RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

LONG RANGE PROGRAM PLAN

September 30, 2019

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

Eric Pridgeon, Staff Director
House Appropriations Committee
221 Capitol
Tallahassee, Florida 32399-1300

Cynthia Sauls 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 2020-21 through Fiscal Year 2024-25. 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 Mary C. Mayhew, Secretary for the Agency for Health Care Administration.

Respectfully Submitted,

Mary C. Mayhew
Secretary of the Agency for Health Care Administration

2727 Mahan Drive • Mail Stop 1
Tallahassee, FL 32308
AHCA.MyFlorida.com

Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL

Florida Agency for Health Care Administration

Long Range Program Plan

Fiscal Years 2020-2021 through 2024-2025

Ron DeSantis
Governor

Mary C. Mayhew
Secretary

Table of Contents

OUR MISSION

Drive transformation of the health care system to increase accountability through improved health outcomes with efficient and effective use of taxpayer resources.

OUR VISION

A high quality, safe and affordable health care delivery system for all Floridians.

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 2022-2023 and maintain 95 percent in each Fiscal Year going forward.

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 2023-2024.

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 2023 – 2024.

Objective 2.B: To increase identification of the amount of overpayments prevented by prevention activities conducted by MPI staff by 5 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 three percent per year of statewide long-term care recipients receiving care in nursing homes to community based care until no more than 35 percent of all Medicaid long-term care recipients receive care in nursing homes in accordance with the statutory provisions in s. 409.983, F.S.

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 50th percentile each year.

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

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

Agency Service Outcomes and Performance Projection Tables

Goal 1: To operate an efficient and effective government.

Health Care Regulation (Division of Health Quality Assurance)

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

Performance Projection Table 1.A:

Baseline Year FY 2018-2019	FY 2020-2021	FY 2021-2022	FY 2022-2023	FY 2023-2024	FY 2024-2025
2,907	3,219	4,292	5,097	5,097	5,097
Percent of Renewal Applications Received via Internet	60.00%	80.00%	95.00%	95.00%	95.00%

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. Rules are being developed to require providers to submit renewal applications online and are expected to be in effect by FY2021-22.

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 2018-2019	FY 2020-2021	FY 2021-2022	FY 2022-2023	FY 2023-2024	FY 2024-2025
3,459	3,113	2,940	2,767	2,421	2,421
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. To obtain the goal, the Agency will continue to publish frequently requested data and information online.

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 2020-2021	FY 2021-2022	FY 2022-2023	FY 2023-2024	FY 2024-2025
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. (Sourced: Agency and Division of IT HR records).

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 2020-2021	FY 2021-2022	FY 2022-2023	FY 2023-2024	FY 2024-2025
$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 2020-2021	FY 2021-2022	FY 2022-2023	FY 2023-2024	FY 2024-2025
$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 three percent per year of statewide long-term care recipients receiving care in nursing homes to community based care until no more than 35 percent of all Medicaid long-term care recipients receive care in nursing homes in accordance with the statutory provisions in s. 409.983, F.S.

Performance Projection Table 3.A:

Service Outcome Measures	Baseline Year FY 2013-14	FY 2020-2021	FY 2021-2022	FY 2022-2023	FY 2023-2024	FY 2024-2025
Number of Long-Term Care Recipients*	83,446	113,418	115,882	117,041	118,211	119,393
Number in Nursing Homes	45,728	50,653	47,648	44,578	41,788	37,211
Percentage in Nursing Homes	54.80%	44.63%	43.71%	40.71%	37.71%	35.00%

*Source: August 2019 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 50th percentile each year.

Service Outcome Measure Projection Table 3.B:

Service Outcome Measure	Baseline Year FY 2011	FY 2020-2021	FY 2021-2022	FY 2022-2023	FY 2023-2024	FY 2024-2025
Percentage of HEDIS measures >= 50th 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 2020-2021	FY 2021-2022	FY 2022-2023	FY 2023-2024	FY 2024-2025
Total Medicaid Member Months	41,504,316	45,525,528	45,970,308	46,406,328	46,835,928	47,259,924
Target Recipient Member Months in SMMC	35,278,669	38,696,699	39,074,762	39,445,379	39,810,539	40,170,935
Projected Recipient Member Months in SMMC	31,199,904	34,539,144	34,628,700	34,709,400	34,783,560	34,851,960
Target Percentage of Medicaid Recipient Member Months in SMMC	85.00%	85%	85%	85%	85%	85%

*Source: August 2019 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 2020-2021	FY 2021-2022	FY 2022-2023	FY 2023-2024	FY 2024-2025
Projected PMPM Costs for SMMC Enrollees	$318.69	$323.98	$332.55	$340.86	$351.09	$362.32
Estimated Growth Percentage from Previous Year	--	2%	3%	3%	3%	3%

*Source: August 2019 Social Services Caseload Estimating Conference. Actual future caseloads will change.

Linkage to Governor's Priorities

4. Health Care – Promote innovation, reduce costs and combat state crises.

AHCA Agency Goals

Improving Health Care Affordability & Transparency

- AHCA is focused on creating increased price competition among health care providers to reduce health care costs and spending through transparency and initiatives to encourage consumers to effectively shop for health care.

- AHCA is fully committed to driving innovation and transformation within the health care system by increasing patients' ability to view and access provider-level cost and quality data. Florida's health care transparency tools will empower and enable Floridians to make informed decisions using meaningful information about the cost and quality of health care services in their area.

- The Agency has enhanced the health care transparency information available to the public by expanding the nationally recognized FloridaHealthFinder.gov consumer website and implementing the complementary website, FloridaHealthPriceFinder.com.

- The Agency also redesigned the way users interact with FloridaHealthFinder.gov to make it easier for them to find the information they need, and to present both cost and quality information together on the same screen. The website's facility locator engine was reconfigured to recognize a user's general vicinity and automatically present providers within a 50 mile radius, requiring minimal "clicks" by the user. Viewers can then filter the data by the type of provider, type of services, specific location, name, or other features.

- Individual health care provider profile pages have been enhanced with direct access to the provider's "quality report card" and pricing information.

- The website's "compare" tools were also simplified, making it easier as faster for consumers to get to the information that is most meaningful to them.

5. Public Safety – Protect our communities by ensuring the health, welfare and safety of our citizens.

AHCA Agency Goals

Increasing Access to Behavioral Health Services and Community Supports

- AHCA is committed to coordinating efforts across state government to provide greater access to behavioral health services and supports.

- Embarking on Governor and First Lady DeSantis' call-to-action to ensure people with serious mental illness and substance use disorders are connected to accessible and appropriate community treatment, AHCA in April 2019 announced that federal approval had been granted to allow the Agency to create a housing assistance pilot program as part of the Florida Medicaid program.

- The Agency submitted an amendment to the state's 1115 Managed Medical Assistance (MMA) waiver, and the Centers for Medicare and Medicaid Services approved the amendment request allowing the Agency to pay for flexible services for people with severe mental illness (SMI) or substance use disorders (SUD), including, but not limited to, temporary housing assistance.

- The Agency anticipates initial implementation of the pilot program by late 2019.

- The pilot program will operate in Pinellas, Pasco, Seminole, Orange, Osceola, and Brevard counties.

- Eligible recipients will include MMA enrollees, aged 21 and older with SMI, SUD or SMI and SUD, who are homeless or at risk of homelessness due to their disability.

- The Florida Legislature has appropriated $10,000,000 annually for this initiative.

- The services that will be provided include:

    - **Transitional housing services:** services that support an individual to prepare for and transition into housing. Examples include: conducting a tenant screening and housing assessment that identifies preferences and barriers related to successful tenancy, developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, assisting with the housing application process, and developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

    - **Individual housing and tenancy sustaining services:** services that support the individual in being a successful tenant in housing arrangement and able to sustain tenancy. Examples include: education and training on the roles, rights

and responsibilities of the tenant and landlord; coaching on developing and maintaining key relationships with landlord/property managers; assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction; advocacy and linkage with community resources to prevent eviction; and coordinating with tenant to review, update, and modify their housing support and crisis plans.

- **Mobile crisis management:** intensive on-site intervention to recipients experiencing a behavioral health crisis provided by a team of behavioral health professionals who are available 24/7/365.

- **Self-help/peer support:** Person centered service promoting skills for coping with and managing symptoms while utilizing natural resources and the preservation and enhancement of community living skills with the assistance of a peer support specialist.

6. Public Integrity – Protect taxpayer resources by ensuring the faithful expenditure of public funds.

AHCA Agency Goals

Reducing the cost of Prescription Drugs

- Florida Canadian Prescription Drug Importation Program:
    - Program will provide access to lower cost high quality prescription drugs from Canada.
    - Determined anticipated cost savings to the state in excess of $150 million annually.
    - On behalf of Governor DeSantis, AHCA submitted Florida's Canadian Prescription Drug Importation Concept Paper to the U.S. Department of Health and Human Services on August 21, 2019.
    - AHCA is working on developing the specifications for the competitive solicitation for a vendor to operate the program. The solicitation will be released in 2019.

Increased Medicaid Fiscal Sustainability

- Increasing Quality and Reducing Inappropriate Utilization in Medicaid
    - AHCA has convened and will continue to convene health care providers and health plans to focus on reducing preventable emergency room use, preventable hospital readmission and admission; work toward improved birth outcomes; and improve transitions of care for elderly population.
    - AHCA has actively focused on transforming a transactional focus within Medicaid and the Managed Care plans to a pay for performance, outcomes driven payment structure.
    - Every managed care contract has current quality targets that must be achieved.
    - AHCA has organized an ongoing provider learning collaborative to target implementation of initiatives to reduce ER use for super-utilizers of the ER: Fall 2019.
    - To improve mental health quality outcomes, the Agency is implementing a federal Supportive Housing pilot in two regions of the state to provide housing support services for individuals in Medicaid with serious mental illness and/or substance use disorder who are homeless or at risk of homelessness. Pilot should be operational by late 2019.

Trends and Conditions Statements

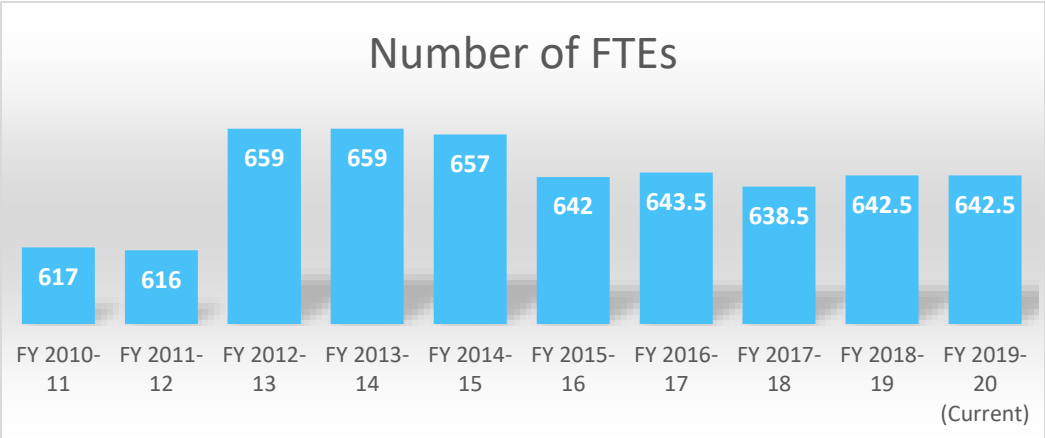
The Agency for Health Care Administration (Agency) was statutorily created by Chapter 20, F.S., as the chief health policy and planning entity for the state. The mission of the Agency is to "drive transformation of the health care system to increase accountability through improved health outcomes with efficient and effective use of taxpayer resources." 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 community stakeholders 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 to "drive transformation of the health care system to increase accountability through improved health outcomes with efficient and effective use of taxpayer resources" by administering oversight of regulated health care providers, monitoring commercial managed care organization provider network agreements, responding to consumer complaints against facilities, promoting access to health information through FloridaHealthFinder.gov, and promoting integrity in the Medicaid program.

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 following chart illustrates the changes in the number of HQA's budgetary 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.



