oppaga

Program Review

October 2001 **Report No. 01-50**

Consolidation of Medical Quality Assurance Governance Structure Only a Partial Solution

at a glance

State law divides responsibilities in the Medical Quality Assurance Program between the Department of Health and the Agency for Health Care Administration. Bifurcation has led to some duplication in program oversight as well as diffused accountability, disputes and poor coordination between staff of the two agencies. The program also has several problems unrelated to divided governance, including performance concerns and inherent conflicts in the regulatory process. A 2002 OPPAGA report will further address program performance issues.

- If the Legislature determines that the current problems are serious enough to warrant consolidating the program within a single agency, we believe that the optimal placement choice would be in the Department of Health.
- If the Legislature determines that consolidation is not warranted, we recommend that the two agencies work together to improve program accountability, controls, and coordination.

Purpose

The 2001 Legislature required OPPAGA to study the feasibility of maintaining the entire Medical Quality Assurance function of the Department of Health (DOH), including enforcement, within a single department. Our review focused on two questions.

- What problems exist because the program functions are divided between two agencies?
- What are the advantages and disadvantages of various options for placing the program within a single agency?

We focused our review on the program's activities related to regulating health care professions.

Background

The mission of the Medical Quality Assurance Program (MQA) is to protect and promote the health of all persons in Florida by regulating health care practitioners.[1] Health care professionals regulated by the program include doctors, nurses, and dentists among others (see Appendix A for a complete list of regulated professions).

The program has three major components—licensure, public information, and enforcement. Licensure is

[1] Because of our charge we did not include health care facility regulation in our review of DOH's Medical Quality Assurance function. DOH oversees only six types of facilities and the Agency for Health Care Administration investigators carry out these inspections on DOH's behalf.

intended to ensure that practitioners meet minimum standards. The public information component is intended to provide consumers with information to help them make informed decisions when selecting practitioners. The enforcement component is designed to discipline practitioners who have violated minimum standards of care and licensure requirements.

Program organization

State law divides program responsibilities between the DOH and the Agency for Health Care Administration (AHCA).

- DOH administers licensure exams, sets licensure requirements, and issues and renews licenses. DOH also disseminates information through the practitioner profiling system available on the Internet for Florida citizens to access to make informed decisions when selecting a physician. The department also provides administrative support to the professional boards.
- DOH oversees 42 regulated health care professions, including physicians, nurses, and dentists. The boards oversee licensure activities, make rules for the practice of their professions, and determine discipline for practitioners who violate board rules and other laws.
- AHCA receives and investigates complaints filed against health care practitioners and facilities, makes determinations regarding legal sufficiency, and prosecutes cases in front of the professional boards. AHCA conducts these enforcement functions through an Interagency Memorandum of Understanding with DOH.

Enforcement process

The area of program responsibility that is most divided between DOH and AHCA is the enforcement process. (See Appendix B for a flow chart of the enforcement process.) When AHCA receives a complaint filed against health care practitioners or facilities, staff determines whether it meets the state's threshold of legal sufficiency.[2] If the complaint meets this criterion, AHCA conducts an investigation by interviewing witnesses and others with knowledge about the incident and gathering documents such as medical records. Exhibit 1 shows the number of complaints and investigations for Fiscal Years 1998-99 through 2000-01.

Once the investigation is complete, AHCA legal staff prepares a recommendation about whether the evidence supports disciplinary action against the health care practitioner and presents its recommendations to the relevant professional board's probable cause panel.[3] The panel reviews documents and expert testimony and can close the complaint or, if they find probable cause, pursue disciplinary action against the practitioner. Exhibit 1 shows the number of probable cause findings and formal complaints for Fiscal Years 1998-99 through 2000-01.

Practitioners have several options once they are formally charged with a disciplinary infraction. If they agree with the charges they can negotiate a settlement agreement, like a plea bargain in a criminal case. Under the current system, both DOH and AHCA general counsels and the DOH Secretary review settlement agreements before they are presented to the boards.

Practitioners may also choose to answer the charge in an informal hearing before the full board or request a full-scale hearing before the Department of Administrative Hearings.[4] Because professional discipline can have serious

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[2] Legal sufficiency is defined broadly in statute. According to s. 456.073 *F.S.*, a complaint is legally sufficient "if it contains ultimate facts that show a violation of this chapter, of any of the practice acts relating to the professions regulated by the department, or of any rule adopted by the department or a regulatory board in the department has occurred."

[3] A probable cause panel is composed of a smaller group of board members, usually three or four members, although some boards have non-members participating on probable cause panels. Board members may take turns serving on their probable cause panels and are recused from voting with the whole board on final discipline for those cases heard before the probable cause panel.

[4] The Division of Administrative Hearings is established within the Department of Management Services (s. 20.22, *F.S.).*

consequences including the loss of licensure, many practitioners charged with violations hire attorneys.

