTC Health Plan or as part of the recipient's services in a Comprehensive Managed Medical Assistance (MMAB) plan. Each recipient is identified as receiving LTC services in a community setting or in an institutional setting or nursing home. This measure counts the total number of individual unique months per year that are paid for Medicaid recipients receiving LTC services in a community setting.

Validity:
This is a valid measure of the size and scope of the Medicaid LTC program and can be used to track changes in enrollment and services provided to the LTC population over time and can nominally track the success in moving LTC recipients to non-institutional settings for care. This is not a valid measure of program performance as total enrollment is determined by factors outside the Agency's control.

Reliability:
Claims and encounter data 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 as well as unique recipient identifiers and place of service.

Discussion:
State budget appropriations are based on estimates established by the Social Services Estimating Conference (SSEC). The target standard and number of recipients receiving LTC services in the program should be measured against that standard.

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Long-Term Care/68501500
Measure #31: Number of Case Months (Nursing Home)

Action (check one):

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

Proposed Change to Measure:
One of the Agency's goals since the implementation of the Statewide Medicaid Managed Care (SMMC) program in 2014 is to ensure that the majority of Medicaid recipients receiving long-term care (LTC) benefits do so in a community setting whenever possible. One of the overarching performance goals for Medicaid is to transition LTC 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 3A).

The standard has not been changed to reflect changes in law or policy objectives. Enrollment standards should be based on estimating conference predictions developed the previous year from anticipated economic and population indicators

Data Sources and Methodology:
LTC services data are extracted from Medicaid encounter data and Medicaid eligibility files. Services data is then matched against Medicaid eligibility files to determine eligibility groups. LTC services are covered on a capitated basis for LTC recipients through a specialized LTC Health Plan or as part of the recipient's services in a Comprehensive Managed Medical Assistance (MMA) plan. Each recipient is identified as receiving LTC services in a community setting or in an institutional setting or nursing home. This measure counts the total number of individual unique months per year that are paid for Medicaid recipients receiving LTC services in a nursing home or other institutional setting.

Validity:
This is a valid measure of the size and scope of the Medicaid LTC program and can be used to track changes in enrollment and services provided to the LTC population over time and can nominally track the success in moving LTC recipients to non-institutional settings for care. This is not a valid measure of program performance as total enrollment is determined by factors outside the Agency's control.

Reliability:
Claims and encounter data 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 as well as unique recipient identifiers and place of service.

Discussion:
State budget appropriations are based on estimates established by the Social Services Estimating Conference (SSEC). The target standard and number of recipients receiving LTC services in the program 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 Prepaid Health Plans/ 68501600
Measure #32: Percent of Hospitalizations for Conditions Preventable by Good Ambulatory Care

Action (check one):

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

Proposed Change to Measure: Delete in favor of Measure #33A and #33B.

Data Sources and Methodology:

Proposed Standard/Target: N/A

Validity: Not a valid measure.

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; and
- 33B-New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Ages 21 and over in full service capitated managed health care plans.

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Prepaid Health Plans/ 68501600
Measure #33: Percent of Women and Child Hospitalizations Preventable with Good Ambulatory Care

Action (check one):

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

Proposed Change to Measure: Delete in favor of Measure #33A and #33B.

Data Sources and Methodology: N/A

Proposed Standard/Target: N/A

Validity: Not a valid measure.

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

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Action (check one):

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

Proposed Change to Measure:
This represents a replacement to the existing categories currently measured for ambulatory sensitive hospitalizations.

Data Sources and Methodology:
Hospitalizations are extracted from Medicaid encounter data and Medicaid claims data. Hospital data is then matched against Medicaid eligibility files to determine eligibility groups. Ambulatory sensitive conditions are identified by ICD-9 and/or ICD-10 diagnosis codes and Diagnosis Related Groups (DRGs), using the algorithm and methodology outlined by the federal Department of Health and Human Services, Agency for Healthcare Research and Quality. The percentage of hospitalizations that occur for Ambulatory Sensitive Conditions within the measure target group are divided by the total hospitalizations for that group to arrive at a percentage. This measure is calculated annually for the LRPP based on prior calendar year encounters/claims (e.g., Calendar Year 2013 for the LRPP published in 2014).