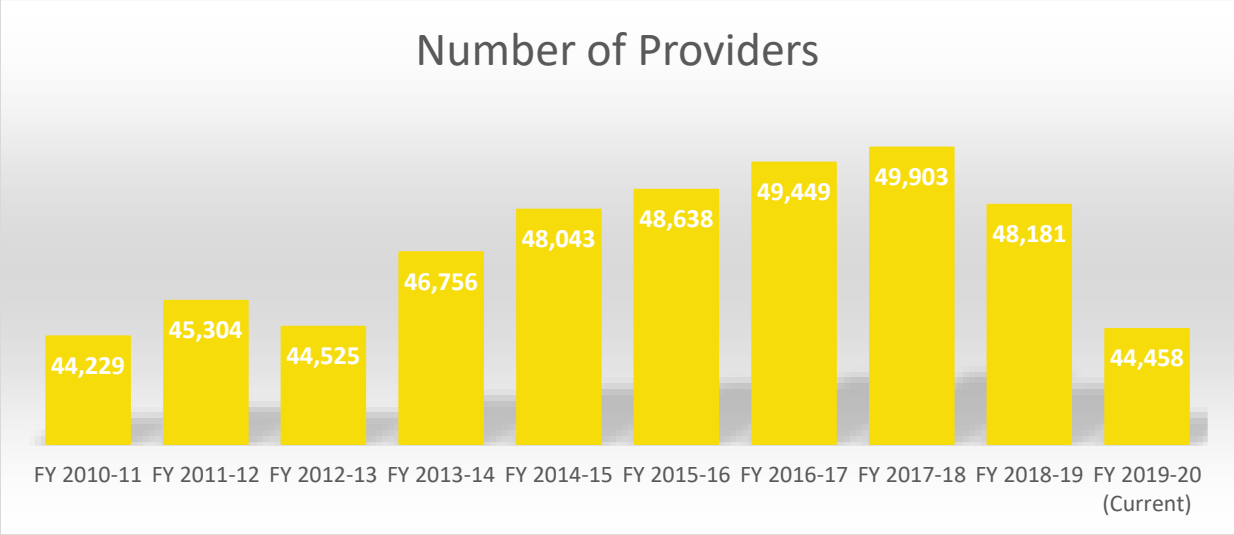
The Division's static workforce continues to be taxed by workload increases and faces challenges of recruitment, retention and increased demands. As the State Survey Agency for the state of Florida as defined under the Section 1864 Agreement, the Agency is responsible for conducting investigations and surveys of regulated health care providers. The workforce required for completion of health facility survey work requires technical expertise and many positions require a professional registered nursing license. Recruitment and retention of survey and survey management staff positions continues to be challenging given low salaries, heavy travel, supervisory duties and rigorous hours to complete the required workload timely. Priority complaints and facility onsite visits after disaster events such as hurricanes impose additional strain. The chart below illustrates the five year growth associated with survey and investigation work.

Current Workload Growth	FY 2014-15	FY 2018-19	Five Year Growth
Nursing Home Facility Related Incidents	7,041	14,003	99%
Adverse Incidents	3,599	6,551	82%
Complaints	9,154	13,108	43%
Complaint Investigations	5,653	7,917	40%
Serious Deficiencies	25,196	30,217	20%
Surveyable Provider Growth	18,107	19,601	8%
Regulatory Sanctions	1,778	3,144	77%
Regulatory FTE Growth	596	597	0%

The Division also struggles with workforce challenges in the Office of Plans and Construction, the bureau that conducts architectural plan reviews and construction surveys of all design and construction of hospitals, ambulatory surgical centers, intermediate care facilities and nursing homes to ensure that facilities are in compliance with building and life safety rules, codes and standards. Plan review and construction design requires licensed and trained architects and engineers with expansive knowledge of the highly specialized requirements for these health care facility types. The routine surveys for new construction and renovations are time sensitive and the Agency is unable to compete with industry salary averages.

Where possible, the Agency seeks to streamline operations by removing regulations that are either out-of-date or duplicative. Effective July 1, 2018, state licensure requirements were removed for clinical laboratories and health care risk managers. The Agency continues to inspect and certify clinical laboratories under the federal 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 are no longer 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. Also effective July 1, 2018, providers holding a health care clinic certificate of exemption from licensure must renew their exemption biennially. This program has historically never required renewal; it is anticipated that many exemptions are for organizations no longer in business. Thousands of health care clinic exemptions are being removed from the Agency's provider counts. Health care clinic exempt

providers were never subject to inspection as this decline does not represent workload decline. The chart below illustrates how the Agency's provider count is affected by the changes.



The following chart displays key Division workload activities for the fiscal year.

State Licensure and Federal Certification	Fiscal Year 2018-19 Volume
Licensure Applications Approved – Facilities and Providers	21,379
Facility Inspections	21,825
Nursing Home Facility Related Incidents	14,003
Financial Reviews	2,616
Plans and Construction Reviews	5,178
Complaints Reviewed	13,108
Complaints Investigated	7,917
Criminal Background Screening Checks	411,526
Criminal Background Exemption Applications	3,278
Certificate of Need Applications, Exemptions, and Notifications	124
Certificate of Need Condition Compliance Reviews	737

Consumer and Public Information	Fiscal Year 2018-19 Volume
Florida Health Finder Views	3,265,185
Consumer Calls to Call Center	48,128
Public Record Requests	3,459
Background Screening Unit Calls	96,000
Adverse Incidents Received	6,612
Electronic Health Record Incentive Payments to Hospitals	3 Payments Totaling $656,484
Electronic Health Record Incentive Payments to Providers	1,493 Payments Totaling $12,737,229
Encounter Notification Service Patient Lives in System	9.3 Million
Encounter Notification Service Alerts Delivered	13,762,926

Managed Care Regulation	Fiscal Year 2018-19 Volume
Managed Care Plan Health Care Provider Certificate Applications	48
Workers Compensation Plan Health Care Provider Certificate Applications	26
Managed Care Plan Risk Assessment Surveys	34
Balance Billing Complaints	272

Licensure Actions by Final/Emergency Order	Fiscal Year 2018-19 Volume
Immediate Moratorium on Admissions	5
Emergency Suspension Orders	10
License Surrenders	4
Denied Renewals	25
Revocations	20
Renewal Applications Withdrawn from Review	42
Denied Change of Ownership Applications	16
Fines and Fees Imposed	2,214 Totaling $3,017,176
Initial Applications Denied	41

Medicaid Program Integrity	Fiscal Year 2018-19 Volume
Medicaid Program Integrity Complaints	2,373
Referrals to Medicaid Stakeholders, Program Integrity/Anti-Fraud Professionals, and Other Related Agencies on Common Issues	852
Prevention of Overpayments to Medicaid Providers by Conducting On-Site Visits	108
Pre-Payment Reviews	10,948 Claims Reviewed
Payment Restrictions Imposed	1,043
Prevention of Overpayments	$48.0 Million
Sanctions and Managed Care Organization Assessments	303
Recovery Totals	$48.0 Million
Overpayments Identified	$18.1 Million

Facility Closures	Fiscal Year 2018-19 Volume
Failed to Renew	3,324
Closed	738
License Surrenders	28

Repeal of Certificate of Need Requirements for Hospitals and Hospital Services

Historically, new general acute care hospitals, replacement hospitals located greater than one mile from the existing location, freestanding specialty hospitals, long term care hospitals, as well as certain types of hospital services (transplant services, pediatric cardiovascular services, neonatal intensive care units, mental health services and comprehensive medical rehabilitation

units) required a certificate of need (CON) prior to construction and licensure. Applicants needed to attest to meeting certain minimum standards such as staffing, equipment and financial requirements within the CON application.

House Bill 21, Hospice Licensure (2019 Legislative Session) removed all hospital and hospital services from the necessity of receiving a CON prior to construction and licensure by July 1, 2021. This is accomplished in two phases. The first phase removed CON requirements for all Class 1 hospitals (general acute care, long-term care and rural) and any previously defined tertiary services within these Class 1 hospitals on July 1, 2019. Previously defined tertiary services include neonatal intensive care units, comprehensive medical rehabilitation units, pediatric open surgery and pediatric cardiac catherization programs, and adult and pediatric transplant programs. The second phase goes into effect on July 2, 2021 and includes specialty hospitals (children's, freestanding mental health facilities, and freestanding comprehensive medical rehabilitation).

The law change removed a barrier to the establishment of new licensed programs, therefore an increase in hospital facilities and services could be expected and would result in additional workload to the Agency in the areas of physical plant architectural, engineering plan review, licensure applications and inspections. The Agency is developing licensure rules and standards for programs for which standards previously existed in the CON statute and rules.

Emergency Status System

During Fiscal Year 2017-18, the Agency began a substantial in-house IT project 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, planning or operations for emergencies and natural disasters, as required by s. 408.821(4), F.S. Facilities have the ability to maintain their own user accounts, enter and save pre-hurricane season planning information and report situational awareness information during emergency events.

Phase I was completed in the summer of 2018, making it possible to utilize ESS for its first major event, Hurricane Michael. In its current state, ESS collects the necessary information for the Agency to effectively manage an emergency event. Phase II is underway and aims to incorporate more functionality and tools for Agency staff and partners to utilize during an emergency event.

The replacement system was built to keep a history of entries and minimized the use of free text fields, which prove to be difficult for reporting. Significant efforts to design a user-friendly interface occurred along with extensive user acceptance testing. Numerous in-person and web-based training sessions have been held for new users, both internal and external. The system feeds data outputs to a customized dashboard and several reports for ease of receiving and using information.

Agency personnel have traveled around the state to join emergency management authorities at local/regional meetings where the Agency's role in emergency management was discussed and training on ESS provided. The Agency's outreach efforts have led to 95.14 enrollment percent of all required facilities.

Hurricane Response

Agency preparation activates for Hurricane Michael began on October 7, 2018. Hurricane Michael marked the opening of the first major event for impacted regions in the Agency's new Emergency Status System. The Agency provided 24-hour technical support as needed to Emergency Support Function 8 (Health and Medical) and to the Department of Health's Patient Movement Section, while immediately began pre-storm contact and information gathering with providers while health care facilities in the Florida panhandle initiated evacuation plans.

Staff participated in State Emergency Response Team, Florida Health Care Association and Florida Hospital Association conference calls while the Agency's own Consumer Hotline was opened for 24-hour operation. A Hurricane Michael webpage was launched for continual updates as information became available. Supporting functions of the Emergency Status System provided automated reports that updated every 15 minutes to utilize.

The substantial storm made landfall in the Florida panhandle on October 10, 2018, causing massive destruction. Several health care facilities sustained severe physical plant damage, causing some facilities to request an inactive license status. Agency staff worked around the clock in conjunction with health care associations to reach out to facilities in impacted areas, conducting wellness check site visits at facilities and assisting hospitals with discharge planning issues. See below for the chart on Hurricane Michael Statistics.

Hurricane Michael Statistics*	
Evacuations – Nursing Homes	9
Power Loss – Nursing Homes	27
Damages – Nursing Homes	12
Evacuations – Assisted Living Facilities	26
Power Loss – Assisted Living Facilities	44
Damages – Assisted Living Facilities	21
Evacuations – All Reporting Facility Types (Includes NHs and ALFs)	71
Power Loss – All Reporting Facility Types (Includes NHs and ALFs)	110
Damages – All Reporting Facility Types (Includes NHs and ALFs)	57
Post-Storm Visits by Agency Surveyors	260

*Numbers represent only those reported to the Agency and may underrepresent the actual number of impacted facilities.

Agency preparation activities for Hurricane Dorian began on August 26, 2019. Staff were stationed at the State Emergency Operations Center to assist the Department of Health. An event was opened in the Agency's Emergency Status System requesting reporting for all regions in Florida. Agency field operations staff were stationed all along the east coast, including staffing the Brevard and Palm Beach County Emergency Operations Centers. A Hurricane Dorian webpage was launched with continued updates as information became available.

The Agency launched a new interactive tool designed to specify each individual licensed nursing home and assisted living facility's status related to the availability of a generator at fl-generator.com. Each facility was assigned a "Current Generator Status" from information the Agency has been collecting as facilities come into compliance with the emergency power plan rules. If a facility's permanently installed generator is not yet available, the facility must have a temporary generator onsite, a plan to have one delivered or a plan to evacuate for any

emergency power plan loss. Agency surveyors conducted 95 visits to nursing homes and assisted living facilities on the east coast with an unknown generator status to collect this information. The Agency was able to confirm that every nursing home and assisted living facility along Florida's East Coast from Palm Beach County north into Nassau County had a generator onsite or had plans to evacuate.

Post-storm activities by the Agency included wellness visits for nursing homes, assisted living facilities, adult family care homes and other residential facilities as necessary to verify resident safety. Facilities that lost power were visited daily until power was restored. Agency surveyors coordinated visits to affected facilities, prioritized based on resident acuity.
While most of Florida was spared from the impacts of Hurricane Dorian, the Bahama Islands were devastated, and the Agency's focus shifted to anticipating Florida health care facilities' bed availability information as medical evacuees were moved off the islands.

Emergency Power Plan Rules

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 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 were required to implement their emergency power plan by June 1, 2018; however, the rules allowed for extensions under certain circumstances until January 1, 2019. Florida Statutes also grant the ability for facilities to apply for a variance from the rule allowing more time to implement their emergency power plan beyond January 1, 2019. Any facility with an approved variance is required to have an adequate plan to protect patients during a power outage, such as having a temporary generator onsite, a plan to obtain a generator within 24 hours of a power outage, or a full evacuation plan.

Key reasons for delays in implementation include the availability of proper equipment, installation scheduling and mechanical engineering plan reviews and approvals. Many of these facilities are very large and require custom generators to provide proper cooling. Facilities have struggled with the inability to schedule installation for custom generators and appropriate electrical wiring and connection. Facilities must work with engineers and in some cases architects to develop implementation plans which require review and approval by local or state officials.

Onsite investigations are being conducted at noncompliant facilities. Deficiencies are cited and additional regulatory actions are initiated as appropriate.

The Agency has publicly posted a transparent interactive dashboard specifying each facility's compliance. Learn more about the emergency power plan rules and visit the dashboard here: http://ahca.myflorida.com/MCHQ/Emergency_Activities/EPP.shtml.

Governor DeSantis' Transparency Initiative

The DeSantis Administration is fully committed to driving transformation within the health care system by increasing patients' ability to view and access provider-level cost and quality data.