Exhibit 1
Complaints Against Health Care Practitioners, 1998-2000 [1]

	1998-99	1999-00	2000-01
Total Complaints[2]	19,291	16,329	14,750
Investigations Completed by AHCA	5,488	6,346	5,325
Probable Cause Found	2,361	1,685	1,947
Probable Cause Not Found	4,372	4,010	4,765
Formal Complaints Filed by Boards	2,183	2,055	1,843

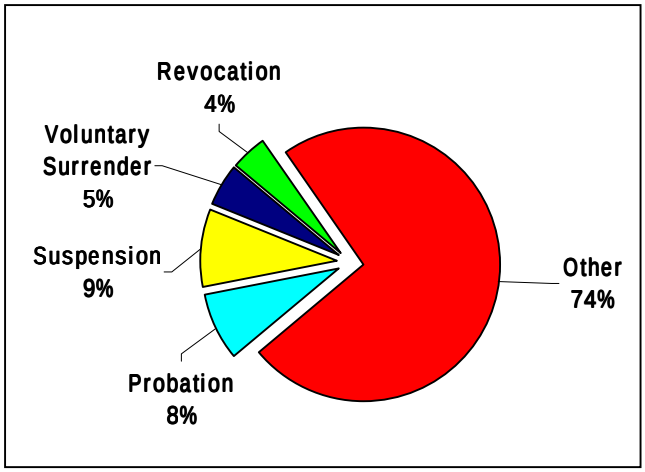
[1] Because practitioner discipline is an ongoing process, not all complaints received in a given year will result in completed investigations. In the same way, findings of probable cause and formal discipline may result from complaints filed in previous years.

[2] Total complaints does not include unlicensed activity complaints.

Source: Department of Heath and Agency for Heath Care Administration.

Exhibit 2 shows the types of discipline handed out to practitioners in Fiscal Year 2000-01. Serious discipline such as revocation or suspension composes one-fourth of all discipline while non-serious or rehabilitative discipline such as a reprimand or fine composes 74% of all practitioner discipline.

Exhibit 2
Type of Practitioner Discipline Imposed on Regulated Health Care Practitioners During Fiscal Year 2000-01



Source: Agency for Health Care Administration.

History

Until 1992 the Department of Business and Professional Regulation (formerly the Department of Professional Regulation) administered the program. In 1992 the Legislature consolidated various health care activities and regulatory functions, including the MQA program, under the newly created Agency for Health Care Administration. At that time, AHCA had responsibility for all program functions.

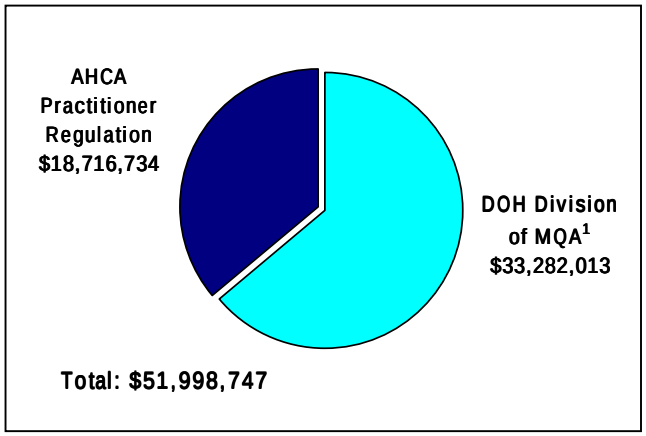
The Legislature established the current program structure in 1997 when it created the Department of Health. This legislation authorized DOH to contract with AHCA to provide consumer complaint, investigative, and prosecutorial services for the program. An Interagency Memorandum of Understanding between the two agencies governs this division of responsibility. Under this arrangement, while the Legislature appropriates funds for the program's enforcement function to AHCA, the agency cannot receive the funds without approval from DOH.

Program resources

Funding for the MQA program comes primarily from the Medical Quality Assurance Trust Fund. Established by the Legislature, the trust fund receives monies from licensure and other fees from regulated health care professions. AHCA's enforcement program has 273 full-time equivalent positions and received 36% of the program's Fiscal Year 2001-02 trust fund appropriations.

The Department of Health has 293 full-time equivalent positions allocated to program functions, and received 64% of the program's Fiscal Year 2001-02 trust fund appropriations (see Exhibit 3). Concern over the MQA trust fund has increased due to recent estimates that project a trust fund deficit of $7.7 million at the end of Fiscal Year 2002-03.

Exhibit 3
Estimated Medical Quality Assurance Trust Fund Expenditures, Fiscal Year 2001-02



[1] The Department of Health has 40 FTEs and $7.2 million in trust fund expenditures outside the division of MQA.

Source: Department of Heath and Agency for Heath Care Administration.

Findings

The program has several problems

The enforcement process involves protracted legal proceedings and a natural tension exists between boards and prosecutors that would most likely exist irrespective of whether the program were to be consolidated within a single agency. This occurs because the two functions of prosecution and adjudication of complaints have inherent conflicts that exist even in those regulatory programs that are consolidated in a single agency. For example, prosecutors may focus more on standards of evidence and whether they can make and win their case against a practitioner. Board members, because of their substantive expertise, may be convinced that the practitioner is guilty of wrongdoing and should be disciplined and may be dismayed by legal decisions not to pursue a case against a practitioner. Board members believe that the boards are held responsible for the final outcome, despite the fact that prosecutors and investigators have tremendous impact on whether practitioners are disciplined. Having boards and prosecutors within a single agency such as is the case with the Department of Business and Professional Regulation (DBPR) does not guarantee that friction will not exist. DBPR staff acknowledged that tension exists between its agency staff and the boards even with prosecutors, investigators and boards housed within the same department.