Enrollees/beneficiaries are divided into “ages 1 through 20” and “21 and older” age groups because the Medicaid benefit package varies for adults and children. Children under one year of age have almost no hospitalizations that fit these criteria. Further, many do not have established Medicaid identifications at the time of hospitalization and cannot be matched to Medicaid eligibility files. These measures, therefore, concentrate on the children ages one through 20 where appropriate. The following groups would be excluded from this measure:

a. Sixth Omnibus Budget Reconciliation Act (SOBRA) for pregnant women;
b. Women eligible for Medicaid through the Family Planning Waiver;
c. Medicaid recipients domiciled or residing in an institution, including nursing facilities, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an Intermediate Care Facility/Developmentally Disabled (ICF/DD);
d. Medicaid recipients whose eligibility was determined through the medically needy program;
e. Qualified Medicare Beneficiaries (QMBs);

Measure #33A: Percent of All Hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (Conditions Preventable by Good Ambulatory Care): Ages 1 through 20 in Full Service Capitated Managed Care Plans – Page 2

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

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

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

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

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

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Action (check one):

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

Proposed Change to Measure:
This represents a replacement to the existing categories currently measured for ambulatory sensitive hospitalizations.

Data Sources and Methodology:
Hospitalizations are extracted from Medicaid encounter data and Medicaid claims data. Hospital data is then matched against Medicaid eligibility files to determine eligibility groups. Ambulatory sensitive conditions are identified by ICD-9 and/or ICD-10 diagnosis codes and Diagnosis Related Groups (DRGs), using the algorithm and methodology outlined by the federal HHS, AHRQ. The percentage of hospitalizations that occur for Ambulatory Sensitive Conditions within the measure target group are divided by the total hospitalizations for that group to arrive at a percentage. This measure is calculated annually for the LRPP based on prior calendar year encounters/claims (e.g., Calendar Year 2013 for the LRPP published in 2014).

Enrollees/beneficiaries are divided into “ages 1 through 20” and “21 and older” age groups because the Medicaid benefit package varies for adults and children. Children under one year of age have almost no hospitalizations that fit these criteria. Further, many do not have established Medicaid identifications at the time of hospitalization and cannot be matched to Medicaid eligibility files. These measures, therefore, concentrate on the children ages one through 20 where the measure relates to children. This proposed measure is for adults over age 21. The following groups would be excluded from this measure:

a. Sixth Omnibus Budget Reconciliation Act (SOBRA) for pregnant women;
b. Women eligible for Medicaid through the Family Planning Waiver;
c. Medicaid recipients domiciled or residing in an institution, including nursing facilities, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an Intermediate Care Facility/Developmentally Disabled (ICF/DD);
d. Medicaid recipients whose eligibility was determined through the medically needy program;
e. Qualified Medicare Beneficiaries (QMBs);

Measure #33B: Percent of All Hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (Conditions Preventable by Good Ambulatory Care): Ages 21 and Older in Full Service Capitated Managed Care Plans – Page 2

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

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

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

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

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

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Prepaid Health Plan/68501600 [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

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LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Healthcare Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Prepaid Health Plan/68501600 [Budget Entity No Longer Valid]
Measure #35: Number of Case Months Services Purchased (Families)

Action (check one):

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

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

Validity:
N/A

Reliability:
N/A

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LRPP Exhibit IV: Performance Measure Validity and Reliability

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

Action (check one):

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

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

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

Validity:
The Agency is committed to acting decisively and pursuing more aggressive penalties for poorly performing facilities. Data collected for this outcome enable the Agency to determine how well facilities are performing, but is not a realistic measure of 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 2018

LRPP Exhibit IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #37: Percent of Investigations of Alleged Unlicensed Facilities and Programs that have been Previously Issued a Cease and Desist Order that are Confirmed as Repeated Unlicensed Activity

Action (check one):

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

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

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

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

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

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LRPP Exhibit IV: Performance Measure Validity and Reliability

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

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

Data Sources and Methodology:
Versa Regulation (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 FRAES/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.