Florida's health care transparency tools will empower and enable Floridians to make informed decisions using facility level cost and quality data of health care services in their area. The Agency has enhanced the health care transparency information available to the public by expanding the nationally recognized FloridaHealthFinder.gov consumer website and implementing the complementary website, FloridaHealthPriceFinder.com. The Agency also redesigned the way users interact with FloridaHealthFinder.gov to make it easier for them to find the information they need, and to present both cost and quality information together on the same screen. The website's facility locator engine was reconfigured to recognize a user's general vicinity and automatically present providers within a 50-mile radius, requiring minimal "clicks" by the user. Viewers can then filter the data by the type of provider, type of services, specific location, name, or other features. The individual provider profile pages have been enhanced with direct access to the provider's "quality report card" and pricing information. The website's "compare" tools were also simplified, making it easier as faster for consumers to get to the information that is most meaningful to them.

Upon inauguration, Governor DeSantis directed the Agency for Health Care Administration to:

- Expedite the Launch of Provider-level price estimates for hospitals and ambulatory surgical centers
- Bring together price and quality information for consumers and create tools to make it easier for consumers to compare individual providers' performance and costs for specific services.
- Educate the public about available transparency tools and the importance of using reliable price and quality information.

Medicaid Behavior Analysis

Medicaid Program Integrity has been investigating a significant number of Behavior Analysis (BA) rendering and group providers believed to be engaged in fraud and abuse since March of 2017. As of August 2019:

- 114 BA providers have been referred to the Office of the Attorney General's Medicaid Fraud Control Unit.
- Overpayment recovery audits either completed or in process for 551 BA providers of which:
    - 100 cases have reached a dollar value in aggregate amount of $10,830,590.13 for closed cases; and
    - Approximately $26.3 Million in potential overpayments under review.
- Sanctions have been imposed or are in process of being imposed regarding 66 BA providers.

Home Health Agency Moratorium

In July 2013, the Centers for Medicare and Medicaid Services (CMS) imposed a moratorium on enrollment of new home health agencies in Florida Medicaid. The moratorium was initially for Miami-Dade and Monroe counties, was later (2014) expanded to include Broward County, and then (2016) expanded to a statewide moratoria. It has been continually extended, in six-month

increments, since that time. However, on January 8, 2019, the Agency for Health Care Administration was informed that the home health moratorium that had been imposed by CMS would not be automatically extended beyond January 29, 2019. Since being advised of that possibility, the Agency has been evaluating the potential risk to the Medicaid program should the moratoria cease, and CMS has agreed to continue the statewide moratorium to allow for this risk assessment and implementation of additional program safeguards.

Opioids

Although the Agency does not currently have an active fraud detection or prevention project underway regarding the national opioid epidemic, the Agency has partnered with outside resources who, with participating universities, are working to identify new ways to use data to enhance patient outcomes, control costs, and potentially identify practitioners who pose a greater fraud risk due to utilization and other risk factors. Recent CMS publications confirm that Florida's ongoing efforts, which include clinical-based payment edits, have kept opioid prescribing rates in Florida Medicaid lower than most of the rest of the nation.

Division of Information Technology

Administration and Support

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 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.

DMS – Division for State Technology (DST)

The Department of Management Services Division for State Technology (DST) was established in 2019, by the Florida Legislature, House Bill 5301, to centralize computing services and oversee the state's essential technology projects. Agencies will collaborate with the DST to develop and comply with all information technology standards. Fiscal Year 2019-2020 will be

focused on cloud service standards as the agencies are encouraged to adopt cloud computing as the preferred technology.

Cloud-First Solution Initiative

As a result of the 2019 Legislative Session, 282.206, F.S., became a new law regarding a *Cloud-first policy in state agencies* which requires the Agency to focus on cloud-based hosted IT architecture and services. IT is required to develop a strategic plan to be updated annually to address its inventory of applications located at the DST state data center.

The Agency is required to submit the strategic plan by October 15 of each year to the Office of Policy and Budget in the Executive Office of the Governor and the chairs of the legislative appropriations committees.

For each Agency application, the plan must identify and document the readiness, appropriate strategy, and high-level timeline for transition to a cloud-computing service based on the application's quality, cost, and resource requirements. This information must be used to assist the state data center in making adjustments to its service offerings and future IT procurement projects.

Vision for Information Technology

The Agency recognizes the need for critical routine operations 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:

- Address the rapidly growing need for technology to implement and support health policy legislation at the federal and state level;
- Support the increasing need for transparency and self-service aggregate analysis along with the importance of securing data from threats and inappropriate disclosure;
- Find common data-sharing exchanges between Florida's Health and Human Services Agencies for improved decision-making capabilities and the delivery of government services.

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 internal and external disparate systems;
- Automation of regulatory processes.

The second trend influencing the Agency's strategic vision is comprised of two variables: (1) the heightened concern and legal requirement to protect sensitive, personal, and confidential information; and (2) 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 for Health Care Administration recognized the need to assess its own cybersecurity vulnerabilities and began a campaign to reduce the risk of exposure and victimization. Beginning in 2016, this campaign has resulted in significant improvements in email phishing exercises and the implementation of managed 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:

- Retaining and attracting experienced skilled IT staff to relieve the Agency's existing competitive disadvantage, and through training opportunities;
- Working with other Agency divisions, the Strategic Enterprise Advisory Services (SEAS) vendor, and Florida Health Care Connections (FX) vendors to improve the governance processes for better project and portfolio management to ensure more effective strategic business alignment;
- Consolidating, modernizing, and integrating 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 chapter 59G, F.A.C., (Medicaid). Other relevant statutes that mandate the management and administration of state and federal Medicaid programs and child health insurance programs as well as the development of plans and policies for Florida's health care industry include chapters 20, 216, 393, 395, 400, 408, 409, 440, 626, and 641, F.S. Medicaid must meet federal standards, or obtain a federal waiver of such, to receive federal financial participation in the program. Although rates of federal participation vary each year and by activity, 60.87 percent of the expenditures for most Medicaid services were reimbursed with

federal funds in Fiscal Year 2018-19. 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, 2018, making it the third most populous state in the nation. Florida's growth rate has been among the fastest in the nation for decades. Between 2011 and 2018 Florida's population grew by almost 14 percent, or more than 2.5 million people.

According to U.S. Census estimates for 2018, Florida had the highest percentage of population age 65 and older accounting for more than 20 percent of the state's total population. For the state population growth between 2011 and 2018, more than 40 percent was attributable to people age 65 years and older. As the baby boom generation, those born between 1946 and 1964, reaches retirement age in the next few years and substantial numbers of retirees relocate to Florida, the demand for health care services will continue to grow. Since the elderly use more health resources per capita than younger populations, the impact of the age distribution on demand for health care will be even greater than total population growth would indicate.

In order to help manage the growth in demand for Medicaid services and to provide greater predictability of costs, Florida implemented the Statewide Medicaid Managed Care program (SMMC). The SMMC program was originally designed with 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, with full implementation on August 1, 2014.

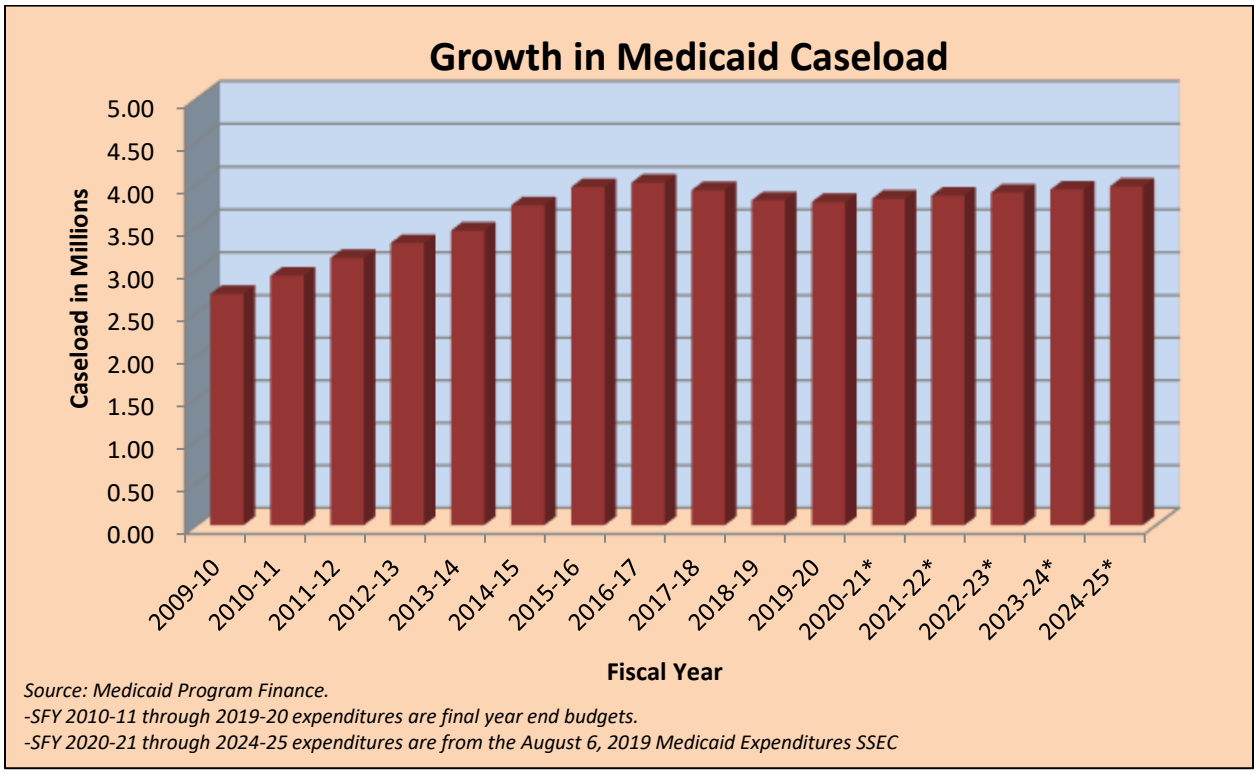
The Agency completed re-procurement for a new 5-year SMMC contract period during Fiscal Year 2018-19. Rather than having two different health plan components in the new contract period, the program now fully integrates MMA and LTC plans as well as adds stand-alone Dental plans.

The Medicaid Program

Medicaid Caseload

At the end of Fiscal Year 2018-19, Medicaid had more than 3.8 million recipients. These individuals receive health care services from more than 109,600 providers that offer services to recipients in both FFS and MMA health plans. Medicaid caseloads in Fiscal Year 2018-19 were almost 59 percent higher than a decade ago in fiscal year 2009-10 (Figure 3-1). Total caseload decreased by about one percent in Fiscal Year 2018-19, over the prior fiscal year and is projected to decrease slightly in Fiscal Year 2019-20, by approximately 0.5 percent or just under 19,000 recipients.

Figure 3-1



Source: Medicaid Program Finance.
-SFY 2010-11 through 2019-20 expenditures are final year end budgets.
-SFY 2020-21 through 2024-25 expenditures are from the August 6, 2019 Medicaid Expenditures SSEC

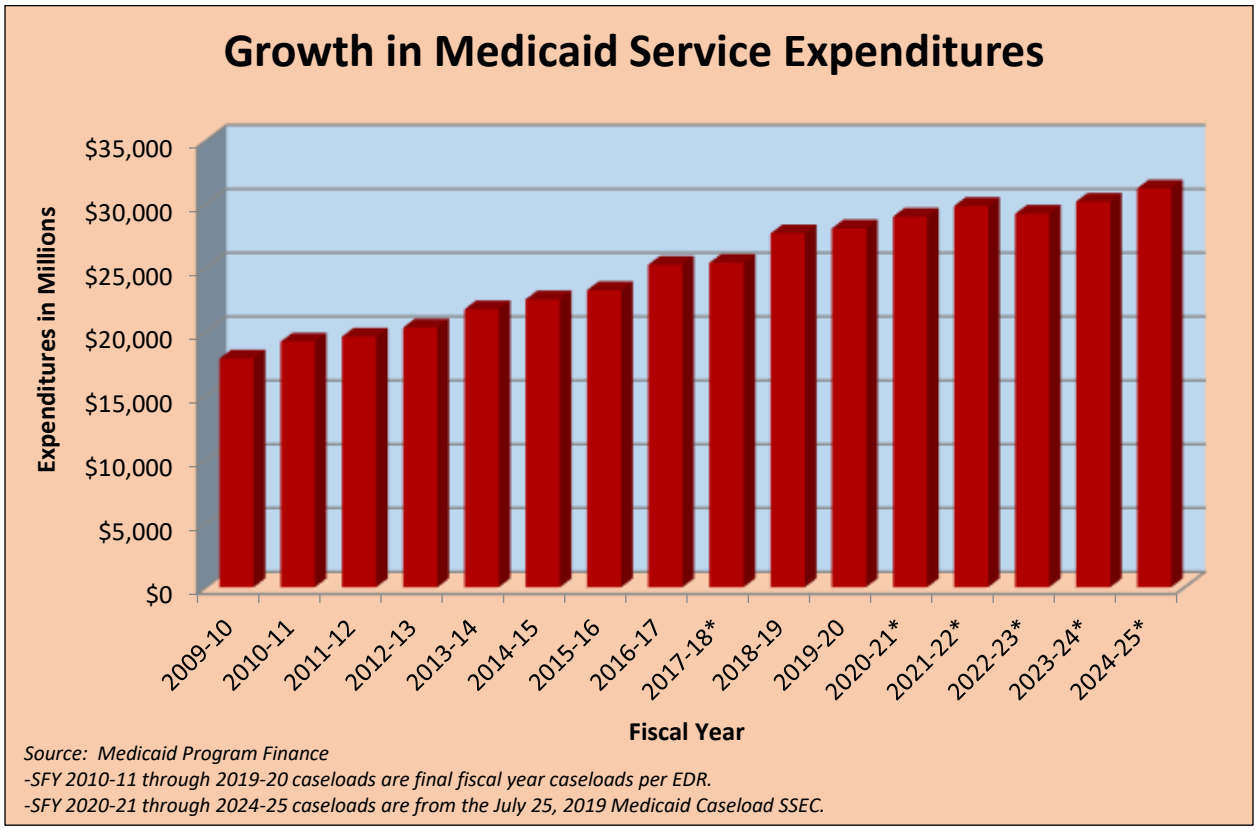
The caseload decreases in recent years reflect factors such as an improving economy, system enhancements, which auto-close the assistance group if the recipient fails to recertify, and the use of additional sources of information for income verification.