A recent OPPAGA report identified several problems with the AHCA's Health Care Practitioner Regulation program that are unrelated to its governance structure.[5] We recommended that AHCA improve its performance in responding to serious complaints against practitioners and facilities. For example, we noted that AHCA failed to take timely action to suspend practitioners who represented an immediate threat to the public. Moreover, the program did not meet its legislative performance standard for taking emergency actions against practitioners. We will examine additional performance issues further in OPPAGA's justification review of the MQA program in the spring of 2002.

[5] *Justification Review: Health Care Regulation Program Agency for Health Care Administration*, Report No. 01-24, May 2001.

The program's governance structure contributes to problems

Although the program has performance problems that are unrelated to its division between two agencies, this governance structure has led to coordination difficulties and conflicts. Specifically,

- some duplication of functions exists between the two agencies because DOH has increased program oversight in an attempt to improve AHCA performance;
- the division of responsibility hinders accountability for resolving performance problems; and
- disputes have occurred between the two agencies related to differing program priorities, disagreements over the level of control that DOH should have over the program, and disputes regarding AHCA's administrative charges assessed to the program's trust fund.

Although program responsibilities are clearly divided, some duplication exists in program oversight

In theory, Medical Quality Assurance functions are clearly divided between the two agencies. DOH has sole responsibility for administering the licensure and public information functions. The enforcement function is divided between the two agencies, and there is a clear separation of responsibilities. DOH establishes policies that AHCA is to follow in enforcing medical professional regulations. AHCA has sole responsibility for receiving and investigating complaints, making determinations regarding legal sufficiency, and prosecuting cases in front of the professional boards. The boards and panels housed under DOH, in turn, determine probable cause and disciplinary action in cases involving the misconduct of their licensees (see flowchart in Appendix B).

However, some minor duplication exists because DOH has added processes and personnel to increase oversight of AHCA activities.[6] For example, although AHCA is responsible for determining the legal sufficiency of complaints filed against health care practitioners, the DOH general counsel and Secretary review the plea agreements already approved by the AHCA general counsel. DOH also has added a budget position to the program to oversee the MQA trust fund and the financial arrangements between the agencies.

DOH also recently established a consumer advocacy section.[7] In the past, DOH would have to rely on AHCA's decision about how cases were handled. One consumer advocate position will review complaints independent of AHCA for consumers who feel inadequate attention was given to their complaint against a practitioner.

Governance structure results in diffused accountability

Management accountability is the expectation that managers are responsible for the quality and timeliness of program performance, increasing productivity, controlling costs, mitigating adverse aspects of agency operations, and assuring that programs are managed with integrity and in compliance with applicable law.

Although the Legislature can hold DOH and AHCA accountable for each portion of the program that they manage, this arrangement makes it more difficult for the Legislature to place responsibility for resolving overall performance problems clearly on one agency or the other. Moreover, by having this function split, it is easier for both agencies to place blame for performance problems on the other agency and evade taking responsibility for its own performance.

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[6] While we could not quantify the extent of duplication, we believe the amount is minor and represents the salaries of less than 1% of the total FTEs.

[7] The consumer advocacy section has additional responsibilities, such as new policies on medical errors. Since this is a new section, the department does not know how much time will be devoted to trouble-shooting enforcement problems.

One example of diffused accountability is demonstrated by cost data related to enforcement cases appealed to the Division of Administrative Hearings. In its 2002-03 Legislative Budget Request, the Division of Administrative Hearings has requested DOH pay $2.3 million for 8,564 hearing hours, which included 7,740 hours of cancelled hearings during Fiscal Year 2000-01. When an agency cancels a hearing in less than 30 days, the agency is required to pay for the hearing hours that would have occurred. DOH contends that AHCA is responsible for 98% of these cancellations costing approximately $2 million. The Division of Administration Hearings has notified DOH of these charges, as the program's administering agency. AHCA staff said it believes the costs to hold a full hearing are saved when a settlement is reached and serves to offset the cancelled hearings charges. However, they also said they were unaware of the Department of Administrative Hearings policy to charge for cancelled hearings and therefore had not sought to make practitioners repay these costs.

Agency officials dissatisfied with current structure

Officials of the two agencies cited a number of concerns with the program's divided governance structure.[8] Most of these stakeholders asserted that the program should be consolidated, although opinions varied about where the program should be located.

- Some stakeholders asserted that the missions of the two agencies are incongruous and result in different priorities being set for program staff. AHCA's mission is to assure accessible, affordable, and quality health care. Practitioner regulation is more process oriented and focuses on the steps necessary for the efficient intake, investigation and prosecution of cases. DOH's primary mission, to promote and protect the health and safety of all residents and visitors in the state, has led to a more customer service, outcome oriented approach as seen in their new consumer advocacy program. Because the program is split between the two agencies, AHCA is the point of first contact for the consumer and DOH can only address consumer concerns after the fact.
- DOH and AHCA management disagree over the level of control that DOH should have over the program. Although AHCA provides enforcement services through an Interagency Memorandum of Understanding, DOH officials told us that AHCA would not agree to include performance standards in the interagency agreement. AHCA officials said they would not agree to performance measures because database changes were incomplete and there was a backlog of cases.