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LRPP Exhibit IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #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 Versa Regulation (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.

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LRPP Exhibit IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #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 Versa Regulation (VR) are centrally collected. Centralized collection of data and management review of supporting data should ensure accurate and consistent reporting.

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LRPP Exhibit IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #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 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 ensure accurate and consistent reporting.

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LRPP Exhibit IV: Performance Measure Validity and Reliability

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

Action (check one):

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

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

Survey deficiency data are maintained in the federal 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 ensure accurate and consistent reporting.

Office of Legislative Affairs – July 2018

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 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 ensure accurate and consistent reporting.

Office of Legislative Affairs – July 2018

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 Versa Regulation (VR).

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

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

Office of Legislative Affairs – July 2018

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 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 ensure accurate and consistent reporting.

Office of Legislative Affairs – July 2018

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:
Annual state licensure surveys for non-accredited hospitals; complaint investigations where risk management related tags were cited; and Code 15 investigations for hospitals. 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 Versa Regulation (VR) are centrally collected. Centralized collection of data and management review of supporting data ensure accurate and consistent reporting.

Office of Legislative Affairs – July 2018

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 #47: Percent of New Medicaid Recipients Voluntarily Selecting Managed Care Plan

Action (check one):

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

Proposed Change to Measure:
Program should be changed to Health Care Services, and Service/Budget Entity should be changed to Executive Direction and Support Services/68500200.

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

Proposed Standard/Target:
Based on SSEC estimates.

Validity:
N/A

Reliability:
N/A

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

Office of Legislative Affairs – July 2018

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 2018

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 2018

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:
Versa Regulation (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 2018

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 data base, as the call was taken. This number was provided to the Agency Contract Manager on a monthly basis as part of the reporting, required by the contract terms. 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 2018

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:
Survey data are maintained in the federal ASPEN and centrally collected. This allows a count of the actual number of surveys conducted during any given period. Centralized aggregation of this data will ensure consistency among several facility types.

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 2018

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. The number of days between the two dates are calculated and an average of this data is taken.

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 2018

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 2018

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:
Projects are logged into the system by facility number, project number and submission number. There can be multiple projects and submissions per facility.

Reliability:
Data is randomly checked against manual source material to ensure accuracy.

Office of Legislative Affairs – July 2018

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Executive Direction and Support Services/68500200
Measure #54: Number of New Enrollees Provided with Choice Counseling

Action (check one):

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

Proposed Change to Measure:
Program should be changed to Health Care Services, and Service/Budget Entity should be changed to Executive Direction and Support Services/68500200.

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

Proposed Standard/Target:
Based on SSEC estimates.

Validity:
N/A

Reliability:
N/A

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

Office of Legislative Affairs – July 2018

LRPP Exhibit IV: Performance Measure Validity and Reliability

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

Action (check one):

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

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

Data Sources and Methodology: The data source is Versa Regulation (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 = percent of renewal applications that were submitted online.

Proposed Standard/Target: 60%

Validity: The target is based on provider responses to the customer service survey regarding the preference of online application submission to paper application submission. The measure is a valid way to identify the level of adoption of the online licensing system and whether or not it has been successful based on 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 2018

LRPP Exhibit IV: Performance Measure Validity and Reliability

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

Action (check one):

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

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

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

Proposed Standard/Target:
3 Business Days

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

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

Office of Legislative Affairs – July 2018

LRPP Exhibit IV: Performance Measure Validity and Reliability

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

Action (check one):

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

Proposed Change to Measure:

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

Proposed Standard/Target: 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 2018