Medicaid Expenditures

With expenditures of an estimated $28.11 billion in Fiscal Year 2019-20, 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. Between Fiscal Year 2009-10 and 2018-19, expenditures in the Medicaid program grew almost 55 percent, from $17.9 billion in Fiscal Year 2009-10, to $27.7 billion in Fiscal Year 2018-19, (Figure 3-2). The primary factor contributing to expenditure growth has been an increase in the total caseload. Implementation of the Statewide Medicaid Managed Care program in 2014 helped constraint 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 2019-20, will be:

- Prepaid Health Plans ($13.67 billion);
- Prepaid Health Plan/Long-Term Care ($4.85 billion);
- Supplemental Medical Insurance (for recipients eligibile for Medicare) ($1.92 billion);
- Low Income Pool ($1.51 billion);
- Home and Community-based Services ($1.15 billion); and
- Hospital Inpatient Service ($920.58 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.

Statewide Medicaid Managed Care

Under SMMC, health plans operate on a regional basis with a total of 11 regions statewide. When first established in 2013-14, the program had two components, Managed Medical Assistance (MMA) and Long-Term Care (LTC).

SMMC Managed Medical Assistance

The MMA component of the SMMC program operates under an 1115 Demonstration Waiver and was designed to implement a statewide managed care delivery system without increasing overall program costs. The MMA program provided 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 included:

- 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.

In addition to the comprehensive array of Medicaid services that MMA plans offer (as well as Dental plans that have begun 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 alternative pain management methods, additional mental health treatments, enhanced adult hearing and vision services, and post-hospital meal delivery. Recipients choose which plan they wish to enroll in their region, which allows them to choose the plan that best fits their needs.

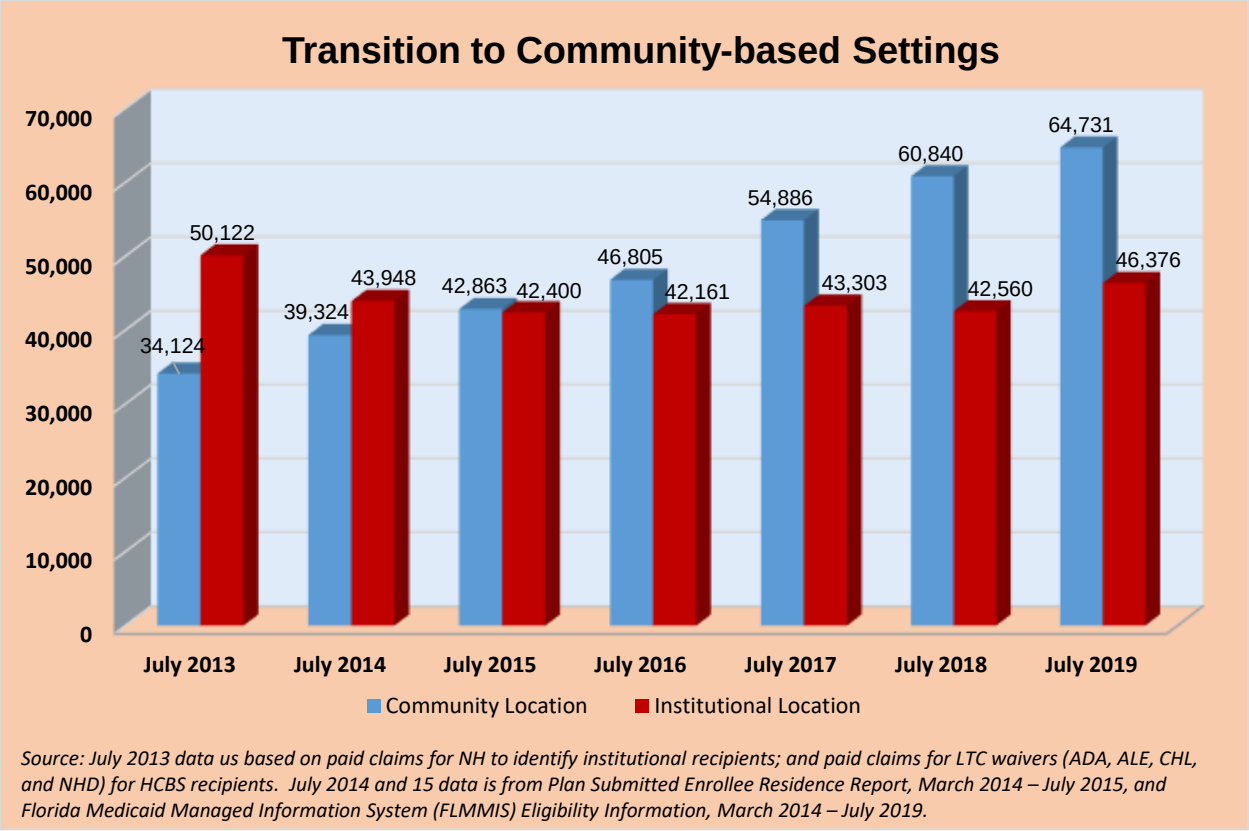
SMMC Long-Term Care

The LTC portion of the SMMC program was 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 a 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 nursing facilities 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 2019, 46,376 LTC enrollees received services in a nursing facility or institutional setting and 64,731 received services in a community setting. That means the percentage of Long-Term Care enrollees receiving services in a community setting was 58 percent, demonstrating the continued commitment to ensuring LTC enrollees access to care in community settings.

Figure 3-3



Source: July 2013 data us based on paid claims for NH to identify institutional recipients; and paid claims for LTC waivers (ADA, ALE, CHL, and NHD) for HCBS recipients. July 2014 and 15 data is from Plan Submitted Enrollee Residence Report, March 2014 – July 2015, and Florida Medicaid Managed Information System (FLMMIS) Eligibility Information, March 2014 – July 2019.

The first five years of the SMMC program were very successful. SMMC offered robust expanded benefits, enhanced provider networks, and better care management. These in turn led to improved health quality outcomes and high patient satisfaction. There has also been increased opportunity for individuals needing Long-Term Care to transition from a nursing facility to their own home or other community living.

Statewide Medicaid Managed Care Re-Procurement

During Fiscal Year 2018-19 Medicaid completed re-procurement of the health plans for the next five-year period as well as procuring dental plans as required by the Florida Legislature. Where the original SMMC program had both a 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 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 through expanded benefits and 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:

- Improved child access to dental care, with an emphasis on preventive care
- A reduction in Potentially Preventable Dental Related Emergency Department Visits

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, and emergency department use;
- Improve birth outcomes; and
- Rebalance long-term services and supports systems by increasing the percentage of enrollees receiving services in the community instead of nursing facilities.

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 more quickly so they can start serving health plan members sooner. Recipients will have better access to care when they need it, improved transportation, and the best benefits package ever with more than 55 benefits offered by health plans and extensive dental benefits offered by Dental plans at no cost to the state.

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 possible.

Medicaid Highlights and Successes During Fiscal Year 2018-19

Behavior Analysis

Florida Medicaid offers coverage of behavior analysis (BA) services for eligible recipients ages birth through 20 years old, when medically necessary. Behavior analysis services provide a way for a person to reduce unwanted behaviors and increase desired behaviors, typically in children with significant maladaptive behaviors such as children on the autism spectrum. In March 2019, 11,376 children received BA services and Medicaid had 9,439 enrolled BA services providers. Estimated expenditures for BA services for SFY2018-19 are expected to be $500 million.

In February 2017, the Applied Behavioral Analysis services transitioned to Behavior Analysis (BA) services, and AHCA promulgated rules that were designed to strengthen provider qualifications and ensure all services were reviewed for medical necessity. After a reassessment of BA services early in State Fiscal Year 2017-2018, the Agency determined that the authorization process for BA services needed to be changed and that a review of the providers furnishing these services needed to be conducted. In February 2018, the Agency changed prior authorization vendors and began enhanced enrollment reviews for new providers.

Moving forward, BA services is piloting a Multi-Displinary Team (MDT) approach to BA services. The MDT approach helps to ensure that children with special health care needs are receiving a comprehensive service package to meet their developmental and behavioral needs. Members of the team include the parent, clinicians from the Agency's prior authorization vendor, the child's health plan, and providers involved in the child's care.

The Agency is also exploring implementing a reward program that recognizes providers that exceed certain quality benchmarks by reducing the frequency of prior authorization reviews. Changes designed to strengthen the monitoring, evaluation, and reporting aspects of BA services are being implemented and by late 2019 the Agency will be implementing Electronic Visit Verification (EVV) in three regions.

Improved Quality and High Satisfaction

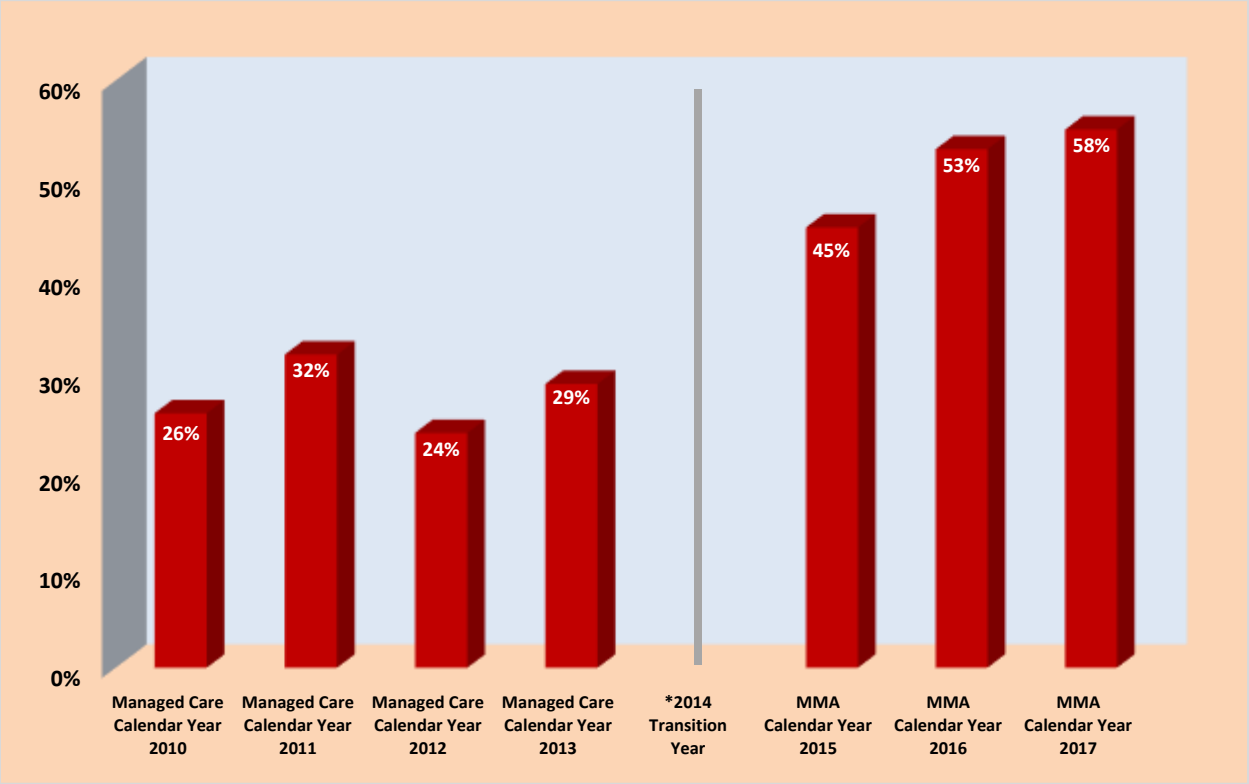
The Division of Medicaid continued to work on improving quality of health care services and has several tools that will help realize these program goals. Medicaid used multiple tools that track quality and performance in health plans. Plans are required to report Healthcare Effectiveness Data and Information Set (HEDIS) measures 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 completes annual 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. Some examples of these quality metrics include children getting immunizations, well-child checkups, prenatal visits for pregnant women, controlling high blood pressure and diabetes, and following up after a person was hospitalized for mental illness. Florida Medicaid health plans' HEDIS scores under MMA are trending upward and continue to be higher than before implementation of the program. In calendar year 2017, Florida's Medicaid health plans performed above the national average on 58 percent of HEDIS measures. Calendar year 2018 was a transition year from the prior MMA contracts to new MMA contracts and results are not yet finalized. 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. The 2019 CAHPS survey reflects a transition period from the previous to new MMA contracts but includes only those who were enrolled with the same plan for at least six consecutive months. Below are the highlights from the 2019 CAHPS results along with 2016 – 2018 results for comparison:

Adult Survey Results

CAHPS Item	Rate Description	2016	2017	2018	2019*
Rating of Health Plan	% of Respondents rating their Health Plan an 8, 9, or 10 on a scale of 0-10	73%	76%	76%	77%
Getting Needed Care	% of Respondents reporting it is usually or always easy to get needed care	80%	83%	81%	82%
Getting Care Quickly	% of respondents reporting it is usually or always easy to get care quickly	82%	84%	82%	83%
Customer Service	% of respondents reporting they usually or always get the help/info needed from their plan's customer service	88%	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%	76%

*2019 statewide rates are preliminary and may change slightly.