  DOH managers assert that they lack control to make needed changes to the program because every policy decision is open to negotiation with AHCA. However, AHCA staff does not perceive a problem with the interagency agreement or DOH's level of program control.
- Most stakeholders we interviewed expressed concern about mistrust and poor communication between the two agencies. One example is a recent dispute involving AHCA's adoption of formal guidelines for its field investigators to use for handling abandoned medical records. DOH officials disagree with the specifics of this policy and maintain that AHCA does not have the authority to make these types of decisions. AHCA officials maintain that they repeatedly asked DOH for guidance and adopted the policy as a last resort because they never received the requested input from DOH. This matter is still in dispute.
- There is an ongoing dispute between the two agencies regarding AHCA's administrative charges to the program's trust fund for Fiscal Year 1999-00 and 2000-01. This dispute involves DOH's

[8] We interviewed DOH and AHCA staff; the seven executive directors of the health profession boards; the chairs of boards of Nursing, Medicine, Dentistry, Pharmacy, Nursing Home Administrators, Chiropractic Medicine, Massage Therapy, Psychology, and Optometry. We chose these boards based on the total number of licensees and total number of complaints filed against licensees.

refusal to release $2.3 million in trust fund reimbursement that AHCA has claimed for program administration. The Legislature resolved the issue of future administrative costs in statute in 2001. However, AHCA is still pursuing the $2.3 million rejected by DOH.

Most states unify medical quality assurance program administration

Florida's bifurcation of Medical Quality Assurance program administration is relatively rare. Most of the most populous states assign the program to a single agency. For example, the California Medical Board both licenses and disciplines medical doctors. Illinois' Department of Professional Regulation has separate licensing/testing and enforcement divisions but houses both within a single agency. Similarly, Michigan's Bureau of Health Services within its Department of Consumer and Industry Services handles complaints and oversees the investigation process, while the department's Regulatory Division conducts the investigations. Administrative law examiners preside over prosecution hearings and determine if a violation has occurred. None of the large states we reviewed divide licensure and enforcement functions as is done in Florida.

The division of governance for a regulatory program is also unique within Florida. The Department of Business and Professional Regulation regulates 38 non-health related professions and businesses, including veterinary medicine, cosmetology, landscape architecture, electrical contractors, and construction contractors. In that agency, the Division of Regulation carries out complaint intake and investigation and prosecutors are housed within the department's general counsel's office. The regulatory boards adjudicate cases and impose disciplinary penalties. A separate Division of Professions handles testing and licensure for all regulated professions. [9]

Options

We identified two options the Legislature could consider regarding the program's governance structure—maintaining the current divided governance structure or consolidating the program within a single agency. We assessed the options of consolidating the program within DOH, AHCA, and the Department of Business and Professional Regulation. Exhibit 4 summarizes the advantages and disadvantages of each option.

Conclusions and Recommendations

Some stakeholder concerns are unrelated to the program's divided governance structure. These concerns include AHCA's performance and the inherent tension that exists between regulatory boards and enforcement function. However, there is some duplication in program oversight, accountability is diffused, and mistrust and disputes occur between staff from the two agencies.

If the Legislature determines that the program should remain under the current divided governance structure, we recommend that DOH and AHCA work together to make the following changes to improve program accountability, controls, and coordination.

- Develop an Interagency Memorandum of Understanding that more clearly describes the responsibilities of each agency. The agreement should also contain reasonable performance standards for AHCA such as the length of time for final disposition of a case once the professional board has issued a finding of probable cause. [10]

[9] One exception is professional engineers who are regulated through a quasi-public/private system. Under s. 471.038, *F.S.*, the Florida Engineers Management Corporation (FEMC) provides administrative, investigative, and prosecutorial services to the Florida Board of Professional Engineers. The FEMC is a non-profit, single purpose corporation that operates through an annual contract with DBPR.

[10] While we were conducting our review the Department of Health was revising the Interagency Memorandum of Understanding to include detailed performance measures. However, the issue of performance standards has been another source of disagreement between the two agencies.

Exhibit 4
Summary of the Options for the Placement of the Medical Quality Assurance Program