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

	Approved Performance Measures for FY 2017-2018 (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 2017-2018 (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 2017-2018 (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 2017-2018 (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 2017-2018 (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 2017-2018 (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 2017-2018 (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 2017-2018 (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 2017-2018 (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 2017-2018 (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 2017-2018 (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 2017-2018 (Words)		Associated Activities Title
Program: Health Care Regulation		**Code: 68700700**
36	Percent of nursing home facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
37	Percent of investigations of alleged unlicensed facilities and programs that have been previously issued a cease and desist order that are confirmed as repeated unlicensed activity	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
38	Percent of Priority I consumer complaints about licensed facilities and programs that are investigated within 48 hours	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
38A	New Measure - Percent of Priority I consumer complaints about licensed facilities and programs that are investigated within two business days	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020

Approved Performance Measures for FY 2017-2018 (Words)		Associated Activities Title
39	Percent of accredited hospitals and ambulatory surgical centers cited for not complying with life safety, licensure or emergency access standards	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
40	Percent of validation surveys that are consistent with findings noted during the accreditation survey	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
41	Percent of assisted living facilities with deficiencies that pose a serious threat to the health, safety or welfare of the public	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
42	Percent of home health facilities with deficiencies that pose a serious threat to the health, safety or welfare of the public	Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020

Approved Performance Measures for FY 2017-2018 (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 2017-2018 (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 2017-2018 (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 2017-2018 (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
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 2017-18		
SECTION I: BUDGET	OPERATING		FIXED CAPITAL OUTLAY
TOTAL ALL FUNDS GENERAL APPROPRIATIONS ACT		**26,357,340,941**	**0**
ADJUSTMENTS TO GENERAL APPROPRIATIONS ACT (Supplementals, Vetoes, Budget Amendments, etc.)		**273,026,520**	**0**
FINAL BUDGET FOR AGENCY		**26,630,367,461**	**0**