Child Survey Results

CAHPS Item	Rate Description	2016	2017	2018	2019
Rating of Health Plan	% of Respondents rating their Health Plan an 8, 9, or 10 on a scale of 0-10	84%	86%	85%	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%	89%
Customer Service	% of respondents reporting they usually or always get the help/info needed from their plan's customer service	88%	88%	90%	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%	88%

*2019 statewide rates are preliminary and may change slightly.
**Only one plan had sufficient responses to have a reportable rate for this item.

LTC Surveys

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 2018 survey results form a baseline for the LTC program and generally show high levels of satisfaction.

HCBS CAHPS Item	**Rate Description**	**2018 Rate across Plans**
Staff are reliable and helpful	% of respondents reporting staff is always reliable and helpful (vs. usually, sometimes, or never)	82%
Staff listen and communicate well	% of respondents reporting staff always listen and communicate well (vs. usually, sometimes, or never)	81%
Case Manager is helpful	% of respondents reporting Case Manager is always helpful (vs. usually, sometimes, or never)	89%
Choosing the services that matter to you	% of respondents reporting that staff are choosing services that matter all of the time (vs. most, some, or none)	79%
Transportation to medical appointments	% of respondents reporting always having transportation to medical appointments (vs. usually, sometimes, or never)	72%

Personal safety and respect	% of respondents reporting that staff provided them with personal safety and respect	88%
Rating of Personal Assistance and Behavioral Health Staff	% of respondents rating their Personal Assistance/ Behavioral Health Staff a 9 or 10 on a scale of 0-10	82%
Rating of Homemaker	% of respondents rating their Homemaker a 9 or 10 on a scale of 0-10	83%
Rating of Case Manager	% of respondents rating their Case Manager a 9 or 10 on a scale of 0-10	86%

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.

Statewide Information for Plans Currently Operating in Florida Counties

Plan Name	Pregnancy-related Care	Keeping Kids Healthy	Children's Dental Care	Ke
Aetna Better Health of Florida	★★★★★	★★★★☆	★★★☆☆	★
Children's Medical Services *	★☆☆☆☆	★★★★☆	★★★★☆	N/
Clear Health Alliance *	★★★☆☆	N/A	★★☆☆☆	★★
Community Care Plan	★★★★★	★★★★☆	★★★★☆	★
Florida Community Care ‡	N/R	N/R	N/R	
Florida MHS (Magellan) *	★☆☆☆☆	★☆☆☆☆	★★☆☆☆	
Humana Medical Plan, Inc.	★★★★☆	★★★★☆	★★★★☆	
Lighthouse Health Plan, LLC ‡	N/R	N/R	N/R	
Miami Children's Health Plan, LLC ‡	N/R	N/R	N/R	
Molina Healthcare of Florida, Inc.	★★★★★	★★★☆☆	★★★☆☆	★
Prestige Health Choice	★★★☆☆	★★★☆☆	★★★★☆	★
Simply Healthcare Plans, Inc.	★★★★★	★★★★☆	★★★★☆	
Staywell Health Plan	★★★★☆	★★★★☆	★★★☆☆	
Staywell Health Plan of Florida - SMI * ‡	N/R	N/R	N/R	
Sunshine Health Child Welfare Specialty Plan *	★☆☆☆☆	★★★★☆	★★★★★	
ine State Health Plan, Inc.	★★★☆☆	★★★☆☆	★★	

MMA Physician Incentive Program

Florida law requires that managed care plans use effective care management and redirect available resources to pay physicians rates which equal or exceed the Medicare rates for similar services. MPIP is designed to increase compensation for designated physician types who meet certain qualifying criteria, primarily associated with key access and performance measures. The Agency implemented this provision through the MMA Physician Incentive Program (MPIP) on October 1, 2016. At implementation, only Board Certified Pediatricians and Board Certified Obstetricians/Gynecologists who met specified criteria and/or access and quality measures were eligible for enhanced payments. Year Two increased the provider types eligible to participate in the program. Year Three of MPIP rolled out December 2018, January 2019, and February 2019 coinciding with the phased rollout of the new contract period for SMMC.

The provider types covered in Year Three include:

- Pediatric Primary Care Physicians (including General Practitioners and Family Practitioners)
- Specialist Physicians for all services provided to enrollees under the age of 21
- Obstetricians/Gynecologists

Amounts allocated for the MPIP from savings generated by effective care management in quality care are:

Year	Program Year	Allocation
FY2016-17	1	$35 million
FY2017-18	2	$170 million
FY2018-19	3	$270 million
FY2019-20	4	$298 million

Additional information is available on the Agency's website:
http://ahca.myflorida.com/medicaid/statewide_mc/qualified_providers_2018-19.shtml

Recipient and Provider Complaints

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

Number of MMA Related Complaints per 1,000 Enrollees
June 1, 2018 through June 30, 2019

	Jul-2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019
Total MMA Enrollment	3,075,778	3,075,646	3,070,190	3,068,697	3,039,665	3,037,660	3,002,593	2,991,203	2,975,428	2,972,279	2,965,432	2,963,278
Number of Complaints	870	928	741	795	729	906	1,402	1,163	1,060	1,010	1,000	1,051
Complaints per 1,000 Enrollees	0.28	0.30	0.24	0.26	0.24	0.30	0.47	0.39	0.36	0.34	0.34	0.35

Potentially Preventable Health Care Events (PPEs) and Improved Birth Outcomes

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

One opportunity for improving health care efficiencies and increasing lifesaving outcomes is identifying and reducing potentially preventable health care 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 2018-19 Medicaid completed a study of PPEs for the period July 2016 to June 2017. The Agency will use this study to design quality improvement initiatives that drive down the rates of these undesirable health care events. This study is just one example of Medicaid's commitment to improving quality of care.

SMMC health plans have committed to higher performance by reducing potentially preventable events, improving birth outcomes, improving care transitions, improving access to dental care and reducing potentially preventable dental related events. Stakeholder workgroups are working on PPE and birth outcome goals and are focused on selecting evidence-based interventions to reduce PPEs and help plans achieve their performance goals. The birth outcomes workgroup is focused on implementing evidence-based maternal and child health programs and interventions that will reduce the primary Cesarean section (C-section) rate, reduce the pre-term birth rate, and reduce the rate of Neonatal Abstinence Syndrome (NAS).

The Agency is currently exploring the use of PPEs for performance measures in the LRPP. As work with PPEs continues, the target standard can be identified by analysis of historical trends and set in accordance with Agency goals. At present, there is significant lag time in preparing and finalizing the PPE data which is prohibitive for using PPE as a LRPP measure. As processes are improved and PPE data become more current, the Agency would like to move toward using PPE as the standard.

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

Florida Health Care Connections (FX)

Current Florida Health Care Enterprise

The current Florida Health Care Enterprise consists of the Florida Medicaid Management Information System (FMMIS), a Decision Support System (DSS), 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 interconnections and touch points 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, 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. The Agency is taking a strategic, phased approach to replace the current functions of the FMMIS. FX will ultimately transition the FMMIS solution to an interoperable and unified Health Care Enterprise where individual processes, modules, and systems work together to support AHCA. The scope of 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 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, which was completed in 2018, 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 focuses 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, which includes a modern and expandable computer application communication system to use between FX applications (often referred to as an Enterprise Service Bus); This procurement was completed in 2019.;
- Replacement of the current DSS with a more robust, modern Enterprise Data Warehouse that includes other data sources to be used for FX reporting and detailed data analytics. This procurement is underway.

The Agency contracts with DXC Technology Services to act as the fiscal agent responsible for operating FMMIS and DSS. Contract extensions are vital to ensure that Florida has a fully functional FMMIS, DSS, and fiscal agent to support Medicaid operations during the interim planning and developmental periods as we transition to a new modular system.

As the FX project progresses, the Agency anticipates that as the strategy is implemented the functions currently performed in the fiscal agent contract, the FMMIS, and the DSS 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.

Looking Ahead for Medicaid

Over the next year, Medicaid is focused on moving forward with technology improvements, enhancing quality of care and accountability in the Medicaid program. Some of the areas of focus include:

- Procurement and Funding
    - Florida Health Care Connections (FX)
        - Enterprise Data Warehouse
        - Integration Services Integration Platform

- Program Implementations, Operations, and Improvements
    - Canadian Prescription Drug Importation Program
    - SMMC
    - Dental
    - Behavior Analysis
    - Telehealth
    - APD Waiver Redesign
    - Florida Medical Schools Quality Network
    - Working People With Disabilities Program

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. The new five-year contracts with SMMC health and dental plans the Agency has additional tools that will allow us to continue to advance 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 further development of Florida Health Care Connections (FX) including integration of Medicaid Enterprise Systems to improve interoperability and communication between different platforms.

Medicaid anticipates submitting legislative budget requests for provider rate increases, funding for Phase III of the FX project, and for activities to improve the overall administration of the SMMC program and Medicaid as a whole. Medicaid will evaluate program and plan performance and will continue to evaluate ways to measure and track performance as well as seeking to improve patient care and outcomes on an ongoing basis.

List of All Task Forces, Studies in Progress

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
Administration and Support including Executive Direction			
1.	Section 402.56, F.S.	Florida's Children and Youth Cabinet	Ongoing responsibilities
2.	Section 420.622(9), F.S.	Council on Homelessness	Ongoing responsibilities
3.	Section 499.01211, F.S.	Drug Wholesale Distributor Advisory Council	Ongoing responsibilities
4.	Section 1004.435(4), F.S.	Florida Cancer Control and Research Advisory Council	Annually/February 15
5.	Section 408.910, F.S.	Florida Health Choices Corporation	Ongoing responsibilities
6.	Section 627.6699(11)(b)2,F.S.	Florida Small Employer Health Reinsurance Program	Ongoing responsibilities
7.	Section 624.91, F.S.	Florida Healthy Kids Corporations Board of Directors	Ongoing responsibilities
8.	Part C of the Individuals with Disabilities Education Act as Amended by Public Law 105-17	The Florida Interagency Coordinating Council for Infants and Toddlers (FICCIT)	Ongoing responsibilities
9.	Section 395.40, F.S.	Florida Trauma System Plan Advisory Council	Ongoing responsibilities
10.	Section 409.1451(7), F.S.	Independent Living Advisory Council	Ongoing responsibilities
11.	Section 427.013, F.S.	Commission for the Transportation Disadvantaged	Ongoing responsibilities
12.	Section 14.2019, F.S.	Florida Suicide Prevention Coordinating Council	Ongoing responsibilities

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
13.	Chapter 2012-120, Laws of Florida	Statewide Task Force on Prescription Drug Abuse and Newborns	Ongoing responsibilities
14.	Section 893.055, F.S.	Prescription Drug Monitoring Program	Ongoing responsibilities
15.	Executive Order No. 07-148	Commission on Disabilities	Ongoing responsibilities
16.	Section 893.055, F.S.	Program Implementation and Oversight Taskforce on Prescription Drug Monitoring	Ongoing responsibilities
17.	Supreme Court of Florida No. AOSC16-44	Taskforce on Substance Abuse and Mental Health Issues in the Courts	Ongoing responsibilities
18.	Chapter 2014-161, Laws of Florida	Statewide Council on Human Trafficking	Ongoing responsibilities
19.	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
20.	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
Division of Health Quality Assurance			
21.	Section 408.909(9), F.S.	Annual report on Health Flex to be submitted jointly with the Office of Insurance Regulation	Annually/January 1
22.	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
23.	Section 400.191(2), F.S.	Nursing Home Guide Quarterly Report	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 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
29.	Section 429.19, F.S.	Assisted Living Facilities Annual Report on Fines	Annually/July 30
30.	Section 627.6699, F.S.	Florida Health Insurance Advisory Board (FHIAB)	Ongoing responsibilities
31.	Section 408.05(3)(c), F.S.	Internet platform to research price of health care services and perform price comparisons	Ongoing responsibilities
32.	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
33.	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
34.	Section 408.0611(4), F.S.	Annual Electronic Prescribing Report	Annually/January 31
35.	Section 408.062(1)(e), F.S.	Health Care Expenditures Report	Annually/due date unspecified
36.	Section 408.062(1)(h), F.S.	Retail prices charged by pharmacies for the 100 most frequently prescribed medications	Quarterly (met as ongoing)
37.	Section 408.062(1)(i), F.S.	Annual Report of Emergency Department Utilization and Services	Annually/January 1
38.	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
39.	Section 395.0197(8), F.S.	Quarterly and Annual summaries and trend analyses of adverse incidents	Quarterly and Annually
40.	Section 408.05(6), F.S.	State Consumer Health Information and Policy Advisory Council	Ongoing Responsibilities
41.	Section 400.60501, F.S.	Hospice outcome measures	Annually
42.	Section 408.909(9), F.S.	Annual report on Health Flex to be submitted jointly with the Office of Insurance Regulation	Annually/January 1
43.	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
Division of Information Technology			
44.	None.		
Division of Medicaid			
45.	Section 409.818, F.S.	Florida KidCare Grievance Committee	Ongoing responsibilities
46.	Section 409.91213, F.S.	Low Income Pool (LIP)	Quarterly progress reports and annual reports for 1115 waivers
47.	Section 765.53, F.S.	Organ Transplant Advisory Council	Ongoing responsibilities
48.	Section 409.91195, F.S.	Pharmaceutical and Therapeutics Committee	Ongoing responsibilities
49.	Section 16.615, F.S.	Council on the Social Status of Black Men and Boys	Ongoing responsibilities
50.	Section 409.818(2)(c), F.S.	Kid Care Coordinating Council (Membership Only)	Ongoing responsibilities
51.	Section 409.8177(2), F.S.	Florida KidCare Enrollment Report on enrollment for each component of Florida KidCare Program	Ongoing responsibilities
52.	Section 409.908(2)(b)5, F.S.	Nursing Care Cost Report: Annual Report on direct and indirect care costs	Ongoing responsibilities