Options	Advantages	Disadvantages
Option 1: Maintain the current governance structure	• No further disruption to the program • The program has made some performance improvements in recent years, including reduced case backlogs and higher numbers of practitioners sanctioned	• Continued duplication in some oversight processes and personnel • Continued diffused accountability • Continuing mistrust and poor coordination agency personnel
Option 2: Consolidate program within a single agency	• Would streamline program administration and management with a single mission and chain of command • Would increase flexibility to seek ways to reduce costs and improve performance • One agency would be responsible for setting policies on topics such as abandoned medical records and unlicensed activity investigations. • Would give continuity to the program	• May not necessarily result in improved performance • May not necessarily result in a cost savings • Does not address issues about the enforcement process • Disrupts the program, which has undergone major changes in recent years • Transition costs to move FTEs in the central program office and in the field
Consolidate within DOH	• Fits with agency mission to protect the health of Florida consumers • Program officials have expressed an interest in taking over the program and asserts it would improve performance • DOH has statutory authority for enforcement • Having a medical doctor as Secretary, required by statute, can highlight important program issues	• Department faces mounting pressures due to pending trust fund deficit and adding enforcement might further burden the program • Concern that regulatory function would overwhelm the public information function of DOH
Consolidate within AHCA	• Fits with AHCA's regulatory mission • Fits with AHCA's facility licensure and enforcement • Agency officials believe important progress has been made and momentum of these improvements would be lost unless enforcement remains at AHCA	• Would require statutory revisions to move the program from DOH to AHCA • Stakeholders we interviewed perceive strong likelihood of political opposition to a move to AHCA • Secretary of AHCA is not a medical doctor by statute • Recent OPPAGA reports have identified management problems in several AHCA programs
Consolidate within the Department of Business and Professional Regulation (DBPR)	• Fits with DBPR regulatory mission and regulation of other professions • Investigative and legal services for DBPR regulated professions are already incorporated under one agency • Similar processes for complaint investigation in place	• Would require statutory changes to move the program from DOH • Stakeholders we interviewed perceive strong political opposition if the program were moved to DBPR • Lacks in-house medical expertise

Source: OPPAGA.

- Form a group that includes both management and staff from DOH and AHCA to identify ways to improve coordination and communication.

If the Legislature determines that it wishes to consolidate the program's governance structure to address ongoing concerns, we believe that the optimal placement choice would be DOH. We believe that consolidation of the MQA program at DOH would be more feasible and easier to accomplish because DOH already has statutory authority for the program. In addition, we believe that the statutory leadership of a medical doctor is important to the program and that the drawbacks to DOH are less significant than the drawbacks related to a consolidation at AHCA or DBPR.

Agency Response

In accordance with the provisions of s. 11.45(7)(d), *Florida Statutes*, a draft of our report was submitted to the Secretaries of the Department of Health and the Agency for Health Care Administration for their review and responses. We received responses from the Department of Health and the Agency for Health Care Administration. The Department of Health generally agreed with our conclusions while the Agency for Health Care Administration generally disagreed. We believe the Agency for Health Care Administration's response underscores the conclusion of our report concerning poor communication, diffused accountability and disputes between the Agency and the Department of Health resulting from the divided governance structure of the MQA program.

The Secretaries' written responses are reprinted in Appendix C beginning on page 12.

OPPAGA provides objective, independent, professional analyses of state policies and services to assist the Florida Legislature in decision making, to ensure government accountability, and to recommend the best use of public resources. This project was conducted in accordance with applicable evaluation standards. Copies of this report in print or alternate accessible format may be obtained by telephone (850/488-0021 or 800/531-2477), by FAX (850/487-3804), in person, or by mail (OPPAGA Report Production, Claude Pepper Building, Room 312, 111 W. Madison St., Tallahassee, FL 32399-1475).

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John W. Turcotte, OPPAGA Director

Appendix A

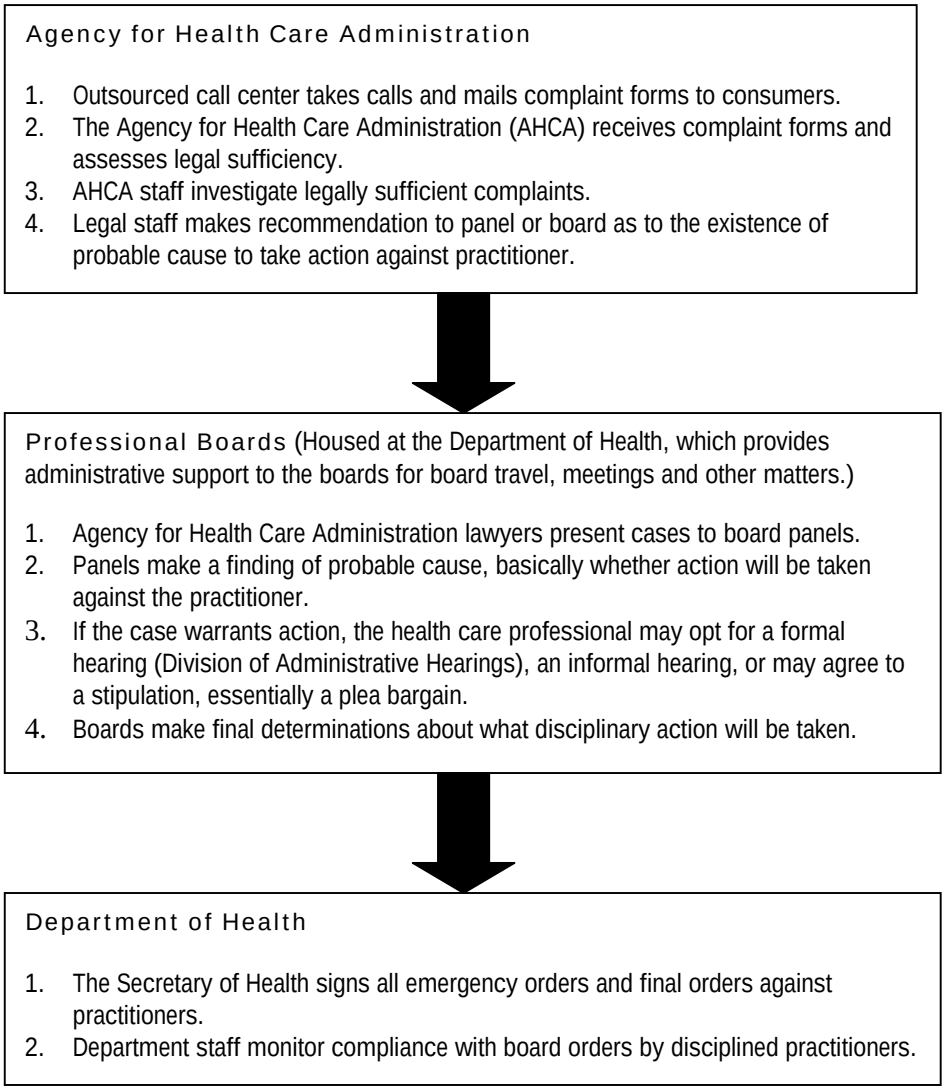
List of Regulated Health Care Professions