SECTION II: ACTIVITIES * MEASURES	Number of Units	*(1) Unit Cost*	*(2) Expenditures (Allocated)*	*(3) FCO*
Executive Direction, Administrative Support and Information Technology (2)				0
Prepaid Health Plans - Elderly And Disabled *	559,622	13,261.12	7,421,215,723	
Prepaid Health Plans - Families *	2,225,878	2,327.68	5,181,122,250	
Elderly And Disabled/Fee For Service/Medipass - Hospital Inpatient * **Number of case months Medicaid program services purchased**	12,935	42,464.03	549,272,200	
Elderly And Disabled/Fee For Service/Medipass - Prescribed Medicines * **Number of case months Medicaid program services purchased**	55,547	6,943.89	385,712,487	
Elderly And Disabled/Fee For Service/Medipass - Case Management * **Number of case months Medicaid program services purchased**	738,912	8.40	6,207,343	
Elderly And Disabled/Fee For Service/Medipass - Hospital Insurance Benefit * **Number of case months Medicaid program services purchased**	117,021	504.93	59,087,717	
Elderly And Disabled/Fee For Service/Medipass - Other * **Number of case months Medicaid program services purchased**	62,264	20,122.22	1,252,889,971	
Women And Children/Fee For Service/Medipass - Hospital Inpatient * **Number of case months Medicaid program services purchased**	143,594	2,821.74	405,185,402	
Women And Children/Fee For Service/Medipass - Prescribed Medicines * **Number of case months Medicaid program services purchased**	268,646	438.84	117,893,764	
Women And Children/Fee For Service / Medipass - Hospital Outpatient * **Number of case months Medicaid program services purchased**	636,375	201.88	128,470,007	
Women And Children/Fee For Service / Medipass - Supplemental Medical Insurance * **Number of case months Medicaid program services purchased**	6,357,209	41.32	262,675,105	
Women And Children/Fee For Service / Medipass - Case Management * **Number of case months Medicaid program services purchased**	3,212,255	0.24	755,492	
Women And Children/Fee For Service / Medipass - Therapeutic Services For Children * **Number of case months Medicaid program services purchased**	265,925	1.50	400,000	
Women And Children/Fee For Service / Medipass - Clinic Services * **Number of case months and Medicaid program services purchased**	6,221,240	0.12	717,247	
Women And Children/Fee For Service / Medipass - Other * **Number of case months Medicaid program services purchased**	691,227	219.16	151,492,048	
Medically Needy - Hospital Inpatient * **Number of case months Medicaid program services purchased**	22,881	3,497.54	80,027,307	
Medically Needy - Prescribed Medicines * **Number of case months Medicaid program services purchased**	28,453	1,812.88	51,581,845	
Medically Needy - Hospital Outpatient * **Number of case months Medicaid program services purchased**	28,453	641.76	18,260,100	
Medically Needy - Supplemental Medical Insurance * **Number of case months Medicaid program services purchased**	59,370	605.96	35,976,070	
Medically Needy - Case Management * **Number of case months Medicaid program services purchased**	28,453	3.90	111,060	
Medically Needy - Therapeutic Services For Children * **Number of case months Medicaid program services purchased**	24,935	53.38	1,331,066	
Medically Needy - Other * **Number of case months Medicaid program services purchased**	28,453	38,129.45	1,084,897,156	
Refugees - Hospital Inpatient * **Number of case months Medicaid program services purchased**	1,470	925.22	1,360,078	
Refugees - Prescribed Medicines * **Number of case months Medicaid program services purchased**	1,470	412,625.66	606,559,727	
Refugees - Hospital Outpatient * **Number of case months Medicaid program services purchased**	1,470	595.52	875,411	
Nursing Home Care * **Number of case months Medicaid program services purchased**	43,392	81,408.60	3,532,481,781	
Home And Community Based Services * **Number of case months Medicaid program services purchased**	40,958	32,983.55	1,350,940,407	
Intermediate Care Facilities For The Developmentally Disabled - Sunland Centers * **Number of case months Medicaid program services purchased**	576	591,349.89	340,617,539	
Purchase Medikids Program Services * **Number of case months Medicaid Program services purchased**	32,581	1,779.84	57,988,815	
Purchase Children's Medical Services Network Services * **Number of case months**	11,256	11,360.44	127,873,066	
Purchase Florida Healthy Kids Corporation Services * **Number of case months**	178,902	1,494.19	267,313,595	
Certificate Of Need/Financial Analysis * **Number of certificate of need (CON) requests/financial reviews conducted**	3,223	719.32	2,318,379	
Health Facility Regulation (compliance, Licensure, Complaints) - Tallahassee * **Number of licensure/certification applications**	42,645	462.94	19,742,239	
Facility Field Operations (compliance, Complaints) - Field Offices Survey Staff * **Number of surveys and complaint investigations**	41,998	1,526.81	64,123,176	
Health Standards And Quality * **Number of transactions**	3,009,470	1.77	5,325,760	
Plans And Construction * **Number of reviews performed**	4,630	1,715.84	7,944,330	
Managed Health Care * **Number of Health Maintenance Organization (HMO) and workers' compensation arrangement surveys**	189	10,351.85	1,956,499	
Background Screening * **Number of requests for screenings**	392,244	2.27	891,059	
Subscriber Assistance Panel * **Number of cases**	176	3,705.49	652,167	
TOTAL			**25,376,079,953**	

SECTION III: RECONCILIATION TO BUDGET			
PASS THROUGHS			
TRANSFER - STATE AGENCIES			
AID TO LOCAL GOVERNMENTS			
PAYMENT OF PENSIONS, BENEFITS AND CLAIMS			
OTHER		**1,199,651,939**	
REVERSIONS		**54,635,983**	
TOTAL BUDGET FOR AGENCY (Total Activities + Pass Throughs + Reversions) - Should equal Section I above. (4)		**26,630,367,875**	

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

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.

- **FX** - Florida Health Care Connections (formerly the Medicaid Enterprise System) is the business, data, services, technical processes, and systems necessary for the administration of the Florida Medicaid Program.

- **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.

- **MES** - The Medicaid Enterprise System is the business, data, services, technical processes, and systems necessary for the administration of the Florida Medicaid Program.

- **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 disenroll 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.

Agency For Health Care Administration
2727 Mahan Drive
Tallahassee, Fl 32308
1-888-419-3456
Http://ahca.myflorida.com

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