Number	Implementing Bill or Statutes	Task Forces and Studies in Progress	Required/Expected Completion Date
53.	Section 409.912 (17)(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
54.	Section 409.91213, F.S.	Medicaid 1115 Waiver Quarterly Report: Agency analysis and the status of various operational areas	Ongoing responsibilities
55.	Section 409.91213, F.S.	Medicaid 1115 Waiver Annual Report: Report documenting accomplishments, project status, quantitative and case-study findings, utilization data, and policy, and administrative difficulties in the operation of the Medicaid waiver demonstration program	Ongoing responsibilities
56.	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
57.	Section 409.912(28), F.S.	EPSDT (Child Health Check-Up) Screening Rates	Ongoing responsibilities
58.	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.
59.	HB19 (2019)	Canadian RX Importation Program	Annually. Report due to the legislature December 1 of every year.
60.	SB 2502 (Implementing Bill) Sections 24 and 25 (2019)	Retroactive Eligibility Report	One time report due January 10, 2020
61.	Specific Appropriation 218 (2019 GAA)	Working People with Disabilities Program	Ongoing. Progress report due June 30, 2020
62.	Specific Appropriation Executive Direction and Support Services (2019 GAA)	Medicaid MMA Auto-Assignment Algorithm	One time report due October 1, 2019
63.	Specific Appropriation 203 and 207 (2019 GAA)	Children's Hospital Reimbursement	One time report due October 31, 2019
64.	SB 2502 (Implementing Bill) Section 26 (2019)	APD/AHCA Waiver Redesign	Final report due September 30, 2019. Additional action depending on Legislative direction.

LRPP Exhibit II: Performance Measures and Standards

Approved Performance Measures for FY 2018-2019 (Words)		Approved Base Year Standards (Numbers)	Prior Year Actual FY 2018-2019 (Numbers)	Approved Standards for FY 2019-2020 (Numbers)	Requested FY 2020-2021 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%
5	Percent of children enrolled with up-to-date immunizations	85.00%	N/A	85.00%	DELETE[4]

Approved Performance Measures for FY 2018-2019 (Words)		Approved Base Year Standards (Numbers)	Prior Year Actual FY 2018-2019 (Numbers)	Approved Standards for FY 2019-2020 (Numbers)	Requested FY 2020-2021 Standard (Numbers)
6	Percent of compliance with the standards established in the Guidelines for Health Supervision of Children and Youth as developed by the American Academy of Pediatrics for children eligible under the program	97.00%	N/A	97.00%	DELETE[4]
7	Percent of families satisfied with the care provided under the program	95.00%	93.1%	95.00%	90.00% (per national standards)
8	Total number of Title XXI-eligible children enrolled in KidCare	228,159	216,350	228,159	171,323 (per the SSEC)
9	Number of Title XXI-eligible children enrolled in Florida Healthy Kids	195,867	176,529	195,867	139,279 (per the SSEC)
10	Number of Title XXI-eligible children enrolled in MediKids	21,000	28,089	21,000	21,723 (per the SSEC)
11	Number of Title XXI-eligible children enrolled in Children's Medical Services Network	11,292	11,732	10,053	10,321 (per the SSEC)
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%
13	Average number of days between receipt of clean Medicaid claim and payment	15	10.34	15	15

	Approved Performance Measures for FY 2018-2019 (Words)	Approved Base Year Standards (Numbers)	Prior Year Actual FY 2018-2019 (Numbers)	Approved Standards for FY 2019-2020 (Numbers)	Requested FY 2020-2021 Standard (Numbers)
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%
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

Approved Performance Measures for FY 2018-2019 (Words)		Approved Base Year Standards (Numbers)	Prior Year Actual FY 2018-2019 (Numbers)	Approved Standards for FY 2019-2020 (Numbers)	Requested FY 2020-2021 Standard (Numbers)
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
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**		

Approved Performance Measures for FY 2018-2019 (Words)		Approved Base Year Standards (Numbers)	Prior Year Actual FY 2018-2019 (Numbers)	Approved Standards for FY 2019-2020 (Numbers)	Requested FY 2020-2021 Standard (Numbers)
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**		
32	Percent of hospitalizations for conditions preventable by good ambulatory care	16.00%	See New Measures 33A and 33B Below	16.00%	DELETE[4]
33	Percent of women and child hospitalizations for conditions preventable with good ambulatory care	16.00%	See New Measure 33A Below	16.00%	DELETE[4]
33A	New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions	N/A	2.92%	25.00%	20.00% (Budget Entity 68501600 no

Approved Performance Measures for FY 2018-2019 (Words)		Approved Base Year Standards (Numbers)	Prior Year Actual FY 2018-2019 (Numbers)	Approved Standards for FY 2019-2020 (Numbers)	Requested FY 2020-2021 Standard (Numbers)
	preventable by good ambulatory care): Ages 1-20 in full service capitated managed health care plans				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% (Budget Entity 68501600 no longer exists, standard should be in Medicaid Services - Individuals Budget Entity 68501400)
34	Number of case months services purchased (elderly and disabled)	1,877,040	N/A	1,877,040	DELETE[4]
35	Number of case months services purchased (families)	9,850,224	N/A	9,850,224	DELETE[4]
Program: Program: Health Care Regulation			**Code: 68700700**		
Service/Budget Entity: Health Care Regulation			**Code: 68700700**		

Approved Performance Measures for FY 2018-2019 (Words)		Approved Base Year Standards (Numbers)	Prior Year Actual FY 2018-2019 (Numbers)	Approved Standards for FY 2019-2020 (Numbers)	Requested FY 2020-2021 Standard (Numbers)
36	Percent of nursing home agencies with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0.00%	6.35%	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%	2.61%	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%	48.21%	25.00%	DELETE[4]
40	Percent of validation surveys that are consistent with findings noted during the accreditation survey	98.00%	100.00%	98.00%	DELETE[4]
41	Percent of assisted living facilities with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0.00%	0.95%	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%	1.35%	0.00%	DELETE[4]

	Approved Performance Measures for FY 2018-2019 (Words)	Approved Base Year Standards (Numbers)	Prior Year Actual FY 2018-2019 (Numbers)	Approved Standards for FY 2019-2020 (Numbers)	Requested FY 2020-2021 Standard (Numbers)
44	Percent of ambulatory surgical centers with deficiencies that pose a serious threat to the health, safety, or welfare of the public	0.00%	3.43%	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%	9.12%	0.00%	DELETE[4]
46	Percent of hospitals that fail to report serious incidents (agency identified)	6.00%	3.58%	6.00%	DELETE[4]
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]

Approved Performance Measures for FY 2018-2019 (Words)		Approved Base Year Standards (Numbers)	Prior Year Actual FY 2018-2019 (Numbers)	Approved Standards for FY 2019-2020 (Numbers)	Requested FY 2020-2021 Standard (Numbers)
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	10,029	7,550	DELETE[4]
52	Average processing time (in days) for Subscriber Assistance Program cases.	53	Program repealed July 1, 2018	53	DELETE[1]
52A	New Measure - Average processing time (in days) for Subscriber Assistance Program and Beneficiary Assistance Program cases	53	Both programs are no longer in existance	53	DELETE[4]
53	Number of construction reviews performed (plans and construction)	4,500	5,178	4,500	4,500

[1] The Agency is requesting this measure to be deleted because the Subscriber Asstistance Program was repealed on July 1, 2018.

Approved Performance Measures for FY 2018-2019 (Words)		Approved Base Year Standards (Numbers)	Prior Year Actual FY 2018-2019 (Numbers)	Approved Standards for FY 2019-2020 (Numbers)	Requested FY 2020-2021 Standard (Numbers)
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%
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
- ☐ Performance Assessment of Output Measure
- ☐ Adjustment of GAA Performance Standards
- ☐ Revision of Measure
- ☒ Deletion of Measure

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
7.70%	N/A	N/A	N/A

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

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

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

- 3A-New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): CMSN enrollees (Title XIX and Title XXI)

External Factors (check all that apply):

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

Explanation: Not solely a Medicaid program.

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

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

Recommendations: This measure should be deleted in favor of a more relevant measure. New measure 3A created to reflect current, measurable data.

Office of Legislative Affairs – July 2019

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

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

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

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

Explanation: 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
- ☐ 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 is unavailable.

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

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

Recommendations: This measure should be deleted in favor of a more relevant measure. New measure 4A created to reflect current, measurable data.

Office of Legislative Affairs – July 2019

LRPP EXHIBIT III: PERFORMANCE MEASURE ASSESSMENT

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

Action:

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

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

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

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

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

External Factors (check all that apply):

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

Explanation: Inconsistent data is collected.

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

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

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

Office of Legislative Affairs – July 2019

LRPP EXHIBIT III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Children's Special Health Care/68500100
Measure #6: Percent of Compliance with the Standards Established in the Guidelines for Health Supervision of Children and Youth as Developed by the American Academy of Pediatrics for Children Eligible under the Program

Action:

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
97.00%	N/A	N/A	N/A

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

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

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

External Factors (check all that apply):

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

Explanation: Data are not available to calculate this measure.

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

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

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

Office of Legislative Affairs – July 2019

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%	91.7%	3.3%	3.5%

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.

Office of Legislative Affairs – July 2019

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	12,843	(98,449)	-88.46%

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. 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.

Office of Legislative Affairs – July 2019

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
- ☒ 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
145,101,035	71,560,455	(73,540,580)	-50.68%

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

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

Explanation: 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 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
- ☐ 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.

Office of Legislative Affairs – July 2019

LRPP EXHIBIT III: PERFORMANCE MEASURE ASSESSMENT

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

Action:

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

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

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

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

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

• 15A-New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Ages 1 to 20 enrolled in Fee-for-Service 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 ☒ Technological Problems
☐ Legal/Legislative Change ☐ Natural Disaster
☐ Target Population Change ☐ Other (Identify)
☐ This Program/Service Cannot Fix the Problem
☐ Current Laws Are Working Against the Agency Mission

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

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

☐ Training ☐ Technology
☐ Personnel ☒ Other (Identify)

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

Office of Legislative Affairs – July 2019

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
- ☐ 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
86.00%	83.1%	(2.9%)	(3.37%)

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: 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
- ☐ Personnel
- ☐ Technology
- ☒ 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.

Office of Legislative Affairs – July 2019

LRPP EXHIBIT III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #18: Average Number of Months between Pregnancies for those Receiving Family Planning Services

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
35.00%	N/A	N/A	N/A

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

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

Explanation: This is calculated as the Total Number of Months Between Births/Total Number of Subsequent Births. Data is not available for the entire range of women receiving family planning services. There is a data lag in receiving Vital Statistics data of almost 24 months. This means that women in the Family Planning Waiver, who gave birth four years ago, only have two year's worth of follow up data available to determine whether they had a subsequent birth. This further means by default that any woman who gave birth four years ago and who subsequently had a second birth (to be included in the denominator) had 24 months or less between pregnancies. Those that have not given birth in those 24 months are excluded from the calculation because no data are available, even if they had a second pregnancy anywhere from 25 to 48 months after their first pregnancy. This artificially truncates the available period at a point below the target standard for this measure. While an alternative could theoretically be to only consider women who had been in the program at least 36 months after their first pregnancy and were therefore even technically able to achieve the standard, that bases the performance measure on something that could have happened five years in the past. A better measure (proposed in Exhibit IV - Measure 18A) would be to look at the percentage of women who have at least 24-28 months between pregnancies (a minimum of 24 months being one of the program goals of the Family Planning Waiver).

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

☐ Personnel	☒ Other (Identify)

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

Office of Legislative Affairs – July 2019

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
☒ 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
15,214,293	153,088	(15,068,902)	(99.04%)

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: 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
☐ Personnel
☐ Technology
☒ 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.

Office of Legislative Affairs – July 2019

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 2019

LRPP EXHIBIT III: PERFORMANCE MEASURE ASSESSMENT

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

Action:

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

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

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

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

Explanation: Medicaid initially sought to delete this measure in 2007 and replace it with a measure that included those receiving care in institutions or those receiving care on a FFS basis through a 1915(b)/(c) waiver. With implementation of the Long-term Care component of the Statewide Medicaid Managed Care program, all Medicaid 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 2019

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
- ☐ 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
16.00%	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 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
- ☐ 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 population.

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

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

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

• 33A-New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Ages 1-20 in full service capitated managed health care plans

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

LRPP EXHIBIT III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Prepaid Health Plan/68501600 (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
☐ 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
16.00%	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: Women and children combined account for more than 85% of the Medicaid population and the existing measure is not significantly different than that for the Medicaid population as a whole. Further, adults and children have very different conditions for which preventive care is effective for preventing hospitalizations. Combining women and children together and excluding adult males gives at best an incomplete picture of access to health care and can also yield a result that unclear or misleading. Medicaid is requesting that the existing measure be replaced with the two measures noted above (33A and 33B), i.e., one for services to Children (ages 1-20) and one for Adults (ages 20+) who are enrolled in an MMA plan. Note also that these measures should be moved under the budget item in Medicaid Service to Individuals.