Regulated Health Care Professions	
Acupuncture	Naturopaths
Athletic Training	Nursing
Audiology	Nursing Home Administrators
Certified Nursing Assistants	Nutrition
Chiropractic Medicine	Occupational Therapy
Clinical Laboratory Personnel	Opticianry
Clinical Social Work	Optometry
Dental Hygiene	Orthotists
Dentistry	Osteopathic medicine
Dietetics	Pharmacy
Electrolysis	Physical Therapy
Hearing Aid Specialists	Physician Assistants
Marriage and Family Therapy	Podiatric Medicine
Massage	Prosthetists
Medical Physicists	Psychology
Medicine	Respiratory Care
Mental Health Counseling	School Psychology
Midwifery	Speech Language Pathology

Source: Department of Health.

Appendix B

Medical Quality Assurance Enforcement Flow Chart



Source: OPPAGA.

Appendix C

Responses from the Department of Health and the Agency for Health Care Administration

In accordance with the provisions of s. 11.45(7)(d), *Florida Statutes*, a draft of our report was submitted to the Secretaries of the Department of Health and the Agency for Health Care Administration to review and respond.

The Secretaries' written responses are reprinted herein beginning on page 13.

Jeb Bush
Governor

John O. Agwunobi, M.D., M.B.A.
Secretary

October 23, 2001

Mr. John W. Turcotte, Director
Office of Program Policy Analysis and
Government Accountability
111 West Madison Street
Tallahassee, FL 32399-1475

Dear Mr. Turcotte:

Thank you for your recent preliminary findings and recommendations regarding OPPAGA's *Program Review* draft report entitled "Consolidation of Medical Quality Assurance Governance Structure Only a Partial Solution."

The Division of Medical Quality Assurance, the Division of Administration, and I have reviewed the draft report and found it an observant and fair evaluation of the issues regarding the division of tasks between the Agency for Health Care Administration and the Department of Health. The Department of Health is committed to making continual Medical Quality Assurance Program improvements and will proceed as directed by the Governor and legislature. Should a transfer to the Department of Health occur, we respectfully request the simultaneous transfer of all related resources to DOH.

If I may be of further assistance, please let me know.

Sincerely,

/s/
John O. Agwunobi, M.D., M.B.A.
Secretary, Department of Health

JOA/tt

4052 Bald Cypress Way • Tallahassee, FL 32399-1701

JEB BUSH, GOVERNOR

RHONDA M. MEDOWS, MD, FAAFP, SECRETARY

October 23, 2001

Mr. John W. Turcotte, Director
Office of Program Policy Analysis
and Government Accountability
111 West Madison Street, Room 312
Claude Pepper Building
Tallahassee, FL 32399-1475

Dear Mr. Turcotte:

Thank you for the opportunity to respond to the conclusions and recommendations included in your draft program review, *Consolidation of Medical Quality Assurance Governance Structure Only a Partial Solution.* Please find enclosed our response to the report recommendations made to the Legislature, and our response to statements found in the report narrative that we found to be in need of clarification or explanation.

If you have any questions regarding this response please contact Rufus Noble at 921-4897 or Kathy Donald at 922-8448.

Sincerely,

/s/
Rhonda M. Medows, M.D.
Secretary

RMM/kd
Enclosure

Agency for Health Care Administration
Response to OPPAGA's Program Review
Consolidation of Medical Quality Assurance Governance Structure Only a Partial Solution

Agency Response to OPPAGA Statements in the Report Narrative:

OPPAGA Exhibit 1, page 3, 1st column:

Agency Response: The total number of complaints, including unlicensed activity and statutory reports (which are reviewed, analyzed and may also result in investigation) are:

Year	Number of Complaints
1998-99	19,641
1999-00	16,682
2000-2001	15,119

OPPAGA Statement - page 4, 2nd column
"A recent OPPAGA report identified several problems with the AHCA's Health Care Practitioner Regulation program that are unrelated to its governance structure. We recommended that AHCA improve its performance in responding to serious complaints against practitioners and facilities."