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

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

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

Recommendations: *(Note also that these measures should be moved under the budget item in Medicaid Service to Individuals.)* Medicaid is requesting that the existing measure be replaced

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

Office of Legislative Affairs – July 2019

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 2019

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 2019

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%	4.33%	4.33% (Over)	200%

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 2019

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%	2.61%	1.39% (Under)	34.75%

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 2019

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 2019

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%	48.21%	23.21% (Over)	92.84%

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 2019

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
98.00%	100%	2.00% (Over)	2.04%

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: Accreditation is an evaluative process in which a health care facility undergoes an examination of its policies, procedures and performance by an external organization (accrediting body) to ensure that it is meeting predetermined criteria. The 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
- ☐ 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: This is not a measure of Agency performance.

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

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

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

Office of Legislative Affairs – July 2019

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%	0.95%	0.95% (Over)	200%

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 2019

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 2019

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%	1.35%	1.35% (Over)	200%

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 2019

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%	3.43%	3.43% (Over)	200%

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 2019

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%	9.12%	9.12% (Over)	200%

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 2019

LRPP EXHIBIT III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation
Measure #46: Percent of hospitals that fail to report serious incidents (Agency identified)

Action:

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
6.00%	3.58%	2.42% (Under)	50.52%

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

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

Explanation: 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 2019

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 2019

LRPP EXHIBIT III: PERFORMANCE MEASURE ASSESSMENT

Department: Agency for Health Care Administration
Program: Managed Health Care
Service/Budget Entity: Health Care Regulation/68700700
Measure #48A: Percent of Complaints of HMO Access to Care Received that are Investigated

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

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

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

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

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

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

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

Office of Legislative Affairs – July 2019

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 2019

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 2019

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	10,029	2,479 (Over)	28.20%

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

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

Explanation: The 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 2019

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	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: Measure is no longer applicable as the Subscriber Assistance Program was repealed on July 1, 2018.

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: Measure is no longer applicable as the Subscriber Assistance Program was repealed on July 1, 2018.

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

Recommendations: The Agency is requesting this measure to be deleted because the program was statutorily repealed.

Office of Legislative Affairs – July 2019

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	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 measure is no longer applicable as both programs have been repealed.

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. The Subscriber Assistance Program (408.7056, F.S.) was repealed on July 1, 2018.

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 2019

LRPP EXHIBIT III: PERFORMANCE MEASURE ASSESSMENT

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

Action:

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
4,500	5,178	678 (Over)	14.01%

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 2019

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 Application

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%	54.18%	24.18% (Over)	57.45%

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 2019

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	1.00 Days	2.00 Days (Under)	100.00%

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

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

Explanation: There are no external factors affecting this measure.

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

Recommendations: The Agency has no recommendations at this time.

Office of Legislative Affairs – July 2019

LRPP EXHIBIT III: PERFORMANCE MEASURE ASSESSMENT

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

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

Approved Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
N/A	3,265,185	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 health care 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 third 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 2019-20.

Office of Legislative Affairs – July 2019

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 (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.

Office of Legislative Affairs – July 2019

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: 8.50 percent, based on baseline calculations utilizing the updated AHRQ methodology, and historical trends since the new measure was proposed.

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 health care 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 2019

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 (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 2019

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 #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 90.00 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: 90.00 percent

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

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

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

While this measure should be as close to 100.00 percent as possible, there will always be some people who choose not to maintain insurance coverage through KidCare or who do not complete the re-enrollment process for reasons outside the control of the KidCare program. While 100.00 percent is ideal, it is not a realistic goal and a standard of 90 percent would reflect a historically high, but desirable outcome.

Office of Legislative Affairs – July 2019

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 (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.

Office of Legislative Affairs – July 2019

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 (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 are unobtainable.

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

Office of Legislative Affairs – July 2019

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.

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.

Office of Legislative Affairs – July 2019

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.

Office of Legislative Affairs – July 2019

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.

Office of Legislative Affairs – July 2019

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. 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.

Office of Legislative Affairs – July 2019

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Executive Direction and Support Services/68500200
Measure #12: Program administrative costs as a percent of total program costs

Action (check one):

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

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

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

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

Office of Legislative Affairs – July 2019

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Executive Direction and Support Services/68500200
Measure #13: Average number of days between receipt of clean Medicaid claim and payment

Action (check one):

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

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

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

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

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

Office of Legislative Affairs – July 2019

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Action (check one):

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

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.

Office of Legislative Affairs – July 2019

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Action (check one):

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

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

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

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

a. Sixth Omnibus Budget Reconciliation Act (SOBRA) for pregnant women;
b. Women eligible for Medicaid through the Family Planning Waiver;
c. Medicaid recipients domiciled or residing in an institution, including nursing facilities, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an Intermediate Care Facility/Developmentally Disabled (ICF/DD);
d. Medicaid recipients whose eligibility was determined through the medically needy program;
e. Qualified Medicare Beneficiaries (QMBs);
f. Special Low-Income Medicare Beneficiaries (SLMBs) or Qualified Individuals at Level 1 (QI-1s);

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

Proposed Standard/Target: 2.00 percent, based on baseline calculations utilizing the updated AHRQ methodology and historical trends since the baseline was established.

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 health care services, from national to local levels. AHRQ is a highly respected national body that has developed survey tools and evaluation programs in use around the country and maintains a database of findings from other states that utilize their tools.

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

Office of Legislative Affairs – July 2019

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Action (check one):

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

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

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

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

a. Sixth Omnibus Budget Reconciliation Act (SOBRA) for pregnant women;
b. Women eligible for Medicaid through the Family Planning Waiver;
c. Medicaid recipients domiciled or residing in an institution, including nursing facilities, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an Intermediate Care Facility/Developmentally Disabled (ICF/DD);
d. Medicaid recipients whose eligibility was determined through the medically needy program;
e. Qualified Medicare Beneficiaries (QMBs);
f. Special Low-Income Medicare Beneficiaries (SLMBs) or Qualified Individuals at Level 1 (QI-1s);
g. Title XXI-funded children with chronic conditions who are enrolled in CMSN;
h. Women eligible for Medicaid due to breast and/or cervical cancer;
i. Individuals eligible under a hospice-related eligibility group; and,
j. Individuals enrolled in a managed care plan.

Proposed Standard/Target: 7.50 percent, based on baseline calculations utilizing the updated AHRQ methodology and historical trends since the baseline was established.

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 health care services, from national to local levels. AHRQ is a highly respected national body that has developed survey tools and evaluation programs in use around the country and maintains a database of findings from other states that utilize their tools.

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

Office of Legislative Affairs – July 2019

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Office of Legislative Affairs – July 2019

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

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: 65.0 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.

Office of Legislative Affairs – July 2019

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #19: Percent of eligible children who received 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. Data are presented on Line 6 of that report as "Participation Percentage." The report is extracted from FMMIS using specified procedure codes and the utilization reports required from the Health plans.

Proposed Standard/Target: 65.0 percent

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 Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #20: Number of children ages 1-20 enrolled in Medicaid

Action (check one):

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

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.

Office of Legislative Affairs – July 2019

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #21: Number of children receiving EPSDT services

Action (check one):

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

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 are 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.

Office of Legislative Affairs – July 2019

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #22: Number of hospital inpatient services provided to children

Action (check one):

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

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 Florida Medicaid Management Information System (FMMIS), subject to regular monitoring by state staff and an annual SAS 70 audit.

Office of Legislative Affairs – July 2019

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #23: Number of physician services provided to children

Action (check one):

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

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 Florida Medicaid Management Information System (FMMIS), subject to regular monitoring by state staff and an annual SAS 70 audit.

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #24: Number of prescribed drugs provided to children

Action (check one):

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

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 Florida Medicaid Management Information System (FMMIS), subject to regular monitoring by state staff and an annual SAS 70 audit.

Office of Legislative Affairs – July 2019

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #25: Number of hospital inpatient services provided to elders

Action (check one):

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

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 Florida Medicaid Management Information System (FMMIS), subject to regular monitoring by state staff and an annual SAS 70 audit.

Office of Legislative Affairs – July 2019

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #26: Number of physician services provided to elders

Action (check one):

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

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 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 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 Florida Medicaid Management Information System (FMMIS), subject to regular monitoring by state staff and an annual SAS 70 audit.

Office of Legislative Affairs – July 2019

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Action (check one):

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

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

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

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

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

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

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

Office of Legislative Affairs – July 2019

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Services to Individuals/68501400
Measure #28: Number of children enrolled in the Medicaid Expansion

Action (check one):

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

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

Validity: N/A

Reliability: N/A

Office of Legislative Affairs – July 2019

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Long-Term Care /68501500
Measure #29: Percent of hospitalizations for conditions preventable with good ambulatory care

Action (check one):

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

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Prepaid Health Plans/ 68501600
Measure #32: Percent of hospitalizations for conditions preventable 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
- 33B-New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Ages 21 and over in full service capitated managed health care plans.

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Prepaid Health Plans/ 68501600
Measure #33: Percent of women and child hospitalizations 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 unclear or misleading. Medicaid is requesting that the existing measure be replaced with the two measures #33A and #33B, i.e., one for services to Children (ages 1-20) and one for Adults (ages 20+) who are enrolled in an MMA plan. Note also that these measures should be moved under the budget item in Medicaid Service to Individuals.

Office of Legislative Affairs – July 2019

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Action (check one):

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

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

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

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

a. Sixth Omnibus Budget Reconciliation Act (SOBRA) for pregnant women;
b. Women eligible for Medicaid through the Family Planning Waiver;
c. Medicaid recipients domiciled or residing in an institution, including nursing facilities, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an Intermediate Care Facility/Developmentally Disabled (ICF/DD);
d. Medicaid recipients whose eligibility was determined through the medically needy program;
e. Qualified Medicare Beneficiaries (QMBs);
f. Special Low-Income Medicare Beneficiaries (SLMBs) or Qualified Individuals at Level 1 (QI-1s);
g. Title XXI-funded children with chronic conditions who are enrolled in CMSN;
h. Women eligible for Medicaid due to breast and/or cervical cancer;
i. Individuals eligible under a hospice-related eligibility group; and,
j. Individuals enrolled in a managed care plan.

Proposed Standard/Target: 5.00 percent, based on baseline calculations utilizing the updated AHRQ methodology and historical trends since the baseline was established.

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 health care services, from national to local levels. AHRQ is a highly respected national body that has developed survey tools and evaluation programs in use around the country and maintains a database of findings from other states that utilize their tools.

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

Office of Legislative Affairs – July 2019

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

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

Action (check one):

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

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

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

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

a. Sixth Omnibus Budget Reconciliation Act (SOBRA) for pregnant women;
b. Women eligible for Medicaid through the Family Planning Waiver;
c. Medicaid recipients domiciled or residing in an institution, including nursing facilities, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an Intermediate Care Facility/Developmentally Disabled (ICF/DD);
d. Medicaid recipients whose eligibility was determined through the medically needy program;
e. Qualified Medicare Beneficiaries (QMBs);
f. Special Low-Income Medicare Beneficiaries (SLMBs) or Qualified Individuals at Level 1 (QI-1s);
g. Title XXI-funded children with chronic conditions who are enrolled in CMSN;
h. Women eligible for Medicaid due to breast and/or cervical cancer;
i. Individuals eligible under a hospice-related eligibility group; and,
j. Individuals enrolled in a managed care plan.

Proposed Standard/Target: 7.50 percent, based on baseline calculations utilizing the updated AHRQ methodology and historical trends since the baseline was established.

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 health care services, from national to local levels. AHRQ is a highly respected national body that has developed survey tools and evaluation programs in use around the country and maintains a database of findings from other states that utilize their tools.

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

Office of Legislative Affairs – July 2019

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Services
Service/Budget Entity: Medicaid Prepaid Health Plan/68501600 [Budget Entity No Longer Valid]
Measure #34: Number of case months services purchased (elderly and disabled)

Action (check one):

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

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

Validity: N/A

Reliability: N/A

Office of Legislative Affairs – July 2019

LRPP EXHIBIT IV: Performance Measure Validity and Reliability

Department: Agency for Health Care 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

Office of Legislative Affairs – July 2019

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 2019

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 confirmed complaints of unlicensed activity in which a location had previously been cited for unlicensed activity, divided by the total number of investigations of alleged unlicensed activity during the period.
Each confirmed complaint of unlicensed activity is maintained in the Agency's regulatory system Versa Regulation (VR). A complaint is confirmed if a tag for unlicensed activity is cited on survey.

Validity: Complaints of alleged unlicensed activity are categorized in their own code, "555," for locations that have never held a license with the Agency. Unlicensed activity can also occur for facilities that previously held a license. These complaints are recorded under the facility's file number.

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

Office of Legislative Affairs – July 2019

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.

Office of Legislative Affairs – July 2019

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.

Office of Legislative Affairs – July 2019

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.

Office of Legislative Affairs – July 2019

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.

Office of Legislative Affairs – July 2019

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 2019

LRPP Exhibit IV: Performance Measure Validity and Reliability

Department: Agency for Health Care Administration
Program: Health Care Regulation
Service/Budget Entity: Health Care Regulation/68700700
Measure #43: Percent of clinical laboratories with deficiencies that pose a serious threat for not complying with life safety, licensure or emergency access standards

Action (check one):

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

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

Survey deficiency data are maintained in the federal 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 2019

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 2019

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 2019

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 2019

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 2019

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 2019

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 2019

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 2019

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 2019

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 2019

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

Data Sources and Methodology: As of July 1, 2018, the Subscriber Assistance Program was repealed. Data is no longer collected.

Validity: This measure should be deleted because the Subscriber Assistance Program is no longer in effect.

Reliability: The Agency is recommending deletion of this measure.

Office of Legislative Affairs – July 2019

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: The Subscriber Assistance Program and the Beneficiary Assistance Program are both no longer in existence. No data is collected.

Validity: This measure should be deleted because both programs are no longer relevant.

Reliability: The Agency is recommending deletion of this measure.

Office of Legislative Affairs – July 2019

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 2019

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 2019

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 2019

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 2019

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 health care information and has the potential to reduce public records requests and ad hoc data queries to the Agency.

Office of Legislative Affairs – July 2019

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

Approved Performance Measures for FY 2018-2019 (Words)		Associated Activities Title
Program: Administration and Support		**Code: 68200000**
1	Administrative costs as a percent of total agency costs	Executive Direction ACT0010; General Counsel/Legal ACT0020 External Affairs ACT0040; Inspector General ACT0060 Director of Administration ACT0080; Planning & Budgeting ACT0090 Grants Management ACT0190; Finance & Accounting ACT0100; Personnel Services/HR ACT0110; Mail Rm ACT0130; Contract Adm ACT0180; Procurement ACT0200; Gen Srvs Adm ACT2090
2	Administrative positions as a percent of total agency positions	Executive Direction ACT0010; General Counsel/Legal ACT0020 External Affairs ACT0040; Inspector General ACT0060 Director of Administration ACT0080; Planning & Budgeting ACT0090 Grants Management ACT0190; Finance & Accounting ACT0100; Personnel Services/HR ACT0110; Mail Rm ACT0130; Contract Adm ACT0180; Procurement ACT0200; Gen Srvs Adm ACT2090
Children's Special Health Care		**Code: 68500100**
3	Percent of hospitalizations for conditions preventable by good Ambulatory care	Purchase MediKids Program Services ACT5110 Purchase Children's Medical Services Network Services ACT5120 Purchase Children's Medical Services Network Services ACT5130

Approved Performance Measures for FY 2018-2019 (Words)			Associated Activities Title
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
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

	Approved Performance Measures for FY 2018-2019 (Words)		Associated Activities Title
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
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			Purchase MediKids Program Services ACT5110

	Approved Performance Measures for FY 2018-2019 (Words)		Associated Activities Title
	Number of Title XXI-eligible children enrolled in Children's Medical Services Network		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
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

Approved Performance Measures for FY 2018-2019 (Words)		Associated Activities Title
		Hospital Inpatient ACT 4510
		Hospital Inpatient ACT 4710
15A	New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Ages 1 to 20 enrolled in Fee-for-Service, MediPass, and Provider Service Networks	Hospital Inpatient -Elderly and Disabled/Fee-for-Service ACT4010
		Hospital Inpatient ACT4210
		Hospital Inpatient ACT 4510
		Hospital Inpatient ACT 4710
15B	New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Ages 21 and Over enrolled in Fee-for-Service, MediPass, and Provider Service Networks	Hospital Inpatient -Elderly and Disabled/Fee-for-Service ACT4010
		Hospital Inpatient ACT4210
		Hospital Inpatient ACT 4510
		Hospital Inpatient ACT 4710
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	Physician Services ACT4230

Approved Performance Measures for FY 2018-2019 (Words)			Associated Activities Title
	receiving family planning services		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
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

Approved Performance Measures for FY 2018-2019 (Words)			Associated Activities Title
			Clinic Services ACT4330
22	Number of hospital inpatient services provided to children		Hospital Inpatient ACT4210 Therapeutic Services for Children ACT4310
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

Approved Performance Measures for FY 2018-2019 (Words)			Associated Activities Title
26	Number of physician services provided to elders		Physician Services-Elderly and Disabled/ Fee-for-Service ACT4030
			Supplemental Medical Insurance-Elderly and Disabled/Fee-for-Service ACT4050
			Prescribed Medicines- Elderly and Disabled/Fee-for-Service ACT4020
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			Nursing Home Care ACT5020

Approved Performance Measures for FY 2018-2019 (Words)			Associated Activities Title
	New Measure - Percent of all hospitalizations that were for Ambulatory Sensitive Conditions (ASCs) (conditions preventable by good ambulatory care): Institutional Care and Waiver Programs		Home and Community Based Services ACT5030 Capitates Nursing Home Diversion Waiver ACT5060
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 2018-2019 (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 2018-2019 (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
39	Percent of accredited hospitals and ambulatory surgical centers		Health Facility Regulation (Compliance, Complaints) - Field Offices

	Approved Performance Measures for FY 2018-2019 (Words)		Associated Activities Title
	cited for not complying with life safety, licensure or emergency access standards		Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
40	Percent of validation surveys that are consistent with findings noted during the accreditation survey		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
41	Percent of assisted living facilities with deficiencies that pose a serious threat to the health, safety or welfare of the public		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
42	Percent of home health facilities with deficiencies that pose a serious threat to the health, safety or welfare of the public		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
43	Percent of clinical laboratories with deficiencies that pose a 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) -

Approved Performance Measures for FY 2018-2019 (Words)			Associated Activities Title
			Tallahassee ACT7020
44	Percent of ambulatory surgical centers with deficiencies that pose a serious threat to the health, safety or welfare of the public		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
45	Percent of hospitals with deficiencies that pose a serious threat to the health, safety or welfare of the public		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
46	Percent of hospitals that fail to report serious incidents (agency identified)		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
47	Percent of new Medicaid recipients voluntarily selecting managed care plan		Health Facilities and Practitioner Regulation - Medicaid Choice Counseling ACT7150
48	Percent of complaints of HMO patient dumping received that		Managed Health Care ACT7090

	Approved Performance Measures for FY 2018-2019 (Words)		Associated Activities Title
	are investigated		
48A	New Measure - Percent of complaints of HMO access to care received that are investigated		Managed Health Care ACT7090
49	Percent of complaints of facility patient dumping received that are investigated		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020
50	Number of inquiries to the call center regarding practitioner licensure and disciplinary information		Health Facility Regulation (Compliance, Licensure, Complaints) - Tallahassee ACT7020 This measure is no longer handled by the Agency. Was transferred to DOH in 2009 with renewal of call center contract.
51	Total number of full facility quality-of-care surveys conducted		Health Facility Regulation (Compliance, Complaints) - Field Offices Survey Staff ACT7030 Health Facility Regulation (Compliance, Licensure, Complaints) -

Approved Performance Measures for FY 2018-2019 (Words)			Associated Activities Title
			Tallahassee ACT7020
52	Average processing time (in days) for Statewide Provider and Subscriber Assistance Panel cases		Subscriber/Beneficiary Assistance Panel ACT7130
52A	Average processing time (in days) for Subscriber Assistance Program and Beneficiary Assistance Program (SAP/BAP) cases		Subscriber/Beneficiary Assistance Panel ACT7130
53	Number of construction reviews performed (plans and construction)		Plans & Construction ACT7080
54	Number of new enrollees provided with choice counseling		Health Facilities and Practitioner Regulation - Medicaid Choice Counseling ACT7150

Approved Performance Measures for FY 2018-2019 (Words)			Associated Activities Title
55	Percent of Renewal Applications Received Electronically via the Online Licensing Application		Health Facility Regulation (Compliance, licensure, complaints) - Tallahassee ACT7020
56	Average processing time (in days) for review of Applicant Financial Information		CON / Financial Analysis ACT7010
57	Number of FloridaHealthFinder.com website hits		Florida Center for Health Information and Transparency

Exhibit VI: Unit Cost Summary

AGENCY FOR HEALTH CARE ADMINISTRATION	FISCAL YEAR 2018-19			
SECTION I: BUDGET		OPERATING		FIXED CAPITAL OUTLAY
TOTAL ALL FUNDS GENERAL APPROPRIATIONS ACT			29,204,673,843	0
ADJUSTMENTS TO GENERAL APPROPRIATIONS ACT (Supplementals, Vetoes, Budget Amendments, etc.)			-2,101,411,873	0
FINAL BUDGET FOR AGENCY			27,103,261,970	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	13,159.66	7,364,434,584	
Prepaid Health Plans - Families *	2,225,878	2,236.85	4,978,944,418	
Elderly And Disabled/Fee For Service/Medipass - Hospital Inpatient * **Number of case months**	15,317	31,262.38	478,845,942	
Elderly And Disabled/Fee For Service/Medipass - Prescribed Medicines * **Number of case months**	55,591	5,754.48	319,897,080	
Elderly And Disabled/Fee For Service/Medipass - Physician Services * **Number of case months**	128,769	2,193.18	282,413,366	
Elderly And Disabled/Fee For Service/Medipass - Hospital Outpatient * **Number of case months**	128,769	735.36	94,692,106	
Elderly And Disabled/Fee For Service/Medipass - Supplemental Medical Insurance * **Number of case**	1,450,777	1,073.05	1,556,760,133	
Elderly And Disabled/Fee For Service/Medipass - Case Management * **Number of case months**	713,029	8.13	5,795,581	
Elderly And Disabled/Fee For Service/Medipass - Hospital Insurance Benefit * **Number of case**	123,659	431.94	53,413,736	
Elderly And Disabled/Fee For Service/Medipass - Other * **Number of case months Medicaid**	68,460	22,523.58	1,541,964,419	
Women And Children/Fee For Service/Medipass - Hospital Inpatient * **Number of case months**	170,037	2,092.06	355,728,426	
Women And Children/Fee For Service/Medipass - Prescribed Medicines * **Number of case months**	268,859	358.84	96,476,949	
Women And Children/Fee For Service / Medipass - Hospital Outpatient * **Number of case months**	699,697	182.88	127,962,478	
Women And Children/Fee For Service / Medipass - Supplemental Medical Insurance * **Number of**	6,243,411	45.56	284,477,508	
Women And Children/Fee For Service / Medipass - Case Management * **Number of case months**	3,099,738	0.23	705,377	
Women And Children/Fee For Service / Medipass - Other * **Number of case months Medicaid**	760,006	260.34	197,858,236	
Medically Needy - Hospital Inpatient * **Number of case months Medicaid program services**	23,405	3,026.97	70,846,131	
Medically Needy - Prescribed Medicines * **Number of case months Medicaid program services**	29,106	1,450.26	42,211,385	
Medically Needy - Hospital Outpatient * **Number of case months Medicaid program services**	29,106	624.42	18,174,269	
Medically Needy - Supplemental Medical Insurance * **Number of case months Medicaid program**	58,212	165.34	9,624,483	
Medically Needy - Case Management * **Number of case months Medicaid program services**	29,106	3.56	103,693	
Medically Needy - Other * **Number of case months Medicaid program services purchased**	29,106	40,268.87	1,172,065,725	
Refugees - Hospital Inpatient * **Number of case months Medicaid program services purchased**	1,457	213.42	310,951	
Refugees - Prescribed Medicines * **Number of case months Medicaid program services**	1,457	419,407.41	611,076,600	
Refugees - Hospital Outpatient * **Number of case months Medicaid program services purchased**	1,457	130.96	190,815	
Nursing Home Care *	47,157	77,302.50	3,645,353,813	
Home And Community Based Services *	59,715	23,191.65	1,384,889,458	
Intermediate Care Facilities For The Developmentally Disabled - Sunland Centers *	543	646,397.98	350,994,105	
Purchase Medikids Program Services * **Number of case months Medicaid Program services**	38,077	2,236.15	85,145,713	
Purchase Children's Medical Services Network Services * **Number of case months**	12,452	12,695.32	158,082,136	
Purchase Florida Healthy Kids Corporation Services * **Number of case months**	201,193	1,576.29	317,137,882	
Certificate Of Need/Financial Analysis * **Number of certificate of need (CON) requests/financial**	3,153	867.44	2,735,036	
Health Facility Regulation (compliance, Licensure, Complaints) - Tallahassee * **Number of**	21,379	865.50	18,503,531	
Facility Field Operations (compliance, Complaints) - Field Offices Survey Staff * **Number of surveys**	21,825	2,860.17	62,423,273	
Health Standards And Quality * **Number of transactions**	3,006,976	1.67	5,010,610	
Plans And Construction * **Number of reviews performed**	5,178	1,517.24	7,856,253	
Background Screening * **Number of requests for screenings**	411,526	2.26	931,870	
TOTAL			25,704,038,071	
SECTION III: RECONCILIATION TO BUDGET				
PASS THROUGHS				
TRANSFER - STATE AGENCIES				
AID TO LOCAL GOVERNMENTS				
PAYMENT OF PENSIONS, BENEFITS AND CLAIMS				
OTHER			1,320,884,067	
REVERSIONS			78,339,893	
TOTAL BUDGET FOR AGENCY (Total Activities + Pass Throughs + Reversions) - Should equal Section I above. (4)			27,103,262,031	

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.

- **ESS** -The Emergency Status System is used for reporting information regarding licensed health care facility emergency status, planning or operations for emergencies and natural disasters. Facilities have the ability to maintain their own user accounts, enter and save emergency planning and resource information and report situational awareness information during emergency events.

- **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.

- **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.

- **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

Printed By AHCA Multimedia Design