Agency Response:
The Agency recognized that performance issues needed to be addressed and did so through process mapping and analysis. This resulted in the identification and implementation of immediate improvement opportunities. The Agency, in the last two years, dramatically improved the productivity and the timeliness of our statutory obligations. For example, the program has increased the compliance rate for the analysis, investigation and recommendation of probable cause from 80% in January 2000 to an average of 90% for the first quarter of fiscal year 2001-02. Another example of improvements in the enforcement program is evident in the recognition recently received by the Board of Medicine. The Federation of State Medical Boards rated the Florida Board of Medicine #3 in the nation in the total number of disciplinary actions taken (up from #7 in 1998) and #3 in the number of actions taken amongst the large states, based on the number of licensees (up from #12 in 1998). These improvements are a direct result of a 90% increase of the cases presented by the AHCA enforcement team to the Florida Board of Medicine for disciplinary action.

OPPAGA Statement - page 4, 2nd column
"...we noted that AHCA failed to take timely action to suspend practitioners who represented an immediate threat to the public. Moreover, the program did not meet its legislative performance standard for taking emergency actions against practitioners."

Agency Response:
The Performance Based Budgeting Measures "the % of Priority I complaints resulting in emergency actions" and "the average number of days to take emergency action on Priority I investigations" are but two measures by which to judge the performance of the Agency. Performance improvements are constantly sought by the Agency as can be seen in the increase in the "% of Priority I complaints resulting in emergency actions" from 13% in fiscal year 1999-00 to 29% in fiscal year 2000-01.

OPPAGA Statement - page 5, bottom of 1st column
"...some minor duplication exists because DOH has added processes and personnel to increase oversight of AHCA activities. For example, although AHCA is responsible for determining the legal sufficiency of complaints filed against health care practitioners, the DOH general counsel and Secretary review the plea agreements already approved by the AHCA general counsel. DOH also has added a budget position to the program to oversee the MQA trust fund and the financial arrangements between the agencies."

Agency Response:
The added processes and personnel that DOH has used for the oversight of AHCA activities, including a budget position to manage the financial arrangements, were a positive addition to the oversight of the program. Because a business relationship exists between the departments, each business partner is expected to oversee the terms of the interagency agreement. While the AHCA General Counsel is not a signatory to the settlement agreements, review is done through the General Counsel's office for quality assurance purposes.

OPPAGA Statement - page 5, 2nd column
"DOH also recently established a consumer advocacy section. In the past, DOH would have to rely on AHCA's decision about how cases were handled. One consumer advocate position will review complaints independent of AHCA for consumers who feel inadequate attention was given to their complaint against a practitioner."

Agency Response:
It is AHCA' s understanding that the Consumer Advocacy Section at DOH was created for the purpose of reviewing medical errors, as recommended by the Commission on Excellence in Health Care. Moreover, the agency assumes that the liaison functions were added to establish a mechanism to assist the consumer in obtaining information from one department or the other. AHCA was not advised that this section had any oversight responsibilities over its enforcement activities. The Consumer Advocacy Section generally has not functioned in that capacity as only 5 inquiries have been made spanning from complaints dismissed in 1996 to present. More importantly, of these five inquires, the majority were requested after the consumer had exhausted all statutory avenues and was unwilling to accept the outcome of the Board's decision. The Consumer Advocacy Section assists the consumer in understanding the authority of the regulatory boards.

OPPAGA Statement - page 5, 2nd column
“Management accountability is the expectation that managers are responsible for the quality and timeliness of program performance, increasing productivity, controlling costs, mitigating adverse aspects of agency operations, and assuring that programs are managed with integrity and in compliance with applicable law."

Agency Response:
The Agency established and continuously monitors internal performance measures as well as those that are established by law. For example, the average compliance rate with the 180-day statutory mandate for completion of complaints from analysis through recommendation of probable cause is approximately 90% for the first quarter of fiscal year 2001-02. The 180-day standard is one of the most ambitious in the country.

OPPAGA Statement -page 6, 1st column
"In its 2002-03 Legislative Budget Request, the Division of Administrative Hearings has requested DOH pay $2.3 million for 8,564 hearing hours, which included 7,740 hours of cancelled hearings during fiscal year 2000-01. When an agency cancels a hearing in less than 30 days, the agency is required to pay for the hearing hours that would have occurred. DOH contends that AHCA is responsible for 98% of these cancellations costing approximately $2 million."

Agency Response:
AHCA is required by Florida Statutes to submit cases to the Division of Administrative Hearings within 15 days from receipt of an election of rights for a formal hearing. The analysis of the case that is necessary to lead to a satisfactory settlement in lieu of the formal hearing process cannot be accomplished within 15 days. Given sufficient time for negotiations and the engagement of discovery options, the vast majority of cases generally result in satisfactory settlements. Cases are closed at DOAH (cancellations) as a result of a successfully negotiated consent agreement and are generally in the best interest of the prosecution and the public. However, under the DOAH funding plan, agencies are charged for the hearing time for cases that were cancelled due to a settlement being reached. The hearing cancellation rate for all agencies at DOAH is approximately the same - around 90%. The contract for formal hearings is between DOH and DOAH.

OPPAGA Statement - page 6, 1st column
"AHCA's mission is to assure accessible, affordable and quality health care. Practitioner regulation is more process oriented and focuses on the steps necessary for the efficient intake, investigation and prosecution of cases. DOH's primary mission, to promote and protect the health and safety of all residents and visitors in the state, has led to a more customer service, outcome oriented approach as seen in their new consumer advocacy program."

Agency Response:
The missions of the Agency and the Department of Health are fundamentally the same, to protect the public. The enforcement program is directly responsive to both complainants and respondents (licensees) alike. Internal timeframes and performance standards as well as statutory requirements mandate a process-oriented system to ensure the efficient handling of complaints.

OPPAGA Statement - page 6, 2nd column
"Although AHCA provides enforcement services through an Interagency Memorandum of Understanding, DOH officials told us that AHCA would not agree to include performance standards in the interagency agreement."

Agency Response:
Performance measures were not originally included in the interagency agreement because the Agency did not have the means to collect the data during the conversion to the new DOH database. Moreover, data was unreliable in the early phases of the database conversion and the Agency was working through a backlog of complaints caused by a 43% increase in the number of complaints received in fiscal year 1996-97. Thus, the agency questioned the accuracy of any performance measure based on this backlog as it would not be a true reflection and measure of the work performed. The Agency would not oppose the inclusion of performance measures in the interagency agreement.

OPPAGA Statement - page 7, 1st column
"There is an ongoing dispute between the two agencies regarding AHCA's administrative charges to the program's trust fund for fiscal year 1999-00 and 2000-01. This dispute involves DOH's refusal to release $2.3 million in trust fund reimbursement that AHCA has claimed for program administration. The Legislature resolved the issue of future administrative costs in statute in 2001. However, AHCA is still pursuing the $2.3 million rejected by DOH."

Agency Response:
It is AHCA's position that the intent of the 2001 Legislative action was to resolve the dispute regarding the method of allocating administrative costs, both past and present. The MQA program was transferred to the DOH in July 1997. For fiscal years 1997-98 and 1998-99 administrative costs were charged to and paid by DOH in the same method they have challenged and withheld payment for in fiscal years 1999-00 and 2000-01. The initial challenge to AHCA came in September 2000, at which time DOH notified AHCA of it's intent to reduce administrative costs reimbursements to 5% of the direct costs of the program. In paying the bill for the fourth quarter of fiscal year 1999-00 DOH withheld all administrative costs in excess of 5% of the direct costs for the entire fiscal year (1999-00). The Legislative solution that the OPAGGA Report indicates is for the future is in fact the same method of administrative costs distribution AHCA has been using since it first received the MQA program from the Department of Business and

Professional Regulation. It is AHCA's position that the Legislature validated the methodology AHCA has been using from beginning.

Agency Response to OPPAGA Conclusions and Recommendations:

Conclusion:
Some stakeholder concerns are unrelated to the program's divided governance structure. These concerns include AHCA 's performance and the inherent tension that exists between regulatory boards and enforcement function. However, there is some duplication in program oversight, accountability is diffused, and mistrust and disputes occur between staff from the two agencies.

Agency Response:
The missions of the two agencies are fundamentally the same in that both work first to protect the public. Staff continues to work towards positive resolutions to difficult issues wherever the program resides. AHCA's performance has continued to improve each year as resolutions to the challenges faced by the program are found.

Recommendation:
If the Legislature determines that the program should remain under the current divided governance structure, we recommend that DOH and AHCA work together to make the following changes to improve program accountability, controls, and coordination.

- *Develop an Interagency Memorandum of Understanding that more clearly describes the responsibilities of each agency. The agreement should also contain reasonable performance standards for AHCA such as the length of time for final disposition of a case once the professional board has issued a final order.*

- *Form a group that includes both management and staff from DOH and AHCA to identify ways to improve coordination and communication.*

Agency Response:
Performance measures imposed on AHCA and DOH as partners in any contractual arrangement can only improve the program's performance relative to quality, quantity and timeliness. The OPPAGA recommendation has incorrectly identified the Agency as the responsible party for "the length of time for final disposition of a case once the professional board has issued a final order". In fact, this length of time is not under the Agency's control. The Office of the Attorney General prepares final orders.

The Agency and DOH formed the joint DOH/AHCA Quality Assurance Committee, initially meeting in the winter of 1999. Meetings of that group should, as recommended, continue.

Recommendation:
If the Legislature determines that it wishes to consolidate the program's governance structure to address ongoing concerns, we believe that the optimal placement choice would be DOH. We believe that consolidation of the MQA program at DOH would be more feasible and easier to accomplish because DOH already has statutory authority for the program. In addition, we believe that the statutory leadership of a medical doctor is important to the program and that the drawbacks to DOH are less significant than the drawbacks related to a consolidation at AHCA or DBR.

Agency Response:
Any recommended action adopted by the Legislature will receive the full cooperation of the Agency in its implementation.